

# Let's Ask 4: Questions for Consumers and Providers About Health Insurance

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*\*Participants in the Collaborative on Health Literacy and Access, Health Care Coverage, and Care of the Institute of Medicine Roundtable on Health Literacy*

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# Let's Ask 4: Questions for Consumers and Providers About Health Insurance

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## INTRODUCTION

Good health is important—for our work, our play, and our everyday lives. There are many things we can do to maintain good health. We can exercise, eat healthy foods, and not smoke. But sometimes we need medical care to help keep us from getting sick or help us get better when we are sick or injured. Medical care is expensive, so having health insurance is critical to helping us get and pay for the care we need. According to Bovbjerg and Hadley (2007), “Uninsured people receive less medical care and less timely care, they have worse health outcomes, and lack of insurance is a fiscal burden for them and their families.”

More than 45 million Americans were without health insurance in 2012 (Martinez and Cohen, 2013). The Patient Protection and Affordable Care Act (ACA) contains provisions designed to increase the number of insured in the United States, yet most Americans do not understand how the ACA will affect them and their options for health insurance ([click here for video](#)). The ACA is broad, has many components, and is hard to understand. We believe it is critical for both health care providers and consumers to be able to answer four basic questions:

1. What are my choices for health insurance?
2. How do I get it?
3. How do I use it?
4. How much will it cost me?

We conducted a widespread search to identify materials that are easy to access and understand, and that could be used to answer these four questions. Although there is an enormous amount of available information about the ACA, that information is scattered among many sources, the sources are frequently difficult to find, and often they are not easily understood. Therefore, we concluded that new tools, developed using the principles of health literacy, were needed.

We decided to focus on two broad audiences for whom information would be developed. The first is health providers and students in the health professions; the second is consumers. We thought that creating a series of presentations, one to answer each of the four questions, would be an appropriate way to reach providers and students. These presentations would be based on four

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<sup>1</sup> Participants in the Collaborative on Health Literacy and Access, Health Care Coverage, and Care of the Institute of Medicine Roundtable on Health Literacy.

sets of slides. For consumers, an easily understandable consumer guide was needed. These tools can be used by health providers and consumers to begin a shared conversation about choosing and using a health insurance plan.

### **Slides**

But how could we go about identifying and putting that information together so that it could be provided in a 1-hour presentation for each of the four questions? And how would we make sure that the information was reliable, understandable, and usable? To accomplish what we set out to do, we created the Let's Ask 4 project team, an unfunded interdisciplinary volunteer medical research team at Emory University. Team members performed an extensive literature search, gathering key information and resources required to answer the four questions. Hundreds of different sources were used, since no single source contained all of the needed information. Team members then tested the information from these sources in order to understand the practical application and potential challenges of using the information. For example, team members applied for Medicaid, called the Medicare helpline, and visited with employer human resource managers. All of the literature was collated into a PowerPoint presentation for each of the four questions, and these presentations were sent to a National Advisory Board for review.

After multiple rounds of input and edits, we presented the completed slides in a lecture series to more than 250 allied health students and resident physicians to test and improve the material. We incorporated feedback and revisions from multiple teaching sessions to finalize the slides. We also presented the slide sets to the Institute of Medicine Roundtable on Health Literacy and underwent one final review from industry experts, including health insurers, medical educators, pharmaceutical leadership, and health policy representatives.

### **Consumer Guide ([click here for guide](#))**

Once we had the information needed to answer the four questions summarized in four slide sets, we turned our attention to putting that information into a format that consumers could understand and use. The content for the consumer guide was initially based on the content and process of the slide sets. However, given the different audiences for the slide set (health professionals) and the consumer guide (consumers), we knew it was imperative that the consumer guide be easier to read, easier to understand, and actionable.

As we did in developing the slide sets, we applied health literacy principles to develop a document that is easy for consumers to understand and use. Specific techniques used included minimizing the use of words with many syllables, using headers that clearly describe content, ensuring white space, incorporating photographs that engage and reinforce the message, using interaction (e.g., a checklist for consumers to use), and active voice.

