PPACA Handbook

Individual & Family Guide

Understanding & Shopping for Health Insurance

By

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PPACA Handbook: Individual & Family Guide
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1st Edition

Forward

This book is intended to serve as a shopping guide for an Individual purchasing insurance for themselves or their family. The hope is that after reading this book, a person can have a better understanding of health insurance and the types of health insurance plan options available for purchase. Reading this book should help a person be able to have a better discussion with a sales representative from an insurance agency or an insurance company. Being able to have a better discussion with individuals that help a person purchase health insurance will help a person make better choices on what health insurance plan best meets their needs or those of their family.

The health plan benefit examples and the examples of typical purchasing situations with possible purchasing options provided in this book are intended as a guide to help in the discussion of the common options and solutions currently available to a person buying health insurance today and in the near future. It is still recommended that a person buying health insurance should work with an experienced sales representative and ask all the questions they have when shopping for health insurance. Please remember that many of the ideas and examples in this book have been simplified in the hope of creating a better understanding of health insurance plans and options.

This book does not include or explain any type of Medicare or Medicaid Plan.

Preface

The History of This Book

The author of this book has over twelve years of experience selling health insurance plans to individuals and business owners. In most situations, a lot of time was spent explaining the basics of health insurance and how it worked to those individuals that were shopping for health insurance plans for themselves, their families or their employees. The idea for writing this book was born at that time.

It is hard to help a person choose a health insurance plan when everyone involved is speaking a different language; meaning the person buying insurance, the insurance agent and the insurance company. Everyone has their own way of explaining the benefits that are paid for by a health insurance plan which makes buying a health insurance plan very confusing to most people.

It is very easy for an insurance sales representative to over-simplify the explanation of the benefits that are covered by a health insurance plan, the application process and the underwriting process to a person shopping for health insurance. Often times, people do not end up having a benefit that was needed but not included in the health plan that was sold to the person. This is why it is important to be able to understand the available health insurance plan options and the pros and cons of the shopping process. It is very important that a person asks many questions and understands what health plan benefits they are getting with their health plan; and that the person knows what the potential out-of-pocket expenses could be if the person goes to the hospital for an emergency or is diagnosed with a serious illness.

The Patient Protection and Affordable Care Act (PPACA) has many changes scheduled to take effect on January 1, 2014. Some of these changes are explained in this book; those that relate to a person buying health insurance for themselves or their family.

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Part One

The Basics of Health Insurance

Chapter 1

A Brief History of Health Insurance

In talking about insurance, and only insurance, we are usually talking about coverage for large unforeseen expenses. Basically, coverage just in case something happens. This is what insurance is designed and intended to provide, a safety net. No one wants to file a claim against their homeowners insurance or their auto insurance. However, when we talk about health insurance, a person thinks that they pay enough for their health insurance; so they either want to get their money back by using it as much as possible; or, they have no choice but to buy it because they are sick and need to get medical treatments. Therefore, when we talk about wanting better health insurance, what we really mean is that we want a better health plan or a healthcare management program that gives us the health care benefits that we need at an affordable price and with reasonable co-payments when we go to the doctor or the hospital. This is why health insurance is different from other kinds of insurance; it's not just about catastrophic coverage.

Health insurance works best when large groups of people are grouped together to allow for the costs of treating and maintaining the health of all the individuals in the group to be spread out across the group, including both the healthy and the unhealthy individuals. This is accomplished by having a large group of healthy individuals in a group that has unhealthy individuals in order to help divide the expenses of the unhealthy individuals across the entire group. Otherwise, if only unhealthy individuals wanted health insurance coverage, it would be too expensive for them to buy it and the co-payments would most likely be unaffordable. For this reason, it is important that groups of people with health insurance not be too small; so that the cost of the health insurance and the day-to-day co-payments can be kept affordable.

The benefits that are included in a health insurance program have changed over the last few decades. The changes have primarily followed the demographic changes of the country over the last few generations and change with every generation. Health insurance first became a benefit offered by employers during World War II because companies needed to hire workers to manufacture all the equipment that was needed for the war effort; and the government froze wages in order to keep companies from taking other companies employees by offering them more money. Today, most people are familiar with the health insurance plans that have been offered in the last 40 to 50 years. There are the Indemnity plans (popular in the 1970's and 1980's), the HMO plans (popular in the 1980's and 1990's), and, currently popular, Consumer Driven or High Deductible Health Plans (CDHPs and HDHPs), with the most popular being the HSA (Health Savings Account) Qualified health plans (starting in 2004). Ironically, HSA plans, were originally the Archer MSA program that started in 1997; and are very similar to the Indemnity plans of the 1970's, except that they allow a person to be able to open a bank account that is tax-deductible in order to pay for their medical expenses.

The old Indemnity plans generally had an individual pay for the doctor's office visit and their prescription drugs out of their own pocket and had a very low hospital deductible or co-payment. However, keep in mind that this was at a time when the doctor's office visit cost was not expensive and there were not as many prescription drugs as there are today and there were very few expensive prescription drugs. The average person in the country

at this time also helped keep the costs of healthcare low as the largest group of people in the country was all children, the Baby Boomers. What this means is that not many people were using the hospital because the country was made up of many young people that were generally healthy. This means that the nation's health care system was not used as much as it is today. Back then, the parents of the baby boomers and the baby boomers themselves were not people that liked to go to the doctor.

The next main change after the Indemnity plans was the change to HMO (Health Maintenance Organization) types of plans, at a time when new medical tests and new prescription drugs were just starting to become available; and the costs of these new tests and drugs were very expensive. The HMO's tried to control costs by managing them through a primary care doctor. For those that remember; there were many issues in the first few years of these HMO plans. The HMOs were able to manage costs while the costs were just starting to increase rapidly by mainly limiting care. For example, if your primary care doctor would not give you a referral to a specialist, you could not go to the specialist unless you paid for it yourself. As time went on, the need for a referral went away, and many primary care doctors would just give referrals to avoid complaints and other issues. The average age of the country made HMO plans good options at the time, the early 1980's, as most of the country was in their mid-to-late 20's. The majority of the Baby Boomers were born between 1957 and 1961 even though the birth years for the Baby Boomers are between 1946 and 1964. Therefore, the nation was still relatively young and healthy, and not rushing to have kids.

Overall, HMOs created a "Free Healthcare" mentality by disconnecting people from the true cost of healthcare services by saying to people; pay the premium and get as much care as you need or want for what were then very small co-payments, typically $5 for a doctor's office visit. The HMOs were not expecting people to use medical care or prescription drugs four times as fast as they did when people had paid the whole expense out of their own pockets. The HMOs also did not expect all the new medical tests and new prescription drugs that became available and how much the tests and drugs would cost. The end results created what we have now, very high usage of our nation's healthcare system with quickly increasing health care costs.

This brings us to the plans of the late 1990's through today, CDHPs (Consumer Driven Healthcare Plans); mainly talking about HSA plans (Health Savings Accounts) which are qualified HDHP's (High Deductible Health Plans) and non-qualified HDHP's which are better known as CDHPs. HSAs offer a tax break if you pay the first few thousand dollars out of your pocket before the health plan pays for any of your covered medical expenses. The CDHPs or HDHPs are plans that have a blend of co-payments and deductibles without the option of getting a tax break. Most common of these are plans that have co-payments on prescription drugs but a deductible on medical services, such as paying the first couple of thousand dollars at the hospital before the health plan pays any expenses. These health plans look very similar to the old Indemnity plans. The expectation is that people will do a better job of taking care of themselves and shop around for their medical services and prescription drugs; so, that they will spend less money on the medical services and prescription drugs.

The fact that individuals spend their own money first should make healthcare providers compete on the prices of their medical services, medical tests, and prescription drugs. The idea is that it should help to lower the rate at which prices rise and people will not use as many medical services or prescription drugs; since people have to think about whether or not they want to spend their money first. The thinking that people will not use as much medical care because they have to spend their own money first has not turned out that way over the last decade. As it turned out, the reality is that if people need medical care; they cannot wait. People have to go the doctor or hospital when they get sick; and they have to take their prescription drugs.

A major reason that can be assumed for why CDHPs, HDHPs and HSAs did not actually slow the costs of medical care is that the average age of a person in the country is now much older than it was a generation ago. The Baby Boomers are now primarily in their 50's and 60's; and most people now have a real need for medical care. Plus, many younger people have medical issues that need to be treated. As more illnesses are found by doctors, there is more of a need for medical care.

There are some changes we are currently in the middle of and more that should come in the next few years. The largest change being that the largest age group in the country, the Baby Boomers, is just starting to really use the nation's health care system. They are already leaving the commercial health insurance marketplace and entering the government managed Medicare program; so Medicare covered people will increase significantly over the next ten years. This is one of the reasons that for the first time in two generations; we are seeing a major change with the passage and implementation of the very controversial (PPACA) Patient Protection and Affordable Care Act, also known as Health Care Reform.

There is some hope that the kids of the Baby Boomers, the generation primarily in their Teen's and 20's today, will help even out the rising cost of health insurance. Even though this young group is not the healthiest generation; they are still young, and that has its own benefits. However, and more importantly, they will only help slow the rising cost of health insurance if they actually have health insurance, whether or not they need it today.

Chapter 2

The Roles of the Interested Parties

Person with Insurance

As a person with health insurance, you may not think that there are things that are expected of you. However, there are two basic expectations that are expected of most people. The first is that you take care of yourself; and the second is that you get your needed medical care. These two points will be clarified in the next two paragraphs in order to create a common understanding of the two points.

