CENTER FOR HEALTH LAW & POLICY INNOVATION
Harvard Law School

Marketplace Health Plans Assessment Workbook
September 2013

Beginning in January 2014, state and federal Marketplaces (aka exchanges) will offer a range of insurance plans called qualified health plans (QHPs). As uninsured individuals begin to enroll in these plans in October 2013, it will be critical that each is able to select a plan that includes current health care providers and affordably meets his/her healthcare needs. This workbook is designed to guide assessment of QHPs in two ways.

First, it aims to assist low-income individuals and their health and social service providers in selecting a QHP that best meets their care and treatment needs. This workbook highlights areas of a QHP that will significantly affect access to and cost of care. QHPs are available on state Marketplace websites or at www.healthcare.gov (federally run Marketplaces).

Second, this workbook is meant to build capacity among advocates in assessing the adequacy of QHPs to affordably meet the healthcare needs of individuals living with HIV/AIDS, as well as with common co-morbidities (mental illness, substance use disorder, and/or diabetes). Historically, private health plans have not met the needs of low-income individuals and families, especially those living with complex chronic health conditions or disabilities. Now that more people with lower incomes and complex health conditions will join the private market, insurance companies will need to build plans that provide access to affordable and comprehensive care. For example, although the Patient Protection and Affordable Care Act (ACA) prohibits discrimination on the basis of health status, plans may still be designed to attract the healthy consumers and deter enrollment by those in need of expensive care. Thus, advocates, case managers, and providers will need to monitor new plans to ensure adequacy for all consumers, especially those with more significant healthcare needs. This workbook highlights areas where a QHP may violate the ACA's prohibition on discrimination based on health status, such that it may be flagged for monitoring and enforcement by the state or federal government.

This workbook is designed to guide a step-by-step analysis of the following elements in any given QHP:

1. premium and cost-sharing requirements;
2. outpatient services;
3. inpatient services;
4. provider networks; and
5. prescription drug formularies.

When used in conjunction with the Marketplace Health Plan Assessment Worksheet, it can provide individuals with a comparison of multiple plans to choose from.

If you have questions or need assistance assessing a plan, please contact Katherine Record (krecord@law.harvard.edu)
Please send plan assessments to the Center for Health Law & Policy Innovation of Harvard Law School to maximize dissemination (krecord@law.harvard.edu)

BACKGROUND ON HEALTH INSURANCE PLANS

Health insurance plans each have different provider networks and cover different health benefits. Plans also charge different monthly premiums and require consumers to pay different costs for healthcare services and treatments. These costs include co-pays, co-insurance, and deductibles, which can apply to provider visits, drugs, and procedures. The following terms are essential to understand as they determine the adequacy and affordability of a plan:

- **Premium:** monthly fee an insurance plan charges for plan membership
- **Advance Premium Tax Credit:** money that the government pays directly to a health plan (or to the consumer at the end of the tax year) in order to reduce a consumer's premiums
- **Co-pay:** a set fee a consumer pays for each provider visit, prescription refill, lab test, or other healthcare service (e.g., $10, $20, or more)
- **Co-insurance:** a percentage of the cost of the healthcare service that the consumer must pay (e.g., 30% of the cost of a provider visit or of a procedure)
- **Deductible:** a set annual amount of consumer spending the consumer must pay before the insurance plan pays for any of the costs of care (e.g., $2,500)
- **Out-of-pocket maximum (OOP):** a limit on the total amount of money a plan can require the enrollee to pay for healthcare (in co-pays, co-insurance, and deductibles) during a single year
- **Cost-sharing Subsidy:** money that the government pays directly to a health plan in order to reduce a consumer's out-of-pocket costs
- **Provider network:** the healthcare providers that a health plan contracts with, making them available to provide care to the plan's enrollees
- **Benefits:** the healthcare treatments and services a plan covers (e.g., prescription drugs, surgery, outpatient provider visits, specialty care, mental health treatment)
- **Essential Health Benefits (EHB):** a package of mandatory benefits that all QHPs (plans sold on Marketplaces) must cover

Premium and Cost-Sharing Limits

How much cost-sharing a QHP can impose on a consumer will depend on the "metal" rating of the plan. Marketplaces will sell QHPs offering four different metal levels of coverage: bronze, silver, gold, and platinum. Each level corresponds with a particular percentage of enrollees' healthcare costs that plans in that level must cover. Table A lists the four types of plans that will be available on Marketplaces. The percentage of healthcare costs the plan versus the individual are expected to pay is based on the average cost of healthcare for all plan enrollees (i.e., an individual enrolled in a bronze plan will be responsible for approximately 40% of the cost of his/her healthcare).

