Connecting Youth and Young Adults to the Affordable Care Act:

A Guide for Young Adults to Understand the Affordable Care Act

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TABLE OF CONTENTS

Introduction

You may have heard a lot about the Affordable Care Act (ACA). This act is a bill that got signed into law on March 23, 2010. The intended purpose of the bill is to "expand access to insurance, increase consumer protections, emphasize prevention and wellness, improve quality and system performance, expand the health workforce, and curb rising healthcare costs" (National Conference of State Legislature, 2011).

The purpose of this guide is to explain the Affordable Care Act and to highlight parts of the bill that are important for young adults to be aware of, assess what information is available for young adults to educate themselves about the bill, and identify what additional information still needs to be created for young adults.

What is the Affordable Care Act (ACA)?

The Affordable Care Act (ACA) is an act of legislation that was signed into law on March 23, 2010. The actual bill is over 20,000 pages long and is actually made up of to two separate pieces of legislation: the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

Young Adults and the ACA

This legislation is critical for many people, and many populations will benefit from its provisions. However, there are many parts of the ACA that are specifically important to young adults. This is because young adults are a population that struggle to get and maintain health insurance. About 30% of young adults are uninsured, representing more than one in five of the uninsured (CMS, 2010). This means that there are more young adults who are uninsured than any other population! Young adults also have the highest rate of injury-related emergency department visits among all age groups under age 75. About 15% of young Americans have a chronic condition, and nearly one in ten are reported to have a mental health condition (Young Invincibles, 2014). Young adults use and need health care, and in order to pay for that care, they need health insurance!

One of the most significant changes created by the Affordable Care Act is that insurance plans offering ***dependent*** coverage (meaning that young adults can have insurance through their parents' plan) are required to extend the coverage until the adult child reaches the age of 26. Both married and unmarried dependents qualify for this coverage. All plans that are offered within the individual market or any new employer plans must abide by this rule. The extended dependent coverage also applies to existing employer plans unless the young adult has another opportunity to get coverage through his or her own employer (Healthcare.gov, 2013). For young adults that are in foster care, this provision means that they will be able to keep their Medicaid coverage until they are age 26.

Individual Mandate

One of the most important parts of the Affordable Care Act is that as of 2014, Americans must have health insurance, or they will have to pay a fine in the form of a tax penalty. This is called the ***Individual Mandate****. The fee for not having health insurance varies depending on your

* *See Glossary of terms for words that are* ***bold, italicized and underlined****.*

income, and increases each year, depending on inflation. The following schedule describes what penalties you may end up paying for not having insurance coverage:

- **2014** = $95 per adult and $47.50 per child per year | or 1% of your income (whichever is greater);
- **2015** = $325 per person and $162.50 per child per year | or 2% of your income (whichever is greater);
- **2016** = $695 per person and $347.50 per child per year | or 2.5% of your income (whichever is greater);
- **2017** = Tax Penalty will increase by the rate of inflation going forward | or 2.5% of your income (whichever is greater) (Obama Care Facts, 2014).

With the individual mandate, you still have the choice to NOT have health care coverage, but you will need to pay the fine when it comes time to do your taxes. The other thing that is important to remember is that, if you do not have coverage, paying the fine does NOT mean that you are covered, it means that you have decided you do not need health insurance, and will pay out of your own pocket for any health care or mental health expenses you might have.

Essential Health Benefits

Another key component of the Affordable Care Act that young adults should be familiar with is the provision known as **Section 1302**, which discusses what are known as Essential Health Benefits. This provision requires that all insurance plans, including those offered in the Market place, cover essential health benefits (Catalyst Center, 2013). Essential Health Benefits (EHB) are items and services in the following ten benefit categories:

1. ***Ambulatory*** care services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services *(services that help people gain or regain important skills like speaking or caring for one's self)* (NAMI.org, 2013) and devices
8. Laboratory services
9. ***Preventive*** and wellness services and chronic disease management
10. Pediatric services, including dental and vision care.

These essential health benefits should be equal in scope to a typical employer health plan (Catalyst Center, 2013).