Taking care of yourself may seem like a simple statement; but when talking about your health insurance, it is a little more specific in some of the things that are expected of you. The idea is that you will live a healthy lifestyle by maintaining a healthy diet, exercising regularly and not smoking, drinking alcoholic beverages in excess or using non-prescription drugs. Of course, this idea is different for each person; and most importantly, is something that should be discussed with a doctor.

The other expectation is that you go to the doctor for your annual check-ups and take your prescription drugs as directed by the doctor. In getting annual check-ups and physicals, doctors can more easily detect changes to your health and start treating your medical condition when it is a small issue and help avoid it turning into a big issue. The same is true for making sure you take your prescription drugs that help maintain a medical condition and keep you from getting sicker. There are times when the costs can be a problem; but, there are many organizations now that a person can ask for help from that try and help people with the costs in order to help keep them healthier.

Health Care Provider

The primary role of health care providers is to detect, treat and manage your personal health issues for you and with you. There are many types of providers of health care related services; such as doctors, urgent care clinics, surgical centers, hospitals, nursing homes, medical equipment vendors and pharmacies. One important thing to remember is that health care providers are also businesses, meaning they need to make money in order to pay for the costs of providing you with the health care services you need or the costs of the prescription drugs that you need in order to address your health issues. It does not matter if the provider is for-profit or not-for-profit; they still have to pay their operating expenses and the salaries of the people that work for them.

Health care providers are the people that work with you in order to find out what medical conditions you may have and develop a treatment plan for those medical conditions. They will also give you advice on how to get healthy and stay healthy in order to help you not get sick or develop a medical condition. However, as we all know, some people will develop medical conditions due to family history or from the environment in which they live or work; and it is important for the people that fall into this category to work closely with their health care providers to limit their chances of getting sick or to treat illnesses as quickly as possible from when they start.

An item of concern with health care providers these days is the question of how they bill people they provide medical care for; and if they are trying to make too much money from providing medical services, equipment or prescription drugs. This is a major debate in the country at this time and one that will not be addressed here in this book. However, it is one that people should pay attention to and follow as it will help one in negotiating with health care providers over payments for medical services.

Employer

In today's environment, employers struggle with the decision of whether or not to offer health insurance benefits to their employees; and if they do offer health insurance to their employees, how much of the cost the employer will pay. Many people believe that employers should offer health insurance to their employees; however, there is no requirement today that employers offer health insurance to their employees. Starting in 2014, under health care reform, small employers with fewer than 50 full-time equivalent employees are not penalized for not offering health insurance to employees. However, larger employers, with over 50 full-time equivalent employees, will be subject to a penalty if they do not offer health insurance or affordable health insurance to their employees. If the employer decides not to offer health insurance; they will just need to pay a penalty.

An employer or the representative of an employer who is shopping for health insurance benefits for themselves and their company's employees needs to decide, in advance, what the goal of the health insurance program is going to be and what the employer may be willing to trade off to accomplish that goal. Many employers would say that the number one goal is to keep the cost of the health insurance plan as low as possible; since, health insurance is one of an employer's largest expenses. However, and in most cases, the health insurance plan is also an important part of a strong benefits package; and an overall business operations issue when considering the need to Recruit, Motivate, and Retain the key employees of the business. At the end of the day, the insurance sales representative will show an employer options and service the account; but the sales representative is not an employee and is not there to help run the business or deal with the fall-out if an employer chooses the wrong health insurance program for their employees.

It is very important for an employer to understand their employees, their employee's needs, and their business needs when shopping for a health insurance plan. The cost of a health insurance plan is a major factor in the purchasing decision, but not the only factor when deciding what is best for their business and their employees. After all, a business does not operate without employees; and employees are not as productive when they are not happy, out sick on a regular basis, or worried about paying for medical care for themselves or their immediate family members. This is why it is important to work with a sales representative that is both knowledgeable and diligent in helping an employer achieve the goals of the business by helping the employer choose the appropriate health plan design and by properly servicing your account.

Insurance Agent

The primary role of the insurance agent is to help you find and purchase the health insurance plan that is the best fit for you or your business and your situation. The insurance agent is also the person that can be the point-of-contact for your questions on the health plan you purchased. The agent can occasionally even help you resolve claim issues with the insurance companies. Most insurance agents work with multiple insurance companies and can show you many different options. It is important to know that many insurance agents specialize or focus on specific market segments. What this means is that it is important to work with an agent that has a good understanding of the type of product you are looking to buy. For example, if you are buying health insurance for yourself, you should be looking for an agent that has a very good understanding of the Individual health insurance plans available in the State in which you need health insurance coverage.

Another role of the insurance agent is to teach you about health insurance. An insurance agent should be able to teach you what the health insurance policy that you are buying is going to have for benefits and co-payments. This is something that the agent will be able to do for you as long as you are working with them. Agents also have direct contacts at the insurance companies whose products they sell, meaning that they can usually help get an issue resolved faster than you can on your own. If you are working directly with an insurance company, the insurance company provides you with this service; but you are usually calling into a customer service center. This is a very important service that you should think about when buying health insurance, especially since you are already paying for it as part of your monthly health insurance bill payment.

Insurance Company

The insurance companies have many things that they do, but there are two main things that they have to do when it comes to health insurance. One thing they do is process all the claims payments between everyone involved when a person uses the doctor, the pharmacy, the hospital, etc. The other thing that they do is risk management, which is basically managing the costs of medical care and grouping together very large groups of people, so they can best manage the total amount of money they collect and pay out to providers of medical services.

The pooling of insured's allows for the costs of the medical treatments of the insured individuals in a group to be evenly divided among the group. By having a large group of individuals paying for health insurance, including healthy individuals, it helps to make health insurance more affordable for all individuals. Otherwise, if only unhealthy people purchased health insurance, the price would be completely and totally unaffordable, since the insurance company would have to collect enough in health insurance premium payments to cover all the incurred medical expenses, plus cover their overhead or go out of business. This is actually one of the issues we have today, as many healthy individuals are not buying health insurance, and therefore; are not helping keep the premium costs down; and are forcing those that do need health insurance to pay more and more each year. Both young individuals and healthy individuals do not buy health insurance because they do not feel they need it and because they do not understand that uninsured medical claims are extremely expensive.

Another thing that insurance companies do is to help create and run programs that help people take care of medical conditions they have that may need to be treated regularly. The most common of these types of programs that many people are familiar with are Wellness Programs and Disease Management Programs; for medical conditions such as Diabetes and High Blood Pressure. The reasons that these programs are important is that it is much easier to help a person manage their medical conditions than it is to have them keep getting sicker and needing even more medical care. For example, the cost of helping a person manage their high-blood pressure using medication is probably around $2,000 per year, instead of not helping the person treat their condition and the person has a heart attack or stroke and goes to the hospital for treatment that could easily cost $100,000 or more. The best thing about helping keep a person healthier with these programs is that it is better for everyone! The person with insurance can expect to live a longer, healthier and more productive lifestyle; and the healthcare system in the country runs smoother.

Government

The role of government in healthcare is very complicated and every single person you talk to is going to have a different opinion about what it should be now and in the future. In order to keep things simple, it is best to give a recap of the government's general system and some general program summaries. With the passage of the Patient Protection and Affordable Care Act (PPACA), the national discussion has become even more opinionated; and PPACA is discussed further in Part Two of this book avoiding opinion as much as possible.

When you look at health insurance, you suddenly realize that we are still a Nation of Individual States. Health insurance programs, mandates or required coverage's are completely different in each and every State. There are National guidelines, but they are not as specific as each State's guidelines. Therefore, it makes it difficult to have a discussion on a National program when different States have different required benefits in their State specific health insurance plans. However, PPACA has created a basic list of medical treatments that are the minimum required health insurance benefits offered by all health insurance plans nationally starting in 2014.

Another thing that many States do is provide programs for the uninsured, typically through Medicaid for children and the poor, usually with some financial aid from the Federal Government. These programs fill a much needed gap in our healthcare system by focusing on individuals who either cannot afford to take care of themselves, or in the case of children, who need a lot of preventative care. The preventative care for children is very important as it helps keep future medical expenses down by immunizing them and finding and treating any medical issues they may have before those medical issues become serious. Providing basic coverage to the poor is important because helping them manage their health issues is less expensive than having them use hospitals like they are a doctor's office.

In every State, the State Insurance Department usually has a web site with information on the available programs and how a person can find out if they can get help. It is important to know what help is available in your State, as not all insurance sales agents know about all of the available programs in every State. It is very important to see what programs are available in your State, as an available program may be able to help you with a medical condition when an insurance company may not be able to help you.

Chapter 3

Health Plan Review

Provider Networks: PPO, POS, HMO

These are the three types of health insurance plan names most people are familiar with; Preferred Provider Organization (PPO), Point-of-Service (POS) and Health Maintenance Organization (HMO). The main things that these names do is tell you how big the doctor's network is and if you have any benefits if you go out of the health plans doctors network. Historically, they were very different and the benefits they covered were more difficult to understand. However, today, there are not as many differences as many health plans no longer make you go to your primary care doctor to get a referral to go to a specialist; and most health plans today make the doctor get pre-approval for a medical test. None of these health plans usually cover dental benefits, unless it is due to an accident; or vision benefits, other than maybe an annual check-up or an accidental injury.

The main difference between these health plans today is the size of the network of doctors, hospitals and other medical providers that you can go to in order to get care at a lower cost. PPO health plans tend to have large national networks and include coverage for out-of-network services. POS health plans tend to have regional provider networks and also include coverage for out-of-network services. HMO health plans are typically local networks that do not have coverage for out-of-network services. It is important to know when you are trying to decide which type of health plan you want to buy that you know where you will be going to get your medical care. Emergency Care in the Emergency Room is typically covered by all health plans whether or not the emergency care takes place in-network or out-of-network; however, it actually needs to be emergency care and not a cold if you are outside of the health plans network of hospitals and providers.