Table A – Plan Options in Marketplaces (Based on average % of Healthcare Costs Covered by Plan versus Consumer)

Plan Type	% Healthcare Costs Covered by Insurance Plan	% Healthcare Costs Covered by Consumer
Bronze Plans	60%	40%
Silver Plans	70%	30%
Gold Plans	80%	20%
Platinum Plans	90%	10%

The ACA provides federal tax credits to make premiums more affordable for individuals with income between 100-400% FPL. For those living between 100-250% FPL, cost-sharing subsidies are also available, but only for individuals purchasing silver-level plans (see Appendix B for the 2013 FPL guidelines). It is expected that most people living at or below 250% FPL will buy silver-level plans, in order to access cost-sharing subsidies.[1] Thus, because this assessment workbook is targeted primarily towards consumers living between 100-250% FPL, it focuses on silver plans analysis.

The ACA also limits out-of-pocket (OOP) costs (co-pays, co-insurance, and deductibles) for consumers purchasing a QHP. OOP caps are based on annual Internal Revenue Service calculations and will change each year. In 2014, QHPs may not impose more than $6,350 in OOP spending on any individual ($12,700 for a family). For consumers living between 100% - 250% FPL, the ACA further limits OOP costs. Table B illustrates total caps on both premiums and OOP costs for consumers with income between 100-400% FPL. (Appendix B shows how premium limits are calculated). The federal government will pay the difference between the consumer's OOP cap and the QHP's unsubsidized charges directly to the plan (i.e., the consumer will not ever have to pay the difference in cost).

[1] An individual should examine his/her healthcare needs, associated costs, and available subsidies to determine whether a silver plan (with cost-sharing subsidies) or a gold or platinum plan (covering a higher proportion of healthcare costs) would provide more affordable coverage.

Table B: Total 2014 Cost-Sharing Limits/Year Based on Income (OOP + Premium Limits)			
Income	**Maximum Premium / Year**	**Maximum OOP Costs / Year**	**Maximum Cost-Sharing / Year**
100-150% FPL	$229.80 - $689.40	$2,250	$2345.80 - $2805.40
150-200% FPL	$689.40 - $1,447.74	$2,250	$2805.40 - $3563.74
200-250% FPL	$1,447.74 - $2,312.36	$5,200	$4622.74 - $5487.36
250-300% FPL	$2,312.36 - $3,274.65	$6,350	$8662.36 - $9624.65
300-400% FPL	$3,274.65 - $4,366.20	$6,350	$9624.65-$10716.20

QHP ASSESSMENT[2]

STEP 1: CHOOSE QHPs TO ASSESS

	Plan 1	Plan 2	Plan 3
Issuer Name			
Product Name			
Plan Name			
Plan Type (PPO, POS, HMO, etc)			
Coverage area (counties)			

[2] For simplicity, this assessment workbook refers to plans for individuals, but can be used to assess a family plan as well.

STEP 2: ASSESS PREMIUM AND COST-SHARING (DEDUCTIBLES, CO-INSURANCE, CO-PAYS)

As described above, the ACA limits premiums for individuals living between 100-400% FPL as well as cost-sharing for individuals living between 100-250% FPL (Table B). For example, an individual with income at 200% FPL will not have to spend more than $1,447.74 on his/her premiums each year (the government would pay the difference if the plan charged more), and would not have to spend any more than $2,116 on other OOP costs (co-pays, coinsurance, and deductibles). This means that an individual living at or below 200% FPL would spend no more than $3,563.74 on healthcare annually, including the cost of the insurance plan itself.