We field-tested the initial draft of the consumer guide with a convenience sample of patients from a broad spectrum of an urban community, including inner-city hospital ambulatory care clinic patients, middle- and upper-class patients with children of high-school or college age, attorneys in private practice, financial analysts, Medicare-eligible retired individuals, and graduate students. In total, about 125 consumers were asked what they liked or disliked about the

- language and words;
- layout and design;

- colors;
- charts;
- photographs;
- sample insurance card;
- organization of content;
- font type and size; and
- whether they would read it, glance through it, or throw it away.

We also sent the guide to the National Advisory Board for review. Based on patients’ and advisory board feedback, we modified the content and materials were re-tested. This was an iterative process.

The following sections describe, for each of the four questions, what we identified as key information to include, and then provides a summary overview of that information.

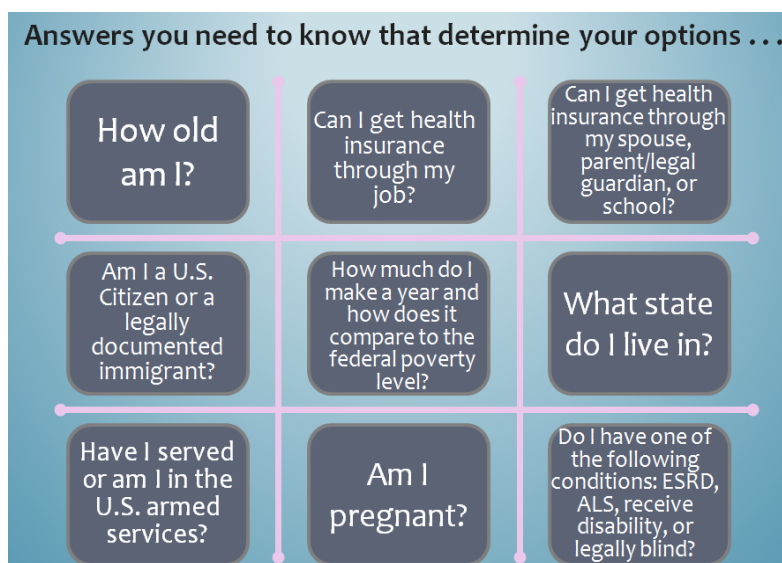
## QUESTIONS

### What Are My Choices for Health Insurance?

The first slide set ([click here for slides](#)) focuses on the question *What are my choices for health insurance?* We included in this set information about why health insurance is important, what important factors determine an individual’s options for health insurance coverage, what public and private insurance options are available, and a few key online resources.

We believe that health insurance is important because it helps people to get in to see a doctor or other health care provider, and is used to help pay for health care services. People who have health insurance usually have better health outcomes. For example, Americans with health insurance are less likely to die from a heart attack compared to those without health insurance (IOM, 2009). Also, the law (the ACA) says that beginning in 2014, all U.S. residents must have health insurance or they will have to pay a penalty.

In order to decide what insurance plan to choose, we identified nine questions that people will need to answer (see Figure 1). The answers to these questions impact which insurance plan is best for any given individual or family.



**FIGURE 1** Nine important questions to answer.

## *Kinds of Health Insurance*

Although we believe the answers to the questions in Figure 1 are basic to deciding which health insurance option is appropriate, more information is needed about each of the available options in order to decide what is best for any given individual or family. Therefore, when developing the slide set to answer Question 1, we included the following information about the various options:

- **Medicare** is for people 65 years of age or older, people receiving disability benefits from Social Security, people with Lou Gehrig's disease (ALS), or people with kidney disease (end-stage renal disease).
- **Medicaid** is for people with very low incomes and people receiving disability payments from Social Security. Each state decides who can get Medicaid in that state and the program may have a different name in some states. For example, the Medicaid program in Connecticut is called Husky Health. Go to [www.medicaid.gov](http://www.medicaid.gov) for information about each state.
- **CHIP** (the Children's Health Insurance Plan) is for children under 19 years old whose families make too much to get Medicaid but still don't make very much. Each state sets its own rules about which children can get free or low-cost health insurance. You can find more information at [www.insurekidsnow.gov](http://www.insurekidsnow.gov).
- **Employer-sponsored insurance:** Each employer that offers health insurance gets to decide what services will be paid for and how much each employee must pay in order to get the health insurance. If you are employed, you can talk with someone in your employer's human resources office to find out what plans are offered.