The other thing you need to think about when buying a health insurance plan is how much it will cost you. One thing to consider is that the larger the network of providers you want to be able to go and see and the more benefits you want the health plan to cover; the more you will pay for the health insurance plan. The easiest way to think about this is that the more you want, the more you pay for health insurance.

Consumer Driven Healthcare Plan (CDHP)

Consumer Driven Healthcare Plans (CDHPs) is the catch phrase for the most recent types of health insurance plans being sold today that were expected to control the increasing cost of health insurance and how many times people use the doctors, etc. The catch-phrase and original program actually started around 1997, when the Archer Medical Savings Account (MSA) program was approved by the government, but only as a test program. The MSA program is the program that became today's Health Savings Account (HSA) program. The most recognized of these types of health insurance programs is the Health Savings Account (HSA) Qualified Plan, which is a specific High Deductible Health Plan and will be explained in the following section.

The idea behind consumer-driven-healthcare is that if you have a financial incentive to take care of yourself; you will take better care of yourself; and, in theory, you will not have to go to the doctor, hospital or other health care providers as much as you do now. By not using these medical services as much as you do today, the overall cost of providing healthcare services nationally will not go up as fast as it has been; and therefore, the future cost of health care should increase slower than it has the last few years. Since you are spending your own money before the insurance company starts to pay for any of the medical services that you use, you are more likely to shop around for your healthcare services. This assumes that you can get actual prices from the health care providers for the medical service you need, so that you can compare prices. Basically, you are being asked to be in charge of how you work with your doctor and figure out the best way to spend your money on medical services. In thinking about CDHP health plans, how much you use the health care system for medical services is very important for you to think about before you buy this type of health insurance plan.

Health Savings Account (HSA) Qualified Plans

HSA Qualified High Deductible Health plans can be explained as a specific group of CDHP health plans that have an up-front deductible and that allow you, if you want to, to pay for your health care expenses with tax free money. The money becomes tax free if you set up a special personal bank account, usually a checking account, which is called an HSA account; and pay your medical bills from that account. However, before you can open an HSA account, you must first have an HSA qualified health plan. In an HSA qualified health plan, the plan deductible applies to just about everything; doctor's office visits, prescription drug costs and hospital expenses. All HSA health plans include Wellness Care as a benefit, meaning that you will not have to pay for recommended wellness visits, such as physicals when you get them.

Many people confuse HSAs with other types of accounts, like Flexible Spending Accounts (FSAs), which many refer to at work as use-it or lose-it accounts. This is not the case with HSAs, as HSA accounts are personal accounts, and if you do not use the money during the year, it stays in your bank account until it is used tax free for medical expenses in the future. Because the HSAs are personal accounts, the bank accounts belong to you and not your employer; so if your employer puts any money in your account, it becomes your money.

The most confusing thing about HSA plans is all of the marketing materials about HSA programs talk almost exclusively about the HSA bank account; and talk very little about the health plan that you have to buy that makes you pay all your medical expenses before the health plan pays any medical expenses. When shopping, you need to look at the health plan that is the HSA Qualified health insurance plan, and decide if you can afford all the medical expenses that you have to pay first. The good things about HSA health plans are that they are less expensive and that you can pay for your expenses with tax free money.

Chapter 4

Universal or Single-Payer

Healthcare Systems

The Universal or Single-Payer Healthcare System is once again a major item of discussion when talking about the affordability of health insurance in this country. It will not be answered in this chapter or this book as it is a very complicated discussion.

Many look at the idea of a single-payer healthcare system as the “only” solution to all of the problems with our current health care system. It is important to know that there still exists a “Private Pay” health care system in many of the countries that have single-payer healthcare systems for those people that can afford to pay for services out-of-pocket instead of having to wait for care.

The idea that these single-payer systems work by limiting access to care, meaning longer waiting times for all medical treatments and the potential closing and consolidation of hospitals and clinics, is only partially true. In fact, today, in this country, many people wait a long time to get their medical care or see a specialist doctor. The reasons that these things happen is not just because the government runs the programs; otherwise our current system would be much better than it is today; and we would not be waiting as long as we do for many of the medical services that we need when we need those medical services.

The overall thing to consider is that a single-payer system is a “system” in these other countries. If you go to a public university to become a doctor, for free, you don’t have huge student loans to pay when you actually become a doctor. You then go to work for a government run hospital which means you do not need to worry about running an office or being sued, because you are working in a government provider network. The thing to think about is that we need to understand that single-payer systems are about more than just negotiating for better prices and guaranteeing everyone health insurance coverage. We need to look at “our system” and look at all the parts of our system if we decide to create a Single-Payer “system” in this country.

A current issue in this country is how much Medicare and Medicaid health care providers are paid by the government. Providers usually get paid a lot less than what it costs them to provide the medical service. The issue is that the private sector, meaning people with their own private insurance and people that get insurance from their employer, have to pay a lot more for their medical services in order to make it so that medical providers do not go out of business. This is a thing we need to make sure we pay attention to or the quality of care in our healthcare system will get worse, and doctors, clinics and hospitals will go out of business. It has become so bad in our country that some healthcare providers in this country are starting to not take health insurance anymore and are now “cash-only” providers of healthcare services. However, the other side of the argument being debated today is if the providers of health care services and products are making too much profit, or operating revenue in the case of non-profit institutions.

Part Two

Patient Protection & Affordable Care Act

“PPACA”

Overview

This section of the book is here to help you understand the very basics of PPACA and how it will affect you and your family personally. It is important to note that many changes have already taken effect since 2010; and that the cost of medical care does not change much at this time. PPACA is not a cure for health care cost control, just a step forward to try and control the cost increases of medical expenses; and a way to make coverage more affordable so that more people can have health insurance.

The greatest impact of PPACA will be on the middle class, meaning the average person that makes under $45,000 per year, or the 4-person family making less than $90,000 per year in Income. Health care reform will also significantly impact “Main Street” businesses, meaning the local “Mom-n-Pop” or local employer, especially Independent Contractors, because health insurance will be Guaranteed Issue and Federally Subsidized. Health care reform health insurance plans are not government insurance! PPACA qualified health insurance plans are private insurance plans that you get help in paying for when you buy it based on your own family income.

Individual States have the option of setting up their own Health Insurance Marketplaces, formerly called Exchanges, which are basically call centers and web sites where you can buy your health insurance; or letting the federal government set one up in their own State. Since you will have to purchase your health insurance through the Health Insurance Marketplace in order to be able to get financial assistance to buy health insurance from the federal government; it is important that you pay attention to how your State decides to set up its own Health Insurance Marketplace.

Chapter 5

Health Plan Benefits Overview

PPACA became a new law back in 2010 and it started a series of changes in the way health insurance will be purchased by individuals, their families and everyone else in the country. The biggest changes will take effect on January 1, 2014; which is when you are guaranteed to be able to buy health insurance whether you are sick or healthy and that you may even get help paying for your health insurance from the federal government. The health insurance plans available to you will also be offered under simpler and new "Metal Plan" categories, such as Silver & Gold. The goal of PPACA is to get everyone health insurance at a price that each person or family can afford to pay based on their own or their family's income.

One important thing that seems to be lost in the debate is that you will be purchasing a "private" health insurance plan, just as you do today. You are not buying a health insurance plan from the government. The main difference is that you will have another place where you can buy health insurance, a Health Insurance Marketplace or Exchange. You may even receive financial assistance for purchasing your health insurance plan from the federal government; but, only if you buy the health insurance plan through a government Health Insurance Marketplace.

Federal government assistance for purchasing insurance is not a new concept; as most farmers' today buy federally subsidized crop insurance from private insurance companies with financial assistance from the federal government; so that if they lose their crops, they can still get some money from their insurance company and hopefully not lose their farm to debt collectors.

There are other major changes to health insurance plans that will be sold in the country. The federal government has created a list of minimum medical benefits that must be covered by a health insurance plan anywhere in the country; and added many other options that help people get and keep health insurance coverage. Some examples of these new changes are; 1) everyone is guaranteed to be able to purchase a health insurance plan no matter how healthy they are at the time; 2) kids can stay on their parents health insurance plans up until they are 26 years old; 3) health insurance plans will be sold on a "community rate" basis, which means no more different rates for men and women; and age brackets will be in one-year increments; and 4) if a State allows it, an insurance company can charge a smoker up-to 50% more for their health insurance than the rate they charge a non-smoker.

A very important new change is the creation of Essential Health Benefits. Basically, Essential Health Benefits (EHB's) are a list of medical services that the federal government says must be covered in every health insurance plan that someone buys after January 1, 2014 as the minimum list of covered health insurance benefits. A health insurance plan can cover more than these minimum covered benefits, but the health insurance plan cannot cover fewer than these minimum covered benefits. In addition, each State can decide whether or not they want more benefits to be covered before an insurance plan is sold in their State. Therefore, it is important that State's decide early if they are going to require health insurance plans sold in their State to cover additional benefits or medical services for the people that live in their State.

Essential Health Benefits

1. Ambulatory Services, like Out-Patient Surgery.
2. Emergency Services, like Emergency Room Care.
3. Hospital Care.
4. Maternity and Newborn Care.
5. Mental Health and Substance Abuse Care, including Behavioral Care.
6. Prescription Drugs.
7. Rehabilitative and Habilitative Care.
8. Laboratory Services.
9. Preventive and Wellness Care, including chronic disease management.
10. Pediatric Services, including Dental and Vision Care for kids.