	Plan 1	Plan 2	Plan 3
Client versus Plan OOP max	Client: $	Client: $	Client: $
(see Table B)	Plan: $	Plan: $	Plan: $

In addition, state programs may offer additional subsidies to help pay premiums, co-pays, co-insurance, and deductibles.[3] For example, if a state's AIDS Drug Assistance Program (ADAP) coordinates with private plans, it may pay an eligible individual's premium or deductible directly to his/her plan. ADAP could also pay the consumer's co-pay to a provider or pharmacy. Such programs vary widely state by state, so it is important to check which types of programs (ADAPs or otherwise) that may exist in your state may provide additional financial support to low-income consumers. Moreover, some ADAPs will only provide premium and/or co-pay assistance for certain plans (not necessarily all plans sold on a Marketplace), and all require that a plan's drug formulary at least match the state's ADAP formulary.

	Plan 1	Plan 2	Plan 3
Additional state financial assistance available to client?		☐ Yes / No ☐	
Plan eligible for ADAP support?	☐ Yes / No ☐	☐ Yes / No ☐	☐ Yes / No ☐

[3] Note that very few state Ryan White Programs assist with provider visit co-pays, but drug co-pay assistance is common (through the AIDS Drug Assistance Program, or ADAP).

STEP 3: ASSESS QHP's OUTPATIENT SERVICES & PROVIDER NETWORK

Access to Providers

	Plan 1	Plan 2	Plan 3
Primary Care Providers	Deductible: Co-pay: Co-insurance: Cap on visits:	Deductible: Co-pay: Co-insurance: Cap on visits:	Deductible: Co-pay: Co-insurance: Cap on visits:
Specialists	Deductible: Co-pay: Co-insurance: Cap on visits:	Deductible: Co-pay: Co-insurance: Cap on visits:	Deductible: Co-pay: Co-insurance: Cap on visits:
Mental Health Providers	Deductible: Co-pay: Co-insurance: Cap on visits:	Deductible: Co-pay: Co-insurance: Cap on visits:	Deductible: Co-pay: Co-insurance: Cap on visits:
Substance Use Disorder Providers	Deductible: Co-pay: Co-insurance: Cap on visits:	Deductible: Co-pay: Co-insurance: Cap on visits:	Deductible: Co-pay: Co-insurance: Cap on visits:

Does this plan contract with the client's current providers (both primary care and specialty)?

Continuity with healthcare providers is critical, particularly for consumers living with complex chronic disease (e.g., HIV/AIDS). A consumer enrolling in a QHP is best served if he/she can select a plan that contracts with his/her current provider(s). To determine this:

1. Call the provider and ask which insurance plans he/she accepts; or
2. Search for the client's current provider on the plan and/or Marketplace website.

Does the plan consider the client's provider to be a primary care provider (PCP) or a specialist?

A consumer may need a referral from his/her PCP (usually a general practice or internal medicine provider) to see a specialist. Currently, many consumers living with HIV/AIDS rely on infectious specialists as their PCPs. If an HIV provider is an infectious disease physician, they are likely classified as a specialist by the health plan. This means that a consumer may not be able to see the HIV provider without a PCP referral and may be subject to pay a higher co-pay. It will be important to know whether your client's HIV provider (or other PCP) is considered a PCP by the insurance company to streamline access to the provider and minimize OOP costs.

Client's Current Providers	Plan 1	Plan 2	Plan 3
PCP: _____	In plan network: Requires referral:	In plan network: Requires referral:	In plan network: Requires referral:
Specialist(s): _____	In plan network: Requires referral:	In plan network: Requires referral:	In plan network: Requires referral:
Mental Health: _____	In plan network: Requires referral:	In plan network: Designated as specialist:	In plan network: Requires referral:
Substance Use Disorder: _____	In plan network: Requires referral:	In plan network: Designated as specialist:	In plan network: Requires referral:
Other Provider(s): _____	In plan network: Requires referral:	In plan network: Designated as specialist:	In plan network: Requires referral:

Are there generally enough providers (of all kinds) in the network that are geographically accessible (including via public transportation if necessary)?