In addition to health insurance, some people can get health benefits in other ways:

- **Veterans Administration Health Benefit Program** (VA) health benefits are medical benefits given to veterans based on their eligibility. Eligibility is decided based on a veteran's service, injuries and illnesses, and income. Benefits also depend on where, when, and how long the veteran served. Family members who were not in the military do not usually get VA health benefits.
- **TRICARE**<sup>®</sup> provides health benefits to active-duty military and their families, uniformed service retirees and their families, individuals who received the medal of honor and their families, families of those who lost a spouse during active duty, and reservists activated for more than 30 days in a row. To be eligible for TRICARE, family members must be enrolled in the Defense Enrollment Eligibility Reporting System.
- **Indian Health Services** is a health care system that provides medical services to Native Americans who are members of a federally recognized Tribe.
- A **state health insurance marketplace** is a place where people can shop for health insurance. The ACA created the marketplaces to make it easier to buy health insurance. The marketplaces will start helping people enroll in October 2013. Health insurance coverage will begin in January 2014. The marketplaces provide information on cost and quality to help people understand what they are buying. They will help people
  1. compare available plans from different insurance companies on price, quality, and benefits.

2. select between different insurance plan levels (called “tiers”) that best fit their health needs.
3. fill out a simple application that will show their insurance options on the marketplace as well as other options they may be eligible for (e.g., Medicaid or CHIP).
4. use an online calculator to determine how much a plan will cost.

But some people may not be able to get one of the health insurance plans or receive health benefits. These people include those who make too much money to qualify for Medicaid but too little money to be able to buy health insurance in the state marketplaces. Undocumented immigrants are not eligible for the marketplaces. These individuals can look for

- **Community health centers:** federally run health centers provide primary and preventive health care. How much you pay is based on how much you make.
- **Free health clinics:** local nonprofit organizations that provide free charity care and some preventive health services.
- **Emergency room services:** anyone seeking treatment through an emergency room is guaranteed emergency care.
- Some health care providers and hospitals will sometimes offer discounts and financial assistance.

### **How Do I Get Health Insurance?**

The second basic question we identified is *How do I get health insurance?* Finding the right health insurance that you can afford may not be easy. We identified key information on how to get health insurance and included it in the second slide set ([click here for slides](#)). Because the law (ACA) says that *everyone* must purchase health insurance or pay a penalty, it is important for individuals to know how to obtain the kind of health insurance that is right for them. Basic information that we included about how to apply is described below.

#### *Medicare*

Some people automatically get Medicare. These are people who are

- turning 65 and already receive Social Security benefits;
- disabled people under 65 who have been receiving Social Security benefits for at least 24 months; and
- people with ALS who are receiving disability benefits from Social Security.

All others have to apply for Medicare. You may apply online ([www.socialsecurity.gov/retire](http://www.socialsecurity.gov/retire) or [www.Medicare.gov](http://www.Medicare.gov)). You may also apply in person at a local Social Security office.

To apply, you need:

- a birth certificate;
- proof of U.S. citizenship or documentation of immigrant status;
- a tax return or W-2 form; and
- if you served in the military, a copy of military service papers.

For questions, you may call 1-800-772-1213 or, for the deaf or speechimpaired, call 1-800-325-0778.

There is a **limited time period** to apply for Medicare. The period is the 3 months before turning 65, the month in which an individual turns 65, and the 3 months after turning 65. Those who miss that time period may have to pay more.

The different parts of Medicare are as follows:

- **Medicare Part A** covers inpatient hospital care, skilled nursing facility care, and hospice and home health.
- **Medicare Part B** covers outpatient care, home health care, durable medical equipment (that is, equipment that lasts, such as walkers or hospital beds, and some preventive care).
- **Medicare Part D** is prescription drug coverage. You do not have to enroll in Part D but if you want to, you must purchase this through a private insurer.
- **Medicare Part C** is called a Medicare Advantage Plan and includes Parts A and B and may include D. It may also include other services, but it may cost more than traditional Medicare. A Medicare Advantage Plan is run by a private insurance company.

### *Medicaid*

Medicaid can be applied for online at [www.medicaid.gov](http://www.medicaid.gov), by phone, or in person. Each state provides in-person assistance, including services for those with disabilities or extremely poor vision, to help with application. The locations where you can apply vary by state but help can often be found through the local Department of Social Services, Department of Family and Child Services, the health department, or a community health center, among others.