Medicaid Changes

Medicaid is also changed by PPACA. For Medicaid; the major change is the expansion of Medicaid Eligibility from 58% of Federal Poverty Level (FPL) income to 133% of FPL income. The 100% level of 2012 FPL for a family of 4 is approximately $23,000 in income, and for an individual, it is approximately $11,000 in income. This will also mean that people that are eligible for both Medicaid for Medicare will now qualify for additional financial assistance through Medicaid. Medicaid will also begin to cover Preventative Care; such as Annual Physicals and Immunizations at no cost.

Individual Federal Medicaid Eligibility Annual Income:

Currently Maximum Annual Income (est.)	$ 6,400
New Maximum Annual Income (est.)	$ 14,600

Family of Four (4) Federal Medicaid Eligibility Annual Income:

Currently Maximum Annual Income (est.)	$ 13,300
New Maximum Annual Income (est.)	$ 30,600

Important: If you live in a State that provides Medicaid to people with much higher incomes than above, you need to check and see if your State is planning to change to the new Federal income level in the table above; or, what the State plans on doing after January 1, 2014 when the above changes go into effect. Some States that allow for people to make more money than the current Federal income level above are actually considering making the Medicaid eligibility income the same as the new Federal incomes. This would mean that if you currently have Medicaid you could lose your Medicaid coverage and have to buy your health insurance plan through a Health Insurance Exchange where you should be eligible for financial help from the federal government to help you buy a health insurance plan.

Chapter 6

Metal Tier Health Plans

Explanation and Examples

The types of health insurance plans you will purchase are being renamed and placed into categories based on how good the health insurance benefits are in each category or "Metal Tier". They are called Metal Tiers because the tier names are based on the names of actual metals; Platinum, Gold, Silver and Bronze; just like the Olympic Medals. The health plans with the lowest copayments and the best benefits are placed into the Platinum Tier; and the basic plans that have a lot of out of pocket expenses on your part and cover the minimum required benefits, will be the plans on the Bronze Tier.

The health plans you purchase today will be placed into one of these tiers along with the many health insurance plans that will be offered in the future. The tiers are based on something called "Actuarial Value" (AV), which is a term comparing how much a person is expected to spend every year on medical services and how much of the medical expenses a person pays out of their pocket. You can think of it as, if you are expected to have $10,000 in medical expenses in a year; a Gold Plan will pay for 80% meaning $8,000 of your medical expenses and you will pay for the other 20%, meaning $2,000.

What does all this mean in actual dollars; no one is really sure at this point in time. This is one of those items that will be figured out between now and October 1, 2013, by States and their Health Insurance Marketplaces. Basically; the general description is:

<u>Metal Tier is based on Actuarial Value (AV)</u>

Platinum Tier Plans pay 90%
Gold Tier Plans pay 80%
Silver Tier Plans pay 70%
Bronze Tier Plans pay 60%

There will also be a limit as to how much each person and each family will spend on Out-of-Pocket expenses based on In-Network medical expenses. The maximum annual out-of-pocket expenses during the year for individuals and families that have a health insurance plan is based on each persons and each family's annual income and is limited to the current HSA health plan limit: estimated at $6,500 for a person and $13,000 for family in 2014.

The minimum required health plan that a person can purchase for themselves or their families will be a Bronze Tier health plan. Otherwise, there is the potential to pay a penalty for not purchasing federally mandated health insurance coverage, unless you qualify for a waiver based on your income. The Bronze Tier plan appears to be the most similar to what people have today based on general research. The Bronze Tier plan may actually be better coverage than most people have today because the new health insurance plans have minimum required Essential Health Benefits (EHB's).

Special Silver Tier Alternative Plans

There will be three additional Actuarial Value health plan options for people that have incomes of between 100% of the FPL and 250% of the FPL. These additional options are available so that people with lower incomes can get a better health insurance plan and still get the federal subsidy when they are buying a health insurance plan through the Health Insurance Exchange; because a person needs to buy a Silver Tier health plan or better in order to get financial assistance to help them pay for the health insurance plan. These three alternate health insurance plan options are only available for people with lower incomes. These health insurance plan options have lower cost-sharing or lower co-payments; and lower maximum annual out-of-pocket expenses.

The Alternate Silver Plans are cost-reduction health plans and are as follows:

100-150% of FPL = 94%, similar to Platinum Plan
150-200% of FPL = 87%, similar to Gold Plan
200-250% of FPL = 73%, similar to Silver Plan

Basically, these three alternate Silver Tier health plan options give people with lower incomes a lower amount of money that they have to spend out-of-pocket on their medical expenses. If you refer to Appendix A and the page titled “Examples of Alternative Silver Tier Plan Benefits”, you will see examples that were created using the Actuarial Value Calculator available online from CCIIO (The Center for Consumer Insurance & Information Oversight). A link to the CCIIO web site and Calculator is provided in Appendix B.

Chapter 7

The Individual Mandate & Penalty

A major part of health care reform is the requirement that everyone must purchase health insurance or pay a penalty, or a tax as it has been renamed. The simplest point, and one example, that can be made in this extremely complicated area of health care reform and the mandate to buy health insurance is this: when we talk about covering cancer treatments as a mandated health insurance benefit; it is not the treatments we are talking about, but the fact that the treatments are saving people's lives, including children. Currently, there are many mandates placed on health care providers; such as hospitals having to treat uninsured patients and Medicare enrollees having to purchase Medicare Part D. If all mandates were to be eliminated; health insurance companies would realistically only offer health insurance plans that covered only very low risk health issues and all healthcare would be pay-as-you-go non-covered benefits. The reason is that health insurance is really not "insurance" as we think of insurance, which is normally just a back-up in case something goes wrong as in the case of a car accident or a home fire. Health insurance as we think of it today is really a health care program that provides benefits that we plan on using on a regular basis.

The "penalty" for not buying health insurance is what many people are talking about at this time. The penalty looks at how much the lowest cost Bronze Tier health insurance plan will cost you, since it is the minimum level of health insurance plan that you are required to buy. If the cost of the minimum available Bronze Tier health insurance plan is more than 8.05% of your income, you do not have to pay a penalty. Generally, this means that most of the middle class will get a "waiver" from the mandate and not have to pay a penalty. Since a family health insurance plan costs approximately $16,000 per year to insure a family, the family would need to have an income of almost $200,000 per year to actually have to pay a penalty. That is estimated by dividing $16,000 by 8.05% which results in just under $200,000.

Important: If you are eligible for a Subsidy, financial assistance, that makes it so that you can buy a health insurance plan through a Health Insurance Marketplace for less than 8.05% of your income, you will most likely be subject to the penalty. This means that if your income is 250% of Federal Poverty Level or below; you will probably have to pay a penalty if you do not buy health insurance.

The annual penalty is the greater of 1% of family income or $95 in 2014, the greater of 2% of family income or $325 in 2015, and the greater of 2.5% of family income or $695 beginning in 2016. Other than for those people with income at or below 250% of Federal Poverty Level, if you estimate the difference in income between the waiver and penalty, you can see that the penalty will generally affect households with incomes over 800% of the Federal Poverty Level. These are the same people that are the most likely to have their health insurance provided to them through their employer.

It is important to note that the penalty is calculated and charged when you do your taxes for the year you were supposed to have health insurance coverage. For example, when you do your taxes for 2014 at the beginning of 2015; that is when you will be charged the penalty, if you owe one.

Chapter 8

Government Subsidies

The goal of health care reform is to get everyone to be covered by a health insurance plan at an affordable price, so that everyone is paying their fair share based on their own or their family's income. If you make between 133% and 200% of FPL (Federal Poverty Level); each State has the option of offering you what is called a BHP (Basic Health Plan) that is run by the State. It is not expected that most States will offer BHPs unless they are low healthcare cost States because the State may have to pay for some cost of the offering the BHP. The 100% adjusted gross income based on the FPL for a family of 4 is approximately $23,000 in income, and for an individual it is approximately $11,000 in income; both are based on 2012 income standards. This means that a family of 4 with annual income under $46,000 could qualify for the BHP, if the State in which they live offers a BHP. Otherwise, they can buy a health insurance plan through a Health Insurance Marketplace and get help from the federal government to pay for part of the monthly cost of the health insurance plan.

The following table provides a guideline on how the Premium Credit subsidy will be calculated, and is based on household income. Basically, this means that it shows you approximately what you will pay for a health insurance plan through a Health Insurance Marketplace. The subsidy is based on the 2nd lowest cost Silver Plan that you can buy on your State's Health Insurance Exchange. There is also a Cost Sharing subsidy based on what one actually spends that will help a person or a family that has income that is between 100% and 250% of FPL, so that the annual maximum Out-of-Pocket expenses will be even lower than the standard Silver Tier plan. *In order to get the federal subsidy that helps you pay for your health insurance, you must purchase your health insurance plan through a Government Health Insurance Marketplace!*

What will you pay for health insurance? It depends on your income.

Family Income		Maximum Cost of Health Insurance
100% - 150% FPL	=	2.00% - 4.00%
150% - 200% FPL	=	4.00% - 6.30%
200% - 250% FPL	=	6.30% - 8.05%
250% - 300% FPL	=	8.05% - 9.50%
300% - 400% FPL	=	9.50%*

*The 9.5% number is important for Employer and Financial Assistance Eligibility, please see the final section in this chapter for details.