Note that this will depend on a consumer's needs and preferences (e.g., comfort with family or friend transportation, based on prior disclosure of condition, or comfort with accessing a transport system, which may be labeled as a healthcare vehicle).

Do consumers need referrals to see specialists? How does a consumer get a referral?

It is important to know the plan's process for allowing a consumer to see specialists (including HIV, mental health, and substance use disorder providers). Consumers generally will need a PCP referral for a specialist visit. This information should be available on the Marketplace website. Some plans, such as Health Maintenance Organizations (HMOs), do not allow consumers to see out-of-network providers. Other plan types, such as Preferred Provider Organizations (PPOs) and Exclusive Provider Organizations (EPOs) allow consumers to see out-of-network providers but at significantly higher cost-sharing levels. EPOs do not require referrals for specialty visits.

	Plan 1	Plan 2	Plan 3
Referral required for specialist?	☐ Yes / No ☐	☐ Yes / No ☐	☐ Yes / No ☐
Out-of-network provider rules			
Special provisions / exceptions for individuals living with HIV?			

Is nutritional counseling or medical nutrition therapy available? If so, are there any limitations?

What is the scope of coverage of case management? Does it specifically include any complex treatment the client needs, or is case management subject to a "medically necessary" determination?

	Plan 1	Plan 2	Plan 3
Nutritional counseling / medical nutrition therapy	☐ Yes / No ☐ Limits: Subject to medically necessary determination: Automatically available for HIV:	☐ Yes / No ☐ Limits: Subject to medically necessary determination: Automatically available for HIV:	☐ Yes / No ☐ Limits: Subject to medically necessary determination: Automatically available for HIV:
Case management	☐ Yes / No ☐ Limits: Subject to medically necessary determination: Automatically available for HIV:	☐ Yes / No ☐ Limits: Subject to medically necessary determination: Automatically available for HIV:	☐ Yes / No ☐ Limits: Subject to medically necessary determination: Automatically available for HIV:

What are the procedures for getting outpatient mental health and/or substance use disorder treatment? Is the provider network for these services adequate?

If a consumer is already using behavioral health services, or would use them if they were affordable and accessible, it is important to choose a plan that contracts with his/her current provider (or provider of choice).

It is also critical to ensure that a QHP covers outpatient mental health and substance use disorder treatments, and to take note of any limitations on number of visits or on coverage of transitional services to assist a consumer to move back into the community (such as halfway houses or boarding houses).

	Plan 1	Plan 2	Plan 3
Mental health treatment coverage limitation?	Cap on outpatient visits: Cap on inpatient days:	Cap on outpatient visits: Cap on inpatient days:	Cap on outpatient visits: Cap on inpatient days:
Substance use disorder treatment coverage limitations?	Cap on outpatient visits: Cap on inpatient days:	Cap on outpatient visits: Cap on inpatient days:	Cap on outpatient visits: Cap on inpatient days:

Discrimination Risk Alert! Limits on mental health or substance use disorder services (both as to the type and quantity of services provided), or differentiation in cost-sharing requirements, may be discriminatory. In addition to the ACA's anti-discrimination provisions that protect against differentiating between consumers on the basis of health status, the ACA requires QHPs to follow parity laws. Parity laws require that coverage of mental health and substance use disorder services must be at least as generous and affordable as coverage of physical health services. In other words, coverage for mental health or substance use disorder visits should be the same as for all specialists. If a plan's rules vary based on the area of specialty, making it harder to see some specialists than it is to see others, these rules will likely be discriminatory in effect. For example, if a plan restricts the number of mental health visits but not other specialty visits, the plan may be discriminatory against consumers living with mental illness. (Appendix A describes the process of addressing discrimination).

STEP 4: ASSESS INPATIENT SERVICES

What cost-sharing schedules are imposed on a consumer for inpatient care, including emergency room visits?