Preventative Health Services

The ACA also requires that all health care plans offered in the marketplace, as well as other plans must cover preventative health services, for free, with no ***co-pay*** or ***deductible***. This is especially critical for the population of young adults, since once they age out of pediatric care, it is less likely that they will access preventative care when they are in good health. Especially if this is an added expense, young people are less likely to get annual physicals or preventative health care services. A recent study using a national sample indicated that close to 70% of

primary care visits by young adults included no preventive counseling (Fortuna, 2009). Screening rates were especially low in the areas critical to young adult morbidity and mortality, such as injury prevention, mental health, sexually transmitted infections, and obesity, ranging from a low of 2.6% of visits including screening for sexually transmitted diseases and human immunodeficiency virus to a high of 9.4% of visits including screening for exercise (Fortuna, 2009).

Pre-Existing Conditions

Other parts of the ACA that are important to young adults to be familiar with are those that prevent discrimination and let more people sign up for health insurance. One of the most significant parts is that health insurance plans can no longer deny coverage to people with ***pre-existing conditions***. This means that if you have a physical or mental health condition that is present *before* you apply for an insurance plan, the company still has to provide you with insurance. Before the ACA, it was legal to turn people down due to pre-existing conditions. This provision went into effect six months after the bill passed in 2010 for children and teens under age 19, and applies to adults overage 19 as of January 2014 (AMCHP, 2010).

Along with not being able to deny coverage based on a pre-existing condition, the ACA also prohibits insurance companies from placing a cap, or financial limit on benefits. This is particularly important for people who require a lot of health services and could reach their limit very early on in their enrollment with the plan. When the ACA was first signed into law, it eliminated lifetime caps for existing or new plans. There could no longer be an annual cap of less than 2 million dollars after September 23, 2012, and as of January, 2014, there are no annual benefit caps allowed (Catalyst Center, 2013).

It is ***very important*** to understand the details of your plan and what it covers, because although "no annual benefit cap" refers to the financial amount the services cost, there can still be a limit on the types or amount of services you receive. For example, a plan *can* specify that you are only allowed 15 mental health sessions per year, or 15 physical therapy sessions per year. This is important to know if you need to have counseling or psychiatric services for any of your medical or mental health conditions.

Mental Health Parity

This is when the **Mental Health Parity** provision of the ACA becomes important. This part of the law states that coverage within insurance plans cannot be more restrictive for mental health services than it is for physical health services. This applies to the number of services, as well as the financial amount that is allowed for medical and mental health services (NAMI, 2013).

Medicaid Expansion

Another component of the ACA that is intended to expand coverage for young adults is the **Medicaid Expansion** provision. This is an optional provision, meaning that states are able to choose if they want to implement it. As of May 30, 2014, 27 states (and the District of Columbia) have expanded their Medicaid programs, 20 states have chosen not expand their Medicaid programs, and 4 are in the planning stages of possible expansion programs (Families USA, 2013). Before the Affordable Care Act, the only people whose health care was covered by Medicaid were: low-income children (under 18), their parents, pregnant women and people with a documented disability who get monthly income though Social Security (NAMI.org, 2013). For

the states that do not elect to expand Medicaid, these are the only populations that will still receive coverage through Medicaid.

So what will the Medicaid Expansion do?

- **More people will qualify for Medicaid.** In addition to the populations mentioned above, all uninsured Americans with incomes 0-138% of the ***Federal Poverty Level*** will now qualify for Medicaid coverage. For example, for family of 1, having an annual income of $15,856 or lower means they could qualify for Medicaid coverage (NAMI, 2013). There may still be exceptions to this rule, for example, people can be denied Medicaid coverage if they have the option to be covered elsewhere, even if they can't afford it (i.e. students, full-time interns, etc.).