<u>Estimated Monthly Health Plan Cost</u>
(Based on 2012 FPL Income)

Monthly Health Plan Cost for an Individual:

100% or $ 11,000/yr = $ 20
150% or $ 16,500/yr = $ 90
200% or $ 22,400/yr = $ 120

250% or $ 28,000/yr = $ 190
300% or $ 33,500/yr = $ 265
400% or $ 45,000/yr = $ 355

Monthly Health Plan Cost for a Family of Four:

100% or $ 23,000/yr = $ 40
150% or $ 34,500/yr = $ 185
200% or $ 46,100/yr = $ 240
250% or $ 57,600/yr = $ 390
300% or $ 69,150/yr = $ 550
400% or $ 92,200/yr = $ 730

In addition, all of these qualified health insurance plans will have Maximum amount of Out-of-Pocket expenses for Individuals and Families that are covered by the health insurance plan and it will based on the HSA limits for you or your family. In 2014, the HSA limits are expected to be $6,500 for Individuals and $13,000 for Families. However, individuals and families with lower incomes will have lower out-of-pocket maximum expenses. In the table below, an estimate of those Maximum-Out-of-Pocket or MOOP expenses is listed by income level.

Family Income and Estimated MOOP
(Based on 2012 Income Limits)

100%-200% FPL = $ 1,983 Individual / $ 3,967 Family
200%-300% FPL = $ 2,975 Individual / $ 5,950 Family
300%-400% FPL = $ 3,987 Individual / $ 7,973 Family
Over 400% FPL = $ 5,950 Individual / $ 11,950 Family

IMPORTANT: If you are eligible for Medicaid; you will probably have to enroll in Medicaid; and not be able to get a subsidy!!! In addition, if you apply for a subsidy, your children may have to enroll in Medicaid. Otherwise, you buy a full price health insurance plan.

If an Employer Offers You a Health Insurance Plan

If your employer offers you a health insurance plan for you or your family and your cost for your part of the health insurance plan based on the employee only cost of the employers health insurance plan and it is less than 9.5% of your income, see table above; you cannot get a federal subsidy to help you pay for a health insurance plan that you buy personally through a health insurance exchange.

If your employer offers you a health insurance plan for you or your family and your cost for your part of the health insurance plan based on the employee only cost of the

employers health insurance plan and it is more than 9.5% of your income, see table above for 400% of FPL income; you do not have to buy your health insurance plan through your employer. This means that you can turn down your employer's health insurance plan, and you can still go to the health insurance exchange and get financial assistance from the federal government to buy a health insurance plan for you or your family.

The Smoker versus the Non-Smoker Charge

The law allows for insurance companies to charge smokers up-to 50% more than what a non-smoker pays for the exact same health insurance plan, as long as the state allows it; and most states are allowing the 50% mark-up.

The financial assistance that you get to buy insurance from the government is based on the non-smoker rate; so the 50% mark-up is 100% paid by you.

Chapter 9

Health Insurance Marketplaces

{Originally referred to as Health Insurance Exchanges}

Government

Individual States are in the process of setting up what are called Health Insurance Marketplaces. Basically, Health Insurance Marketplace will be call centers and web sites where you can buy your health insurance. They will simply be another store you can go to where you can compare and buy health plan insurance plans knowing that all the health plans cover the same minimum required medical benefits. The main difference in the price that you pay will be what you pay when you use the health insurance plan at the doctor, hospital, pharmacy, etc. You will still be able to work with an insurance agent or sales representative to purchase your health insurance plan like many people do today. There will also be newly created types of certified people that will be able to help you on a very local level sign up for the new programs that will be called Navigators and In-Person Assisters.

After January 1, 2014, anyone can buy insurance without having to worry about pre-existing medical conditions either directly from an insurance company or through a Health Insurance Marketplace. In some States, there will be two types of Health Insurance Marketplaces; one for individuals and one for small businesses. Since you will have to purchase your health insurance through the Health Insurance Marketplaces in order to get financial help from the federal government; it is important that you pay attention to how your State sets up its own program.

If your State does not set up its own Health Insurance Marketplace; then the Federal Government has the right to set up its own program in your State. This is important to know because all the States have many differences in the medical benefits that they make health insurance plans pay for in the form of additionally required State mandated benefits. These additional State mandated benefits are in addition to the federally required Essential Health Benefits; and are usually specific to each and every State and put in place by each State in order to address local community medical issues. If a State lets the Federal Government set up and run the Health Insurance Marketplace for them, then the health insurance plans that are sold through that particular Marketplace may not cover the same medical benefits as health insurance plans that are sold outside of the Marketplace. This means that some people may not be getting some of the State specific health plan mandated benefits that they get today.

Private

Private Health Insurance Marketplaces are fairly common today. A private health insurance marketplace is basically a store for insurance. Private marketplaces are operated by some associations or organizations in order to provide their members with an alternative to buying insurance on the open market. There are even some brokers that set up private marketplaces for their clients, and they can be set up for individual or business clients. The idea is that if a group has a lot of people enrolled or enough groups combined have a lot of people enrolled through the private health insurance marketplace; the marketplace may be able to get better pricing or at least offer different plan design or health insurance coverage options than are available in the open market.

Private health insurance marketplaces should continue to exist and even expand after October 1, 2013, when the government health insurance marketplaces start to open. They are seen as a being able to operate alongside and even support the government health insurance marketplaces. Individuals should even be able to access the government health insurance marketplaces through a private health insurance exchange, meaning that individuals should still be able to purchase health insurance plans and still get financial assistance from the government for buying their individual health insurance plans as these private marketplaces are expected to be able to work with the government marketplaces. The main difference will be that the private marketplaces will have more options, including different types of insurance; and be able to show people health insurance plans that are available through the private marketplace as well as the health insurance plans that are available through a government, State of Federal, health insurance marketplace with or without financial assistance from the government.

Part Three

How to Shop for

Individual Health Insurance Plans

Overview

This section of the book is the shopping guide. In has a brief explanation on how to pick a health plan; personal situations with possible solutions; and has some sample health plan designs. The sample metal tier benefit plan designs are included in Appendix A that follows the shopping guide. The plan designs are there in order to help you have a talk about the health plan you want to buy or help you better understand the health plan that you want to buy.

In general, the things that you want to think about when you are buying a health insurance plan are; do you want co-payments or deductibles on some or all of the medical services that you will need to use once you have health insurance. The important thing to think about when you make your final decision is to make sure the health insurance plan is affordable and that the health insurance plan covers the medical services that you need after you buy the health insurance plan. Since you are the buyer, you are the person responsible for making sure you get the right health insurance plan. The sales representative is there to help you, but you need to make sure you ask all the questions you need answered.

Remember; the health insurance plan designs and solutions being provided in this book are a guide that can help you; so that you can have a direct talk with a knowledgeable advisor or sales representative when you are shopping for health insurance.

Chapter 10

Overview:

How to Pick a Health Insurance Plan

When you are looking to buy a health insurance plan for yourself or your family, you need to make sure the health insurance plan covers the medical services that you need; and that you can afford to pay for it. At this time, and until January 1, 2014, individual health insurance plans are usually medically underwritten, meaning that the insurance company asks you lots of medical questions and the insurance company can turn you down for coverage if you are not perfectly healthy. Today, the insurance company, can also cancel your policy until you have it for 2 years and can cancel it all the way back to the first day, if you forget to tell them about a pre-existing medical condition and they find out about it during the 2 year time period. However, starting on January 1, 2014; all new health insurance plans will be guaranteed issue, meaning you no longer can be turned down if you have a pre-existing medical condition. Therefore, you will not need to worry about the 2 year cancellation period.

When you apply for a health insurance plan, you need to think about what benefits you need; how much you will pay for the health insurance plan; and how much you will pay when you use the health insurance plan at the doctor, pharmacy, hospital, etc. If you are worried about keeping what you pay for the health insurance plan low, then you must be willing to pay more when you go to the doctor, pharmacy, hospital, etc. Basically, the less you pay when getting medical care, the more you pay for the health insurance plan, and vice-versa. The examples of health insurance plans that are included at the end of this book; Health Plan A through Health Plan D, are put in order from the most expensive plan (Health Plan A – Platinum Tier Plan) to the least expensive plan (Health Plan D – Bronze Tier/HSA Qualified Plan). This should help you to understand that the cost of a health plan is based on how much you pay when you go to the doctor, pharmacy, hospital, etc.

The CDHP, HDHP and HSA qualified health insurance plans tend to be less expensive because you are buying a health insurance plan that has you pay a lot of your medical expenses before the health insurance plan starts paying your medical expenses. Some of these health insurance plans have you pay a lot on some of your medical expenses first, like only at the hospital; while other health insurance plans have you pay first for all of your medical and prescription drug expenses before the health insurance plan pays any of your medical expenses.

HSA qualified health insurance plans allow you to set money aside tax free in an HSA bank account for your medical expenses, but you also have to pay most of the medical expenses first. You do not have to set up the HSA bank account to get a tax break; because you get the tax break for just depositing the money in the bank account, whether or not you spend it on medical expenses; so there is no reason not to set up the bank account.

Buying Health Insurance under PPACA

As of January 1, 2014, the way you buy health insurance is going to be completely different than it has been your whole life. The new health insurance plans are guaranteed issue, meaning that you cannot be denied coverage if you have a pre-existing condition; and the health insurance plans have to cover the entire list of Essential Health Benefits, at a minimum. Many States will require that the health insurance plans that you can buy in your State must also cover the State's additionally required medical benefits or mandates. This basically means that you know that when you buy a new health insurance plan that it is going to cover all of the basic medical services that you may need; and that all the health insurance plans sold in your State have to cover the same medical benefits, if not more medical benefits.