Type of Care	Plan 1	Plan 2	Plan 3
Inpatient services	Deductible: Co-pay: Co-insurance: Cap on visits:	Deductible: Co-pay: Co-insurance: Cap on visits:	Deductible: Co-pay: Co-insurance: Cap on visits:
Ambulatory Urgent Care	Deductible: Co-pay: Co-insurance: Cap on visits:	Deductible: Co-pay: Co-insurance: Cap on visits:	Deductible: Co-pay: Co-insurance: Cap on visits:
Emergency Room	Deductible: Co-pay: Co-insurance: Cap on visits:	Deductible: Co-pay: Co-insurance: Cap on visits:	Deductible: Co-pay: Co-insurance: Cap on visits:
Skilled Nursing Facility	Deductible: Co-pay: Co-insurance: Cap on visits:	Deductible: Co-pay: Co-insurance: Cap on visits:	Deductible: Co-pay: Co-insurance: Cap on visits:
Mental Health Inpatient	Deductible: Co-pay: Co-insurance: Cap on visits:	Deductible: Co-pay: Co-insurance: Cap on visits:	Deductible: Co-pay: Co-insurance: Cap on visits:
Substance Use Disorder Inpatient	Deductible: Co-pay: Co-insurance: Cap on visits:	Deductible: Co-pay: Co-insurance: Cap on visits:	Deductible: Co-pay: Co-insurance: Cap on visits:

STEP 5: ASSESS MEDICATIONS

Does the plan have your client's medications on its formulary?

Insurance companies usually offer many different health plans. It is likely that most companies will offer multiple QHPs on a Marketplace. It is important to examine the formulary that applies to the particular QHP you are assessing, because formularies vary across plans even within the same insurance company. Formularies for each QHP will be available on Marketplace websites.

Within each formulary, most plans have cost-sharing "tiers", with generic medications available at the lowest cost-sharing levels while expensive brand-name medications require the consumer to pay significantly more.

Finally, prior authorization or step therapy may result in delayed treatment. Prior authorization requires a consumer's prescribing physician to call the insurance plan to get approval for a prescription before it will be covered. Step therapy requires a consumer to try a generic or lower cost drug and prove that it is medically ineffective (treatment must fail or be harmful) before coverage of a more expensive drug is approved. Ensuring that a client's medications will be available to the individual without treatment interruption is especially important where dose disruption may result in marked decline in health (e.g., HIV, schizophrenia, major depressive disorder).

Discrimination Risk Alert! Antiretroviral drugs (used to treat HIV) are often expensive. A consumer may need one or more brand-name drugs that do not have a generic equivalent (or the generic is harmful, ineffective, or requires adhering to a more difficult dosage regimen). Insurance plans impose higher cost-sharing levels for brand-name drugs, especially when a generic is available, even if the generic is not medically effective for a particular consumer. If a health plan requires higher cost-sharing or more step therapy or prior authorization steps for antiretroviral drugs (and treatments of opportunistic infections commonly associated with HIV) than it does for drugs used to treat other diseases, this may amount to prohibited discrimination. (Appendix A describes the process of addressing discrimination).

Client's medications:	Plan 1	Plan 2	Plan 3
________________	On formulary: Co-pay: Co-insurance: Deductible: Prior authorization: Step therapy: Monthly limit:	On formulary: Co-pay: Co-insurance: Deductible: Prior authorization: Step therapy: Monthly limit:	On formulary: Co-pay: Co-insurance: Deductible: Prior authorization: Step therapy: Monthly limit:
________________	On formulary: Co-pay: Co-insurance: Deductible: Prior authorization: Step therapy: Monthly limit:	On formulary: Co-pay: Co-insurance: Deductible: Prior authorization: Step therapy: Monthly limit:	On formulary: Co-pay: Co-insurance: Deductible: Prior authorization: Step therapy: Monthly limit:
________________	On formulary: Co-pay: Co-insurance: Deductible: Prior authorization: Step therapy: Monthly limit:	On formulary: Co-pay: Co-insurance: Deductible: Prior authorization: Step therapy: Monthly limit:	On formulary: Co-pay: Co-insurance: Deductible: Prior authorization: Step therapy: Monthly limit:

Pharmacies

Maintaining an ongoing relationship with a pharmacist can be an important objective for some consumers. In addition, if a consumer living with HIV/AIDS is eligible for ADAP co-pay assistance, it may be important to make sure that the plan provides access to a pharmacy that participates in ADAP (ADAP generally does not reimburse for drugs purchased at non-participating pharmacies).