Family Size:	**100%**	**138%**	**400%**
1	$11,490	$15,856	$45,960
2	$15,510	$21,404	$62,040
3	$19,530	$26,951	$78,120
4	$23,550	$32,499	$94,200

- **The process for applying for Medicaid will be easier.** Individuals using the marketplace to apply for health insurance will be taken through an online application if they meet the income qualifications for Medicaid.
- **It will be easier to keep your Medicaid coverage once you are enrolled.** People who do not have any other insurance coverage can automatically remain enrolled in Medicaid (NAMI.org, 2013). While more people will STAY covered under Medicaid, there are still responsibilities you may have, which can include reporting any change in your family, your income, expenses, or other insurance sources. You may also have to often fill out "annual evaluations" of coverage, to assure your needs are the same.

Health Homes

Within the Medicaid Expansion is **Section 2703,** a provision that implements an innovative, ***integrated care*** model, which utilizes enhanced ***care coordination*** and multi-disciplinary care teams. This means that health care is delivered in a way that takes care of both your physical and mental health, and more people will be involved to help make sure you get the care and services that you need.

In order to qualify to be a part of a ***health home*** and individual must qualify for Medicaid AND have any one of the following:

- Two or more chronic conditions;
- One condition and the risk of developing another; or
- At least one serious and persistent mental health condition.

The chronic conditions that would make an individual qualify include:

- Mental health condition,
- Substance abuse disorder,
- Asthma,
- Diabetes,
- Heart disease, and
- Being overweight (having a BMI of > 25).

States also have the option to add other chronic conditions, but any additions must be approved by the National Centers for Medicaid & Medicare Services (CMS).

Services encompassed in the Health Home provision include:

- Comprehensive care management,
- Care coordination,
- Health promotion,
- Comprehensive transitional care from inpatient to other settings,
- Individual and family support,
- Referral to community and social support services, and
- Use of health information technology, as feasible and appropriate.

Providers that work within a Health Home are expected to do several things including, but not limited to:

- Providing quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services;
- Coordinating and providing access to high-quality health care services informed by evidence-based guidelines;
- Coordinating and providing access to mental health and substance abuse services; and
- Coordinating and providing access to long-term care supports and services (Catalyst Center).

Health homes are tricky because as a patient, you may not know if you are a part of one or not. Being involved in a health home has more to do with where you go to access your health care than what your health insurance plan is, as not all providers are qualified health homes. It is important to understand what is needed to qualify however, because it could be something you could ask your provider about if you feel you need more support coordinating your health care.

What does the ACA have to do with me?

So now that you know what the ACA is and what it consists of, how does it affect you? For starters, as mentioned in the Individual Mandate, you could end up paying a hefty fine for not having health care coverage. Especially for young adults with mental health needs, having health insurance can come in handy to help pay for health care expenses that could otherwise be very expensive.

How Do I Sign Up?

Before you begin to research what plans might be best for you, there are some things you need to know. Find out the following information:

- **Do you currently have insurance coverage?**
    - Becoming familiar with your coverage is an important first step!
        - Are you covered as a dependent on your parents plan?
        - Are you under the age of 26? Are you covered under a student plan (often if you enroll in college, you will receive health insurance unless you select not to)?
        - Were you in foster care on your 18th birthday?
    - If you are covered, what type of plan is it?
        - Does it cover all of your health and mental health needs or are there still out of pocket costs you must plan for (co-pays, deductibles, etc.)?
- **If you are *not* covered, what are your options for health insurance?**
    - Are you enrolled in school full or part-time, with the option to purchase health insurance?
    - Do you have a job that provides a benefits package, or any sort of health care coverage?
    - Were or are you in foster care?
    - Do you receive income from Social Security, or have a documented disability?
- **What are my health needs that will need to be covered by my health insurance?**
    - Are you on any medications?
    - Do you have specific doctors that you need to see regularly, besides your primary care provider (PCP)?
    - Do you use any medical supplies or equipment that you need to keep in stock or replace?
    - Are you in any therapies, or other services that need to be paid for regularly?
    - Do you have a mental health or substance abuse diagnosis?
- **What is your income?**
    - How much money do you make each month, and where does it come from?
    - How much would you be able to budget towards a health insurance plan, if you needed to pay a monthly ***premium***?