The other major difference is that you will have an additional place or online store where you can go to buy a health insurance plan on your own or with the help of a broker, navigator or in-person assister. These Health Insurance Marketplaces are the place where you need to go to in order to be able to purchase your health insurance if you want to be able to get financial assistance from the federal government to help you pay for the health insurance plan. You will be able to buy a health insurance plan by paying a percentage of your income instead of the full cost of the health insurance plan. The health insurance plan that you will have to buy will need to be a Silver Tier health insurance plan, at a minimum, in order to get the financial assistance from the federal government; so it should be a health insurance plan with reasonable benefits.

When you go to the government Health Insurance Marketplace, they will be able to tell you if you are qualified for Medicaid, which will now be 133% of Federal Poverty Level (FPL) instead of the current 56% of FPL. They will also be able to tell you the amount of money or financial assistance that you will be getting from the federal government. If you want to use that money to buy a better health insurance plan, you can use the money to buy the better health insurance plan; but, you will not get any more money than the amount of money that you are told you will be getting for financial assistance to buy the better health insurance plan.

It is very important that you know that if you or your family make less than 400% of FPL, what you pay for your health insurance plan will most likely depend on what you or your family's income is when you buy your health insurance plan. For example, at the beginning of 2014, when you apply for a health insurance plan through the Health Insurance Exchange; there is a computer check done to see what you reported to the IRS as your income in 2012, the most recent year that the computer can check. The financial assistance you get from the federal government is based on the income you reported on your taxes to the IRS in 2012. If your income changes or has changed since you filed your income taxes, you will need to notify the Health Insurance Marketplace; so that they can figure out what you should be paying for your health insurance plan.

<u>Important:</u> If your income is higher at the end of the year when you file your taxes with the IRS; you will be asked to pay back the amount of money that

you got in financial assistance that was more than what you should have been getting in financial assistance from the federal government for that year.

If you or your family's income is greater than 400% of FPL; or you find that you can buy the minimum required Bronze Tier health insurance plan for less than the Silver Tier health insurance plan, even with the financial assistance from the federal government; you will be buying your health insurance plan at the actual price of the health insurance plan. You will not need to buy a health insurance plan through a Health Insurance Marketplace; unless that's the only way your state is now letting health insurance plans be sold in your state. However, you may find that it is easier to shop for a health insurance plan by using a Health Insurance Marketplace's online store; because it will allow you to more easily compare a variety of available health insurance plans and sign up for a health insurance plan directly through the web site or over the phone.

In summary, you need to think about you and your families own financial situation and any medical issue that you may have when you are shopping for a health insurance plan. You need to know what, if any, trade-offs you are willing to make when you are ready to buy your health insurance plan. For example; do you want a health insurance plan that makes you pay all your expenses first; or do you want a health insurance plan that pays most of the expenses for you when you go to the doctor, pharmacy, hospital, etc., so that you have very low co-payments? It is important that you do not rush into a decision, and be honest with the sales representative or person that is certified to help you choose a health insurance plan; because, in the end, you or your family are responsible for all of the medical expenses, not the person assisting you.

Also, make sure you read through the health insurance policy when you get it; and that the health insurance policy you bought is the health insurance policy that you thought you bought when you bought it. Almost all insurance companies allow you to cancel a new health insurance policy within a few days of you getting the policy delivered to you for a full refund of any payments you may have made for the insurance. Therefore, you should use those first few days to confirm that you got the health insurance plan that you thought you bought when you bought it.

The next chapter of this book will give you some ideas on how to make a decision to purchase a health insurance plan for yourself and your family. However, please keep in mind; they are ideas and will not apply to each and every situation that is like the one that is shown in the example situations.

Chapter 11

Examples of Situations

& a Possible Solution

This chapter of the book is here to assist you in your conversations with your health insurance plan advisor or sales representative when you are purchasing your health insurance plan. The situations presented are example situations and ways to think about a possible solution are provided with the reason why that solution may be a possible solution. These examples are here to help you make a decision, but please be careful and make sure you speak to a professional before making your final decision as these are just examples. Your situation may look like one of these situations, but everyone's situation is unique.

The example situations and possible solutions have their own title in bold and the explanation under the title. Please note, you can read each and every situation on its own; so you can read them each on their own.

I am currently on Federal Medicaid

If you are currently on Federal Medicaid for your health insurance today, you should be able to stay on Federal Medicaid under PPACA. The main difference is that you may be able to make more money working and still stay on Federal Medicaid. The extra money you make may change some of the other benefits you may be getting today; so you should ask when you submit your annual paperwork.

For example, to qualify for Federal Medicaid today; a family of four people can only make around $13,000 per year in 2012. In 2014, under PPACA, a family of four can make around $30,500 per year and still be on Federal Medicaid. In you are a single person; you can make around $6,500 per year in 2012. In 2014, you can make around $14,500 per year and still be on Federal Medicaid.

I am currently on State Medicaid

If you live in a State that provides State Medicaid to people with much higher incomes than Federal Medicaid income levels, you need to check and see if your state is planning to change to the new Federal Medicaid income level; or, what your state plans on doing after January 1, 2014, when the changes go into effect.

For example, to qualify for Federal Medicaid today; a family of four people can only make around $13,000 per year in 2012. In 2014, under PPACA, a family of four can make around $30,500 per year and still be on Federal Medicaid. In you are a single person; you can make around $6,500 per year in 2012. In 2014, you can make around $14,500 per year and still be on Federal Medicaid.

However, some States have "State Medicaid" programs that allow for people to make more money than the current Federal Medicaid income levels, and are actually considering making the State Medicaid eligibility income level the same as the new Federal Medicaid income level. This would mean that if you currently have State

Medicaid, you could lose your State Medicaid coverage! This would mean that you would have to buy your health insurance plan through a Health Insurance Marketplace where you should be eligible for financial help from the federal government to help you pay for the health insurance plan.

I have been told I make a little too much money to be on Medicaid

If you have tried to get Federal Medicaid for yourself or your family and you have been told you make a little bit too much money to be able to get Federal Medicaid; you may now find that you may be able to get Federal Medicaid in 2014. The reason is that in 2014 under health care reform, PPACA, you can make up-to around $14,500 per year and still be able to get Federal Medicaid. If you are a family of four, you can make up-to around $30,500 per year and still be able to get Federal Medicaid. However, please remember that some States have State Medicaid programs that allow people to make more money than the Federal Medicaid program and still be able to get State Medicaid.

If you make more money than the new maximum allowed income in order to be able to get Federal or State Medicaid, you will be able to go to a Health Insurance Marketplace in your state and buy a health insurance plan that is based on your or your family's income. This means you should still be able to get financial assistance from the federal government to be able to buy a health insurance plan that is based on your own personal or family income.

What you will want to consider when you are picking a health insurance plan for yourself or your family is what makes more sense for your personal situation. You may be generally healthy and just want a health insurance plan to protect you in case of emergencies; meaning that you pay all the bills up until a certain point and then the health insurance plan pays the bills. You may take medications and go to the doctor regularly; so you may want to get a health insurance plan that pays for most of your medical expenses right away instead of after you spend a lot of money first. The thing to keep in mind is what you will pay for the health insurance plan. If the health insurance plan pays for your bills right away; it is probably going to cost you more than if you pay all your bills before the health insurance plan pays any of your bills.

I am a legal immigrant that has been in the USA for less than 5 years.

If you are a legal immigrant and you have been in this country for less than five years, you cannot get Medicaid.

However, you will be able to buy a health insurance plan directly from an insurance company or through a Health Insurance Marketplace in your State; and still get financial assistance from the federal government to be able to buy the health insurance plan that is based on your own personal or family income. If you make too much money to be able to get financial assistance; you can still buy a health insurance plan.

What you will want to consider when you are picking a health insurance plan for yourself or your family is what makes more sense for your personal situation. You may be generally healthy and just want a health insurance plan to protect you in case of emergencies; meaning that you pay all the bills up until a certain point and then the health insurance plan pays the bills. You may take medications and go to the doctor regularly; so you may want to get a health insurance plan that pays for most of your medical expenses right away instead of after you spend a lot of money first. The thing to keep in mind is what you will pay for the health insurance plan. If the health insurance plan pays for your bills right away; it is probably going to cost you more than if you pay all your bills before the health insurance plan pays any of your bills.

I am less than 19 years old.

If you are less than 19 years old, you are probably able to get Medicaid. If you cannot get Medicaid, you can buy a health insurance plan directly from an insurance company or through the Health Insurance Marketplace in your state. If your parents have a health insurance plan, and you do not have any dependents; your parents should be able to keep you on or add you to their health insurance plan.

If you do not stay on or get added to your parent's health insurance plan, you can buy your own health insurance plan. If you go through the Health Insurance Marketplace in your state; you may be able to get financial assistance from the federal government to be able to buy a health insurance plan that is based on your own personal or family income. If you make too much money to be able to get financial assistance; you can still buy a health insurance plan. You may even be able to buy a health insurance plan that is more like a "just in case" health insurance plan. What this means is that you pay all your medical expenses up-to a certain point and then the health insurance plan pays the rest of your expenses. This type of catastrophic health insurance plan will probably cost you a lot less than for a health insurance plan with low co-payments.

What you will want to consider when you are picking a health insurance plan for yourself or your family is what makes more sense for your personal situation. You may be generally healthy and just want a health insurance plan to protect you in case of emergencies; meaning that you pay all the bills up until a certain point and then the health insurance plan pays the bills. You may take medications and go to the doctor regularly; so you may want to get a health insurance plan that pays for most of your medical expenses right away instead of after you spend a lot of money first. The thing to keep in mind is what you will pay for the health insurance plan. If the health insurance plan pays for your bills right away; it is probably going to cost you more than if you pay all your bills before the health insurance plan pays any of your bills.