	Plan 1	Plan 2	Plan 3
Plan uses preferred pharmacy?			
If yes, geographically accessible to client?			
Plan includes pharmacy that client already uses?			

ADAP coordination with the health plan's medication coverage

A state ADAP may assist with an eligible consumer's drug co-pays imposed by a private plan. If ADAP coordinates with private plans, it would pay this cost directly to a provider or pharmacy. If ADAP does not assist with private insurance affordability, a QHP may be too expensive for low-income consumers, even if subsidies apply.

	Plan 1	Plan 2	Plan 3
ADAP assists with prescription cost-sharing?			
If yes, who does ADAP reimburse?			

STEP 6: ASSESS DIABETES SERVICES (if applicable)

	Plan 1	Plan 2	Plan 3
Equipment & Supplies (note quantity limits if applicable)	Glucose monitors: Syringes: Glucose testing strips: Glucose tablets: Lancets:	Glucose monitors: Syringes: Glucose testing strips: Glucose tablets: Lancets:	Glucose monitors: Syringes: Glucose testing strips: Glucose tablets: Lancets:
Nutritional counseling			
Prescription drugs for treatment of long term obesity			
Diabetes self-management education			
Anti-diabetic drugs	Insulin: Metformin / glucophage: Other drugs client takes: _____	Insulin: Metformin / glucophage: Other drugs client takes: _____	Insulin: Metformin / glucophage: Other drugs client takes: _____
Case or care management	☐ Yes / No ☐ Limits:	☐ Yes / No ☐ Limits:	☐ Yes / No ☐ Limits:
Endocrinologist visit	☐ Yes / No ☐ Referral required? Caps on visits:	☐ Yes / No ☐ Referral required? Caps on visits:	☐ Yes / No ☐ Referral required? Caps on visits:

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STEP 7: ASSESS OTHER SPECIALTY SERVICES

Are there limitations on other specialty services that the client needs or might need? Are there any services your client might need that are specifically excluded from the plan's coverage? (Note that some plan lists of excluded services are non-exhaustive)

	Plan 1	Plan 2	Plan 3
Hospice	Limits:	Limits:	Limits:
Vision	☐ Yes / No ☐ Co-pay:	☐ Yes / No ☐ Co-pay:	☐ Yes / No ☐ Co-pay:
Oral health	☐ Yes / No ☐ Co-pay: Exclusions:	☐ Yes / No ☐ Co-pay: Exclusions:	☐ Yes / No ☐ Co-pay: Exclusions:
Chiropractic care	☐ Yes / No ☐ Co-pay: Limits:	☐ Yes / No ☐ Co-pay: Limits:	☐ Yes / No ☐ Co-pay: Limits:
Laboratory services	Co-pay (PCP ordered): Co-pay (specialist ordered): Limits:	Co-pay (PCP ordered): Co-pay (specialist ordered): Limits:	Co-pay (PCP ordered): Co-pay (specialist ordered): Limits:
X-ray / imaging services	Co-pay: Limits:	Co-pay: Limits:	Co-pay: Limits:
Durable medical equipment	Co-pay: Limits:	Co-pay: Limits:	Co-pay: Limits:

	Plan 1	Plan 2	Plan 3
Home health visits	Cost-sharing: Limits:	Cost-sharing: Limits:	Cost-sharing: Limits:
Rehabilitation services	Cost-sharing: Limits / exclusions:	Cost-sharing: Limits / exclusions:	Cost-sharing: Limits / exclusions:
Habilitative services	Cost-sharing: Limits / exclusions:	Cost-sharing: Limits / exclusions:	Cost-sharing: Limits / exclusions:
Dialysis	Cost-sharing: Limits:	Cost-sharing: Limits:	Cost-sharing: Limits:
Specific exclusions from plan			

Appendix A: Addressing Discrimination

The ACA prohibits QHPs from imposing any pre-existing condition exclusions or other discrimination based on health status, race, sex, age,[4] or disability. This means that a health plan cannot refuse to provide coverage for an illness or injury that you acquired before enrolling in the health plan, or provide you with fewer benefits than it provides others.[5]

Discrimination based on health status can take several forms, and is of special concern to consumers living with complex diseases such as HIV, because treatment involves multiple (often brand-name) drugs and frequent specialist visits that tend to be expensive for insurance companies.