Once you are aware of these pieces of information you will be much more prepared to visit the Health Insurance Marketplace (healthcare.gov).

When Can I Enroll?

You will not always be able to just go in and purchase a plan from the Marketplace. There is a specific time when you are able to do this, called ***Open Enrollment*****.** During open enrollment you can purchase a health care insurance plan this a good fit for you, and your coverage will begin the first of the following month.

For coverage starting in 2016, the Open Enrollment Period begins November 1 2015. For the most current information about enrollment periods visit https://www.healthcare.gov/marketplace-deadlines/

Even if you miss the open enrollment period, there are options for you to get health care coverage in other ways. If you apply for a state program like Medicaid, you can enroll at any time. A plan that you get through your employer, however, must provide a special enrollment period of 30 days following certain life events that involve a change in family status (for example, marriage or birth of a child) or loss of other job-based health coverage. These events

are known as "qualifying life events" (Healthcare.gov, 2014) and could allow you to sign up for coverage if you miss the open enrollment period.

The first steps of the Marketplace will walk you through some questions, (like the ones listed above). Before giving you the option to purchase a private insurance plan, it will show you if you qualify for programs like Medicaid, or government assistance to pay for your premiums. This is known as "***subsidies***."

How do I know which plans are available?

Visiting the HealthCare.gov website (https://www.healthcare.gov/families/) will help you see what plans you qualify for and are a good match for you based on your age, income, and other information.

In the marketplace for your state, there are different level plans to fit your needs depending on what type of coverage you might think you need. The levels are: Platinum, Gold, Silver, and Bronze. Each level covers a higher percentage of your health care costs, with Platinum providing 90% coverage, Gold Covering 80%, Silver covering 70%, and Bronze covering 60% (NAMI, 2013).

If you find that you are still unable to afford a health plan in the marketplace, you may qualify for what is called a "hardship exemption." This will allow you to get a plan known as **Catastrophic Coverage.** Catastrophic plans are insurance plans that cover mostly emergency services, and only 3 primary care visits. The premiums for these plans are usually lower than other plans offered in the marketplace, but the out of pocket costs, like deductibles and co-insurance payments tend to be much higher. This plan may be better financially for young adults in good health and low health needs, but do impose a risk of having to pay more out of pocket if a major accident happens.

According to Healthcare.gov (2013), you may qualify for a hardship exemption, if:

- You were homeless;
- You were evicted in the past 6 months or were facing eviction or foreclosure;
- You received a shut-off notice from a utility company;
- You recently experienced domestic violence;
- You recently experienced the death of a close family member;
- You experienced a fire, flood, or other natural or human-caused disaster that caused substantial damage to your property;
- You filed for bankruptcy in the last 6 months;
- You had medical expenses you couldn't pay in the last 24 months;
- You experienced unexpected increases in necessary expenses due to caring for an ill, disabled, or aging family member;

- You expect to claim a child as a tax dependent who's been denied coverage in Medicaid and CHIP, and another person is required by court order to give medical support to the child. In this case, you do not have the pay the penalty for the child;

- As a result of an eligibility appeals decision, you're eligible for enrollment in a qualified health plan (QHP) through the Marketplace, lower costs on your monthly premiums, or cost-sharing reductions for a time period when you weren't enrolled in a QHP through the Marketplace;

- You were determined ineligible for Medicaid because your state didn't participate in the Medicaid Expansion under the ACA;

- Your individual insurance plan was cancelled and you believe other Marketplace plans are unaffordable; or

- You experienced another hardship in obtaining health insurance.

There are also designated people in each state, called navigators, who are available to help you through this process. You can find out who the supports are in your state by visiting https://localhelp.healthcare.gov/.

To learn more about the Affordable Care Act on your own, and get answers to commonly asked questions, check out Young Invincibles! – an organization focused specifically on health care coverage for young adults (http://health.younginvincibles.org/consumers-2/).

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Glossary

(For a full glossary of all terms related to the Affordable Care Act, check out: HealthCare.gov glossary (https://www.healthcare.gov/glossary/) or Young Invincibles, a resource specific to Young Adults, about the Affordable Care Act (http://younginvincibles.org/issues/health-care/glossary/).