When applying for Medicaid, you may be asked for

- proof of U.S. citizenship or legal documentation of immigrant status;
- proof that you live in the state where you are applying;
- a valid Social Security number;
- a pay stub or other evidence of income;
- a birth certificate; or
- bank account information, if available.

### *Employer-Sponsored Insurance*

Because there is no single way to apply for employer-sponsored insurance, individuals should talk with their employers' human resources representative to find out how to apply.

### *Veterans' Benefits*

It is important to remember that veterans' benefits are not a health insurance plan. The benefits a veteran receives depends on his or her history of military service, specific injuries and illnesses, and financial need. To apply for benefits:

- Go online to [www.1010ez.med.va.gov/sec/vha/1010ez](http://www.1010ez.med.va.gov/sec/vha/1010ez)

- Print and mail the 10-10EZ form, which can be found at the same website: [www.1010ez.med.va.gov/sec/vha/1010ez](http://www.1010ez.med.va.gov/sec/vha/1010ez)
- Call by phone at 1-877-222-VETS (8387) between 8 a.m. and 8 p.m. Eastern time Monday through Friday
- Go in person to a nearby VA clinic or medical center

### *TRICARE®*

To enroll in TRICARE, go online to [www.tricare.mil/Welcome/Enrollment.aspx](http://www.tricare.mil/Welcome/Enrollment.aspx). Commanding officers should also be able to provide more information.

### *Health Insurance Marketplaces*

The options described above have existed for some time and there are established systems in place for finding out more about them. However, health insurance marketplaces are new and every state will have its own health insurance marketplace. These marketplaces are still under development in most states and understanding how to operate in the marketplaces is still uncertain. Yet, we believe that this is one of the most significant pieces of the ACA, and summarizing what is known at this time is key to understanding how to get health insurance through the marketplaces.

Sign-up for health insurance in the marketplaces begins in October 2013, and the health insurance coverage chosen begins in January 2014. Some states will run the marketplace themselves; others will be in a partnership with the federal government; and in some states the federal government will run the marketplace. This means that there will be differences across states. To find out about what is happening in each state marketplace, visit [www.healthcare.gov/marketplace/about/index.html](http://www.healthcare.gov/marketplace/about/index.html). People can use the marketplaces to find insurance if they

- are not offered or cannot afford employer sponsored insurance;
- are not eligible for Medicare or Medicaid; and
- are a U.S. citizen or documented immigrant.

Health insurance plans available in the marketplaces will cost more or less depending on what they cover, and will be divided into different levels or tiers. We believe it is important to understand the basics of these different levels since they differ on how much of health care costs the insurance plan pays and how much the consumer pays. The levels are called platinum, gold, silver, and bronze. Choosing what level is best for a specific individual or family is important. One way to choose which level makes the most sense is based on how much you usually spend on health care and how much you can afford to pay.