For example, if a plan provides different access to drug treatment based on disease status (e.g., placing all antiretroviral drugs in the highest cost-sharing tier), it may be discriminatory. Alternatively, even if a plan appears to cover all treatments equally, it may be discriminatory in practice (e.g., requiring prior authorization for certain services, medicines, or providers, and consistently denying authorization of treatment for people living with HIV or other illnesses that require expensive and frequent care).

Addressing a Discriminatory Benefit Denial

Every insurance company that sells QHPs in a Marketplace must have a process for consumers to appeal benefit denials. When a benefit is denied, the plan must send a notice to the consumer, explaining the right to appeal as well as the process for doing so (including contact information for consumer assistance or ombudsmen offices).

If an appeal is denied (i.e., the plan continues to deny the benefit after doing an internal review of the decision), the consumer can request external review (by a neutral third party) of the plan's decision. A health plan must provide notice of this process as well.

Many states also offer Consumer Assistance Programs (CAPs), funded by the ACA. CAPs provide assistance with consumers' questions or problems regarding health coverage, including filing complaints and appealing decisions made by insurance plans. Other consumer resources are also available to provide assistance (e.g., existing ombudsmen and consumer assistance agencies).

If a plan seems discriminatory, advocates should bring it to the attention of state regulators (typically departments of insurance). States traditionally regulate insurance policies, and will continue to do so under the ACA. HHS will take enforcement action only where a state fails to intervene. Further guidance on how to report suspected discrimination that a state fails to address is forthcoming.

[4] Insurers cannot charge an older person more than three times the premium for a younger person. ACA § 2701.
[5] ACA §§ 1201, 154-56, 1557, 260-61.

Appendix B. Calculating Cost Sharing for Consumers Living Between 100-400% FPL

2013 Federal Poverty Line (FPL) Guidelines					
Family Size	**100% FPL**	**150% FPL**	**200% FPL**	**250% FPL**	**400% FPL**
1	$11,490	$17,235	$22,980	$28,725	$45,960
2	$15,510	$23,265	$31,020	$38,775	$62,040
3	$19,530	$29,295	$39,060	$48,825	$78,120
4	$23,550	$35,325	$47,100	$58,875	$94,200

Premium Limits Based on Income (Individual)		
Income	**Max % Income Spent on Premium**	**Max $ Spent on Premium**
100 - 150% FPL	2 - 4% annual income	$229.80 - $689.40
150 - 200% FPL	4 - 6.3% annual income	$689.40 - $1,447.74
200 - 250% FPL	6.3 - 8.05% annual income	$1,447.74 - $2,312.36
250 - 300% FPL	8.05 - 9.5% annual income	$2,312.36 - $3,274.65
300 - 400% FPL	9.5% annual income	$3,274.65 - $4,366.20

Total Cost Sharing Limits Based on Income (OOP + Premium Limits)			
Income	**Premium Limit ($ cap)**	**OOP $ Limit**	**Total Cost Sharing Limit**
100 - 150% FPL	$229.80 - $689.40	$2,116	$2345.80 - $2805.40
150 - 200% FPL	$689.40 - $1,447.74	$2,116	$2805.40 - $3563.74
200 - 250% FPL	$1,447.74 - $2,312.36	$3,175	$4622.74 - $5487.36
250 - 300% FPL	$2,312.36 - $3,274.65	$6,350	$8662.36 - $9624.65
300 - 400% FPL	$3,274.65 - $4,366.20	$6,350	$9624.65-$10716.20