I am under 26 years old.

If you are less than 26 years old, do not have any dependents and your parents have a health insurance plan; your parents should be able to keep you on or add you to their health insurance plan. If you make too much money to get Medicaid, you can buy a health insurance plan directly from an insurance company or through the Health Insurance Marketplace in your home state.

If you do not stay on or get added to your parent's health insurance plan, you can buy your own health insurance plan. If you go through the Health Insurance Marketplace in your state; you may be able to get financial assistance from the federal government to be able to buy a health insurance plan that is based on your own personal or family income. If you make too much money to be able to get financial assistance; you can still buy a health insurance plan. You may even be able to buy a health insurance plan that is more like a "just in case" health insurance plan. What this means is that you pay all your medical expenses up-to a certain point and then the health insurance plan pays the rest of your expenses. This type of catastrophic health insurance plan will probably cost you a lot less than for a health insurance plan with low co-payments.

What you will want to consider when you are picking a health insurance plan for yourself or your family is what makes more sense for your personal situation. You may be generally healthy and just want a health insurance plan to protect you in case of emergencies; meaning that you pay all the bills up until a certain point and then the health insurance plan pays the bills. You may take medications and go to the doctor regularly; so you may want to get a health insurance plan that pays for most of your medical expenses right away instead of after you spend a lot of money first. The thing to keep in mind is what you will pay for the health insurance plan. If the health insurance plan pays for your bills right away; it is probably going to cost you more than if you pay all your bills before the health insurance plan pays any of your bills.

I just graduated from college.

If you are less than 26 years old, do not have any dependents, and your parents have a health insurance plan; your parents should be able to keep you on or add you to their health insurance plan. If you are over 26 years old and you make too much money to get Medicaid, you can buy a health insurance plan directly from an insurance company or through the Health Insurance Marketplace in your home state.

If you do not stay on or get added to your parent's health insurance plan, you can buy your own health insurance plan. If you go through the Health Insurance Exchange in your state; you may be able to get financial assistance from the federal government to be able to buy a health insurance plan that is based on your own personal or family income. If you make too much money to be able to get financial assistance; you can still buy a health insurance plan. If you are under 30 years old, you may even be able to buy a health insurance plan that is more like a "just in case" health insurance plan. What this means

is that you pay all your medical expenses up-to a certain point and then the health insurance plan pays the rest of your expenses. This type of catastrophic health insurance plan will probably cost you a lot less than for a health insurance plan with low co-payments.

What you will want to consider when you are picking a health insurance plan for yourself or your family is what makes more sense for your personal situation. You may be generally healthy and just want a health insurance plan to protect you in case of emergencies; meaning that you pay all the bills up until a certain point and then the health insurance plan pays the bills. You may take medications and go to the doctor regularly; so you may want to get a health insurance plan that pays for most of your medical expenses right away instead of after you spend a lot of money first. The thing to keep in mind is what you will pay for the health insurance plan.

I just got divorced.

If you are less than 26 years old, do not have any dependents, and your parents have a health insurance plan; your parents should be able to keep you on or add you to their health insurance plan. If you are over 19 years old and you make too much money to get Medicaid, you can buy a health insurance plan directly from an insurance company or through the Health Insurance Marketplace in your state. If you are under 30 years old, you may even be able to buy a health insurance plan that is more like a “just in case” type of health insurance plan.

If you do not stay on or get added to your parent’s health insurance plan, you can buy your own health insurance plan. If you go through the Health Insurance Marketplace in your state; you may be able to get financial assistance from the federal government to be able to buy a health insurance plan that is based on your own personal or family income. If you make too much money to be able to get financial assistance; you can still buy a health insurance plan. You may even be able to buy a health insurance plan that is more like a “just in case” health insurance plan. What this means is that you pay all your medical expenses up-to a certain point and then the health insurance plan pays the rest of your expenses. This type of catastrophic health insurance plan will probably cost you a lot less than for a health insurance plan with low co-payments.

What you will want to consider when you are picking a health insurance plan for yourself or your family is what makes more sense for your personal situation. You may be generally healthy and just want a health insurance plan to protect you in case of emergencies; meaning that you pay all the bills up until a certain point and then the health insurance plan pays the bills. You may take medications and go to the doctor regularly; so you may want to get a health insurance plan that pays for most of your medical expenses right away instead of after you spend a lot of money first. The thing to keep in mind is what you will pay for the health insurance plan. If the health insurance plan pays for your bills right away; it is probably going to cost you more than if you pay all your bills before the health insurance plan pays any of your bills.

I am less than 30 years old and very healthy.

If you are under 30 years old, you may be able to buy a health insurance plan that is more like a “just in case” type of health insurance plan. What this means is that you pay all your medical expenses up-to a certain point and then the health insurance plan pays the rest of your expenses. This type of catastrophic health insurance plan will probably cost you a lot less than for a health insurance plan with low co-payments.

If you go through the Health Insurance Marketplace in your state; you may be able to get financial assistance from the federal government to be able to buy a health insurance plan that is based on your own personal or family income. If you make too much money to be able to get financial assistance; you can still buy a health insurance.

What you will want to consider when you are picking a health insurance plan for yourself or your family is what makes more sense for your personal situation. Since you are generally healthy, you may just want a health insurance plan to protect you in case of emergencies; meaning that you pay all the bills up until a certain point and then the health insurance plan pays the bills. The thing to keep in mind is what you will pay for the health insurance plan. If the health insurance plan does not pay for your bills right away; it is probably going to cost you less than if you pay all your bills before the health insurance plan pays any of your bills.

I retired or took an early retirement and am not eligible for Medicare.

In most cases, you will probably be offered COBRA coverage from the company you worked for when you leave the company. You will also be able to buy a health insurance plan directly from an insurance company or through the Health Insurance Marketplace in your state. If you go through the Health Insurance Marketplace in your state; you may be able to get financial assistance from the federal government to be able to buy a health insurance plan that is based on your own personal income. If you make too much money to be able to get financial assistance; you can still buy a health insurance plan.

What you will want to consider when you are picking a health insurance plan for yourself or your family is what makes more sense for your personal situation. You may be generally healthy and just want a health insurance plan to protect you in case of emergencies; meaning that you pay all the bills up until a certain point and then the health insurance plan pays the bills. You may take medications and go to the doctor regularly; so you may want to get a health insurance plan that pays for most of your medical expenses right away instead of after you spend a lot of money first. The thing to keep in mind is what you will pay for the health insurance plan. If the health insurance plan pays for your bills right away; it is probably going to cost you more than if you pay all your bills before the health insurance plan pays any of your bills.

I do not make a lot of money but I own a lot of things, like a house, a car and a retirement plan.

You can now buy a health insurance plan directly from an insurance company or through the Health Insurance Marketplace in your state. If you go through the Health Insurance Marketplace in your state; you may be able to get financial assistance from the federal government to be able to buy a health insurance plan that is based on your own personal income. If you make too much money to be able to get financial assistance; you can still buy a health insurance plan.

Since you have a lot of things that you own and maybe even a lot of money in the bank, you may want to buy a less expensive health insurance plan to basically protect the things you own in case of a major medical emergency, like a heart attack. What you will want to consider is what makes more sense for you personally when buying a health insurance plan. You may be generally healthy and just want a health insurance plan to protect you in case of emergencies; meaning that you pay all the bills up until a certain point and then the health insurance plan pays the bills. You may take medications and go to the doctor regularly; so you may want to get a health insurance plan that pays for medical services right away instead of after you spend a lot of money first. The thing to keep in mind is what you will pay for the health insurance plan. If you want the health insurance plan to pay for your bills right away; it is going to cost you a lot more than if you pay all your bills before the health insurance plan starts paying your bills.

I do not have any personal health issues and do not take any medications.

If you are less than 26 years old, do not have any dependents, and your parents have a health insurance plan; your parents should be able to keep you on or add you to their health insurance plan. If you are over 19 years old and you make too much money to get Medicaid, you can buy a health insurance plan directly from an insurance company or through the Health Insurance Marketplace in your state. If you are under 30 years old, you may even be able to buy a health insurance plan that is more like a “just in case” type of health insurance plan.

If you do not stay on or get added to your parent’s health insurance plan, you can buy your own health insurance plan. If you go through the Health Insurance Marketplace in your state; you may be able to get financial assistance from the federal government to be able to buy a health insurance plan that is based on your own personal or family income. If you make too much money to be able to get financial assistance; you can still buy a health insurance plan. You may even be able to buy a health insurance plan that is more like a “just in case” health insurance plan. What this means is that you pay all your medical expenses up-to a certain point and then the health insurance plan pays the rest of your expenses. This type of catastrophic health insurance plan will probably cost you a lot less than for a health insurance plan with low co-payments.

What you will want to consider when you are picking a health insurance plan for yourself or your family is what makes more sense for your personal situation. Since you are generally healthy, you may want a health insurance plan just to protect you in case of

emergencies; meaning that you pay all the bills up until a certain point and then the health insurance plan pays the bills. The thing to keep in mind is what you will pay for the health insurance plan. If the health insurance plan does not pay for your bills right away; it is probably going to cost you less than if you pay all your bills before the health insurance plan pays any of your bills.

I have personal health issues and take medications.