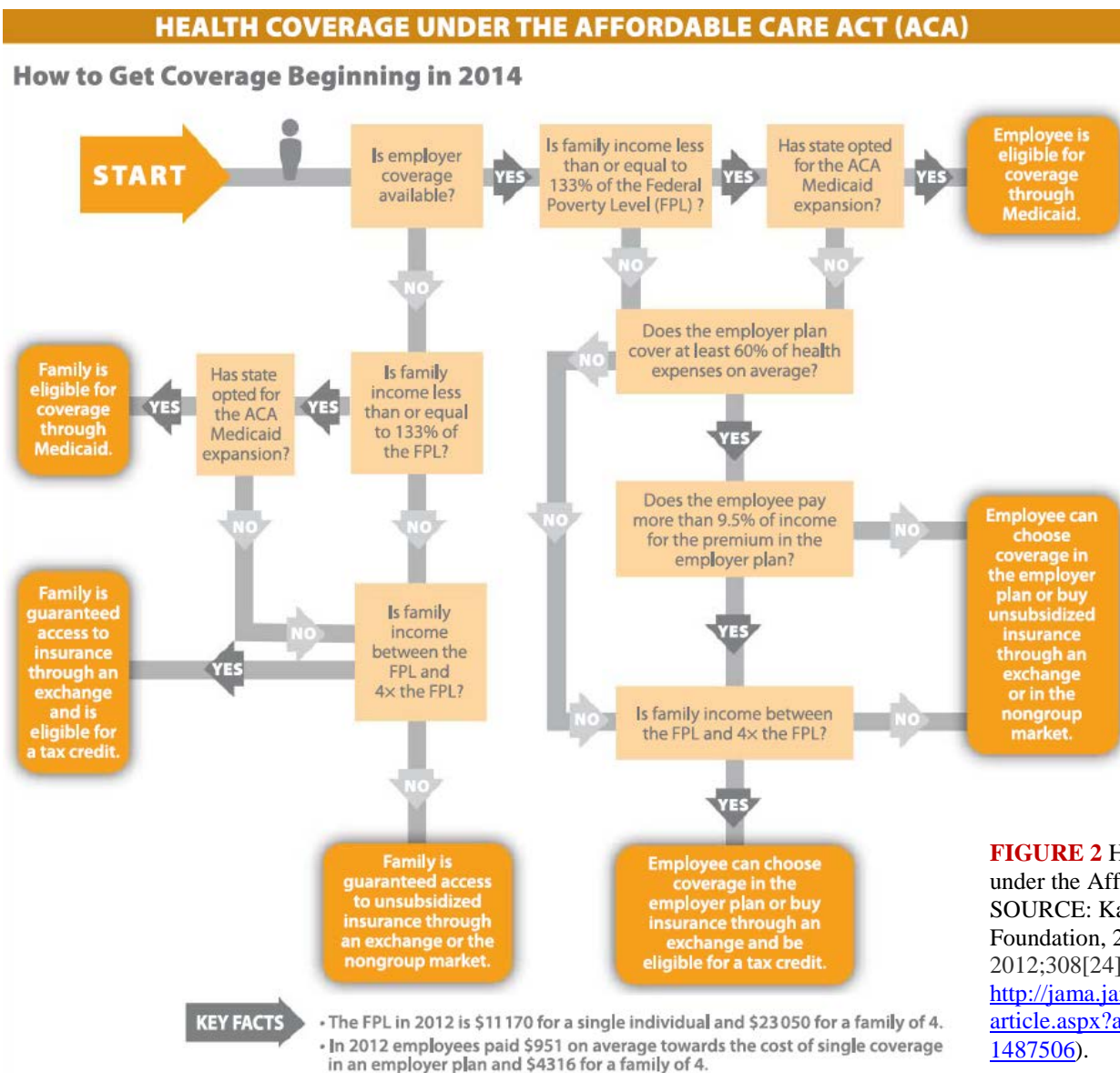
- In the **platinum level**, plans pay 90 percent of the costs of services and the consumer pays 10 percent. Plans in this level have a higher premium, that is, they cost more monthly. Those who use a lot of services may want to consider plans in this level.
- In the **gold level**, plans pay 80 percent of costs of services and the consumer pays 20 percent.



- In the **silver level**, plans pay 70 percent of the cost of services and the consumer pays 30 percent.
- In the **bronze level**, plans pay 60 percent of the costs of services and the consumer pays 40 percent. Plans in this level have lower monthly premiums, but a larger part of the cost for each service is paid for by the consumer. Those who think they will not use many services may want to consider plans at this level.

Every state health insurance marketplace will have consumer assistants to help guide consumers through the marketplace. These assistants will be called *navigators* (trained and licensed according to federal guidelines), *in-person assistors*, and *certified application counselors* (started by local community groups).

Below is a diagram that walks through the steps for getting health care insurance through the ACA.



**FIGURE 2** Health coverage under the Affordable Care Act. SOURCE: Kaiser Family Foundation, 2012 (*JAMA* 2012;308[24]:2556. <http://jama.jamanetwork.com/article.aspx?articleid=1487506>).

For those who still cannot afford a health insurance plan, tax credits and cost sharing subsidies are available based on income ([click here for a guide](#)) to understanding health insurance under the ACA).

### How Do I Use My Health Insurance?

The third basic question we identified is *How do I use my health insurance?* Getting health insurance is important, but knowing how to use that insurance is critical, for both your health and your pocketbook. The more you know about your plan, the better it can be used.