Affordable Care Act (ACA): The health care reform law enacted in March 2010 made up of two parts: The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act. The name "Affordable Care Act" is used to refer to the final version of the law.

Ambulatory Care: Health services that are provided on an outpatient basis, when the patient receives care and departs the hospital on the same calendar day.

Care Coordination: The organization of your treatment across several health care providers. Medical homes and Accountable Care Organizations are two common ways to coordinate care.

Catastrophic Health Plan: Health plans that meet all of the requirements applicable to other Qualified Health Plans (QHPs) but that only cover 3 primary care visits per year before the plan's deductible is met. The monthly premiums for these plans tend to be lower, but the out-of-pocket costs for deductibles, copayments, and coinsurance are generally higher. To be able to purchase a catastrophic plan, you must be under 30 years old OR qualify for a "hardship exemption" in the Marketplace.

Coinsurance: Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount. (healthcare.gov, 2014) This amount varies depending on the plan and type of service that is being paid for.

Co-Pay: A fixed amount (for example, $15) you pay for a covered health care service, usually at the time you get the service. This amount can vary depending on the type of service.

Deductible: The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1,000, your plan won't pay anything until you've met your $1,000 deductible. The deductible may not apply to all services, and varies with each health plan.

Dependent Coverage: Insurance coverage for family members of the person who has the insurance policy, such as spouses, children, or partners.

Durable Medical Equipment (DME): Equipment and supplies ordered by a health care provider for everyday or extended use. These items can include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Federal Poverty Limits (FPL): A measure of income level issued annually by the Department of Health and Human Services. Federal poverty levels are used to determine your eligibility for certain programs and benefits.

Grandfathered Plan: A group health plan, that was created, or an individual health policy that was purchased—on or before March 23, 2010. Grandfathered plans are not required to make many of the changes under the Affordable Care Act.

Health Home: A care management model in which all of an individual's providers and caregivers communicate with each other so that all of a patient's needs are addressed completely, and all needs get addressed.

Integrated Care: An approach that coordinates medical health, behavioral health, and substance abuse consideration all in the same approach.

Marketplace: A resource that helps individuals, families, and small businesses: learn about their health coverage options; compare health insurance plans based on costs, benefits, and other important features; choose a plan; and enroll in coverage. The Marketplace provides information on programs that help people with low to moderate income and resources pay for coverage. This includes ways to save on the monthly premiums and out-of-pocket costs of coverage available through the Marketplace, and information about other programs, including Medicaid and the Children's Health Insurance Program (CHIP). The Marketplace is accessible through websites; call centers, and in-person assistance.

Medicaid: A state-administered health insurance program for low-income families and children, pregnant women, the elderly, people with disabilities, and in some states, other adults. The Federal government provides a portion of the funding for Medicaid and sets guidelines for the program. Medicaid varies state by state and may be called something different in your state.

Mental Health Parity: A provision in the Affordable Care Act that states that coverage within insurance plans cannot be more restrictive for mental health services than it is for physical health services.

Open Enrollment: The period of time during which individuals who are eligible to enroll in a Qualified Health Plan are able to enroll in a plan in the Marketplace. For coverage starting in 2014, the Open Enrollment Period was October 1, 2013–March 31, 2014. For coverage starting in 2015, the proposed Open Enrollment Period is November 15, 2014–February 15, 2015. Individuals may also qualify for Special Enrollment Periods outside of Open Enrollment if they experience certain events (change in income or change in family such as a marriage, divorce, or birth of a baby)

Premium: The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

Pre-existing condition: A health condition that you had before the date that your new health coverage starts.

Preventive Care: Activities to prevent illness such as regular check-ups, immunizations, patient counseling, and screenings.

Subsidies: lowers the amount you spend on your monthly premium, through tax credits or reduces out-of-pocket costs for things like copays, coinsurance, deductibles and out-of-pocket maximum. (Obama Care Facts, 2014)