If you are less than 26 years old, do not have any dependents, and your parents have a health insurance plan; your parents should be able to keep you on or add you to their health insurance plan. If you are over 19 years old and you make too much money to get Medicaid, you can buy a health insurance plan directly from an insurance company or through the Health Insurance Marketplace in your state. If you are under 30 years old, you may even be able to buy a health insurance plan that is more like a "just in case" type of health insurance plan.

If you do not stay on or get added to your parent's health insurance plan, you can buy your own health insurance plan. If you go through the Health Insurance Marketplace in your state; you may be able to get financial assistance from the federal government to be able to buy a health insurance plan that is based on your own personal or family income. If you make too much money to be able to get financial assistance; you can still buy a health insurance plan.

What you will want to consider when you are picking a health insurance plan for yourself or your family is what makes more sense for your personal situation. If you are not generally healthy, you may want to buy a health insurance plan that pays for most of your medical expenses right away instead of after you spend a lot of money first. The thing to keep in mind is what you will pay for the health insurance plan. If the health insurance plan pays for your bills right away; it is probably going to cost you more than if you pay all your bills before the health insurance plan pays any of your bills.

I live in a State that recognizes same-sex marriage. {Impact of DOMA ruling.}

The most important thing to keep in mind if you live in a State that recognizes same-sex marriage is that you will now be considered married by the federal government. This means that both incomes in your household will be added together to calculate your family household income; and whether or not you or your family would be eligible for financial assistance, a subsidy, from the federal government when purchasing health insurance. This also means that if you do not purchase health insurance and are subject to a penalty that the penalty will be based on your household income.

Appendix Section

Appendix A

Examples of Metal Tier Health Plan Benefits

Sample Plan A – Possible Platinum or Gold Tier

Cost Share Example for Major Medical Services Only

In the Table below, items with a "*" next to the co-payment amount may not be paid by the insurance company until after you pay the Deductible, meaning what you pay first, is paid first by you. After you pay your deductible, you then pay the co-payments.

Deductibles	{Per Person – 2x for Family}
- Medical Expenses	$ 500
- Pharmacy Expenses	$ 0
- Combined Medical & Pharmacy	n/a
Out-of-Pocket Maximum Annual Expenses	$ 4,000
Medical Service	Co-Payment by You
- Primary Care Office Visits	$ 15
- Specialist Office Visit	$ 30
- Annual Physicals, Preventative Care, etc.	$ 0
- Emergency Room Visit	$ 100
- Outpatient Surgery	$ 250 *
- Inpatient Surgery or Hospital Stay	$ 500 *
Pharmacy/Prescription Drugs	
- Generic	$ 10
- Preferred Brand Name Drugs	$ 20
- Non-Preferred Brand Name Drugs	$ 30
- Specialty Drugs, Injectable Drugs, etc.	$ 40

Sample Plan B – Possible Gold or Silver Tier

Cost Share Example for Major Medical Services Only

In the Table below, items with a "*" next to the co-payment amount may not be paid by the insurance company until after you pay the Deductible, meaning what you pay first, is paid first by you. After you pay your deductible, you then pay the co-payments.

Deductibles	{Per Person – 2x for Family}
- Medical Expenses	$ 1,000
- Pharmacy Expenses	$ 100
- Combined Medical & Pharmacy	n/a
Out-of-Pocket Maximum Annual Expenses	$ 5,000
Medical Service	Co-Payment by You
- Primary Care Office Visits	$ 20
- Specialist Office Visit	$ 40
- Annual Physicals, Preventative Care, etc.	$ 0
- Emergency Room Visit	$ 100
- Outpatient Surgery	$ 500 *
- Inpatient Surgery or Hospital Stay	$ 500 *
Pharmacy/Prescription Drugs	
- Generic	$ 10
- Preferred Brand Name Drugs	$ 25
- Non-Preferred Brand Name Drugs	$ 50
- Specialty Drugs, Injectable Drugs, etc.	50% Paid by You

Sample Plan C – Possible Silver or Bronze Tier

Cost Share Example for Major Medical Services Only

In the Table below, items with a "*" next to the co-payment amount may not be paid by the insurance company until after you pay the Deductible, meaning what you pay first, is paid first by you. After you pay your deductible, you then pay the co-payments.

Deductibles	{Per Person – 2x for Family}
- Medical Expenses	n/a
- Pharmacy Expenses	n/a
- Combined Medical & Pharmacy	$ 2,000
Out-of-Pocket Maximum Annual Expenses	$ 6,500
Medical Service	Co-Payment by You
- Primary Care Office Visits	$ 30
- Specialist Office Visit	$ 60
- Annual Physicals, Preventative Care, etc.	$ 0
- Emergency Room Visit	$ 150
- Outpatient Surgery	$ 500 *
- Inpatient Surgery or Hospital Stay	$ 500 * (per day)
Pharmacy/Prescription Drugs	
- Generic	$20
- Preferred Brand Name Drugs	$ 40 *
- Non-Preferred Brand Name Drugs	$ 60 *
- Specialty Drugs, Injectable Drugs, etc.	50% Paid by You *

Sample Plan D – Possible Silver or Bronze Tier

{Potential HSA Plan Option}

Cost Share Example for Major Medical Services Only

In the Table below, items with a "*" next to the co-payment amount may not be paid by the insurance company until after you pay the Deductible, meaning what you pay first, is paid first by you. After you pay your deductible, you then pay the co-payments.

Deductibles	{Per Person – 2x for Family}
- Medical Expenses	n/a
- Pharmacy Expenses	n/a
- Combined Medical & Pharmacy	$ 2,000
Out-of-Pocket Maximum Annual Expenses	$ 6,500
Medical Service	Co-Payment by You
- Primary Care Office Visits	$ 30 *
- Specialist Office Visit	$ 60 *
- Annual Physicals, Preventative Care, etc.	$ 0
- Emergency Room Visit	$ 150*
- Outpatient Surgery	$ 500 *
- Inpatient Surgery or Hospital Stay	$ 500 * (per day)
Pharmacy/Prescription Drugs	
- Generic	$20 *
- Preferred Brand Name Drugs	$ 40 *
- Non-Preferred Brand Name Drugs	$ 60 *
- Specialty Drugs, Injectable Drugs, etc.	50% Paid by You *

Examples of Alternative Silver Tier Plan Benefits

Cost Share Example for Major Medical Services Only

In the Table below, items with a "*" next to the co-payment amount may not be paid by the insurance company until after you pay the Deductible, meaning what you pay first, is paid first by you. After you pay your deductible, you then pay the co-payments.

Target Actuarial Value	70%	73%	87%	94%
Deductibles {Per Person – 2x for Family}				
- Medical Expenses	$ 2,000	$ 1,000	$ 500	n/a
- Pharmacy Expenses	$ 100	$ 50	n/a	n/a
- Combined Medical & Pharmacy	n/a	n/a	n/a	n/a
Out-of-Pocket Maximum Annual Expenses	$ 6,500	$ 5,000	$ 4,000	$ 2,000
Medical Service	Co-Payment	Co-Payment	Co-Payment	Co-Payment
- Primary Care Office Visits	$ 30	$ 25	$ 10	$ 5
- Specialist Office Visit	$ 60	$ 40	$ 25	$ 10
- Annual Physicals, Preventative Care, etc.	$ 0	$ 0	$ 0	$ 0
- Emergency Room Visit	$ 150	$ 100	$ 75	$ 50
- Outpatient Surgery	$ 500 *	$ 500 *	$ 250 *	$ 100
- Inpatient Surgery or Hospital Stay	$ 500 * (per day)	$ 500 *	$ 250 *	$ 250
Pharmacy/Prescription Drugs				
- Generic	$ 20	$ 15	$ 10	$ 5
- Preferred Brand Name Drugs	$ 40 *	$ 30	$ 20	$ 10
- Non-Preferred Brand Name Drugs	$ 60 *	$ 40	$ 30	$ 20
- Specialty Drugs, Injectable Drugs, etc.	50% Paid by You *	$ 60 *	$ 40	$ 30

Appendix B

Online Calculator and Other Online Information

Online Calculator: www.ppacacalculator.com

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The following are links to other web sites that can help you learn more about the changes to Medicaid and Medicare.

The link to the Federal Medicaid web site: http://www.medicaid.gov/

The link to the Federal Medicare web site: http://www.medicare.gov/

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If you would like to research and learn more about health care reform, PPACA; the Henry J. Kaiser Family Foundation has an extensive web site discussing health care reform and will provide you with a wealth of information. It is this author's favorite web site for collaborating information from various sources.

Henry J Kaiser Family Foundation web site: http://healthreform.kff.org/

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CCIIO (The Center for Consumer Information & Insurance Oversight)

http://cciio.cms.gov/resources/regulations/index.html#pm

CCIIO Actuarial Value Calculator

http://cciio.cms.gov/resources/files/av-calculator-2-25-13.xlsm

About the Author

Mr. Pinto is an insurance agent with over twelve years of experience specializing in health insurance and health care reform as it relates to individuals and businesses. He started and managed an insurance agency with offices in CT and the Capitol District of NY, which he subsequently sold. He is also a 1st generation American citizen of immigrant parents from Portugal and served in the United States Army National Guard and United States Army Reserve for over twelve years.

Mr. Pinto is an advocate for health care reform and is a member of the "SHOP" Advisory Committee to the Health Insurance Exchange Board in the state of Connecticut, known as Access Health CT, which is a committee that focuses on helping small businesses access the benefits available to them as part of health care reform.

Mr. Pinto is active in many business groups and charitable organizations; and serves as a volunteer to several charitable organizations and community service groups. He was selected by New Haven Business Times magazine to their 13th Annual “Forty under 40” in 2006; a list of up and coming young professionals in the Greater New Haven Region of CT that serve their communities.