The third slide set ([click here for slides](#)) gives information about how to use health insurance once you get it. Each plan has rules about where to get health care services, which doctors and other health care professionals you can see, and how much it will cost. Each of us needs to understand and know the rules of how our insurance works so that we know what health services are covered and can figure out how much different health care services will cost us. There should be no fine print when it comes to insurance!

Using your health insurance plan effectively means that each of us needs to understand some basic terms and options. Some plans provide services through a **network** of providers. A network is made up of doctors and other health care professionals and health care settings (for example, a hospital or a clinic) that agree to provide care to all members of a plan at reduced costs.

It is also important to know that there are three basic ways that health care plans provide services. Knowing which of these approaches is taken by your own plan is critical for using services effectively and efficiently.

1. A **health maintenance organization** (HMO) has a network of providers that deliver services. You must see only those providers in order to get the services paid for by insurance. In an HMO you also need to have a primary care physician. A **primary care physician** is a doctor who takes care of general health problems. If you have a problem that needs a specialist, the primary care physician makes a referral to the appropriate specialist. You *must* get a referral from your primary care physician in order to be sure the plan pays for the specialist.
2. A **preferred provider organization** (PPO) also has a network of providers. You can see any health care provider you want but if that provider is not in the network, it will cost you more money than if the provider were in the network. And, if the provider is not on the network list, you must fill out paperwork to get payment.
3. A **point-of-service plan** (POS) also uses a network of providers. In a POS you must have a primary care doctor but that doctor does not need make a referral in order for you to see a specialist. Just check to be sure the specialist provider is part of the plan's network. Just as with a PPO, it costs more to see providers who are not part of the network.

There are different places that provide different kinds of care. The insurance plan may not cover care in every health care setting so it is important to check your specific insurance plan before getting services at these sites. Some of these places include the following:

- **Urgent care centers** provide extended-hour access for acute illness and injury care that can be used if you can't get an appointment with your primary care physician. You

should check to see if your insurance covers care at these centers. Urgent care centers are *not* the same as emergency rooms.

- **Emergency rooms** should be used only for true emergency situations. These are more expensive so if you do not have an emergency you are better off getting service someplace else. You can always get care at an ER regardless of your insurance plan. But if the medical condition can be treated elsewhere, it will cost you more to be seen in an ER.
- **Retail clinics** provide acute and preventive medical care. They are staffed mostly by nurse practitioners and physician assistants who follow medical protocols for care. They often have extended hours.
- **Public health departments and community health centers** provide immunizations, screening for infectious diseases such as tuberculosis and HIV/AIDS, and some treatment. They often serve as primary care centers for underserved areas.

Some plans provide additional benefits such as mental health benefits, dental care, eye care, medicines, and medical equipment. It is important to find out whether these services are covered. If the insurance plan does not cover these services, the consumer must pay the full price for them.

Under the ACA, all insurance plans are now required to provide a **summary of benefits and coverage** (SBC) that explains the plan in plain language. The SBC must be no more than 4 pages long and include

- a glossary of health coverage and medical terms;
- what the consumer's share of costs is;
- examples that show common benefits; and
- a link to where the actual policy can be found.

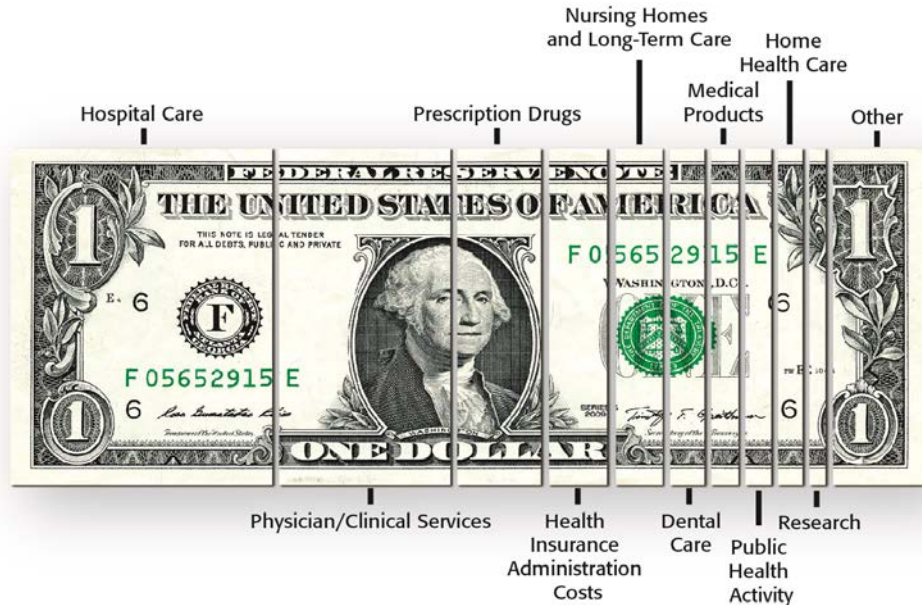
The rules of your insurance and details regarding covered services are in the SBC as well as in the initial enrollment packet. Also, the telephone number on the back of the insurance card is an important resource for getting specific help.

Once you are enrolled, the insurance company will send you a packet with more detailed information about the specifics of the plan as well as contact numbers for any questions. Be sure to read and understand these materials in order to know how best to take advantage of your plan! The insurance card also provides contact information for how to get answers to questions about what services are covered and how to use them. The insurance card is very important and should be carried at all times.

### **How Much Will It Cost Me?**

Most spending for health care costs in the United States is on hospital care, physician or clinical services, and prescription drugs (see Figure 3). As we looked for information to use in answering the question of how much it might cost consumers, we found this to be an extremely complicated question. Medical care costs vary depending on many things, including the kind of health insurance plan you have and the services you use. Still, we believe it is important to try to figure out how much you might pay for different services so that you can make wise choices that fit your pocketbook. The fourth slide set ([click here for slides](#)) talks about some important things

you need to know to figure out how much it will cost to use your health insurance to get medical care services.



**FIGURE 3** Portion of health care spending in the United States by type of services.  
SOURCE: Askin and Moore, 2012.

In trying to figure out how best to explain costs, we believe that there are some common terms you need to understand. A complete list of terms can be found at <http://www.healthcare.gov/glossary/a>. We identified the following as key terms. However, remember that actual costs vary depending on your own specific plan.

- **Premium:** the amount you pay for a health insurance plan (often monthly). There is a premium cost no matter what health insurance plan you have, even if no medical care services are used. Often, the higher the deductible, the lower the monthly premium.
- **Deductible:** the amount owed for health care services before the health insurance plan begins to pay. The costs that count as part of the deductible depend on the insurance plan, so it is important to know the deductible for your specific plan, since it is not the same for all insurance plans. In general, services and prescription medications covered by your plan count toward the deductible. Things that do *not* count toward the deductible include services not covered by the plan, the monthly premium, and copays.
- **Copay:** a fixed *amount* you must pay when receiving care for a covered service.
- **Co-insurance** (cost-sharing): your share of the costs of a covered health service, which is as a percent of service cost.
- **Covered services:** goods or services that insurance companies will help pay for as outlined in the health insurance plan.
- **Formulary:** a list of drugs the insurance plan covers.
- **Out-of-pocket maximum:** the most you pay during a policy period before the health insurance plan pays 100 percent of cost for the services that it covers in each specific plan.
- **Federal Poverty Level (FPL):** measure of income level as set by the federal government.
- **In-network/out-of-network:** in-network providers have contracts with insurance companies to offer lower rates for their services than out-of-network providers.

It is important to know that every time you get a service, you must help pay for the charge for that service. How much you pay depends on what is stated in your particular health insurance plan. Knowing the specific premium, copayments, coinsurance, and deductibles in your own plan is needed in order to be able to figure out how much you will spend for health care.

We have identified four questions that will help in figuring out how much you will have to pay. These are:

- **Is the provider or service in-network?** If the provider or service is out-of-network, there is a higher out-of-pocket payment. This is because the provider or service does not give a discount. Also, there may well be more forms that you will have to fill out and submit in order to get money back from the insurance plan for its share of the costs.
- **Is the provider or service covered by the plan?** If not, you may have to pay the full cost of the service, and those costs cannot be used to help reach the deductible. Ask the provider before getting care if the service is covered by the insurance plan.
- **How much is your insurance deductible, copay, and co-insurance?**
- **Have you met your out-of-pocket maximum for the year?**

We have identified some specific, basic, important information about costs as they relate to different insurance options. That information is provided below, by insurance option.

### *Medicare*

As discussed earlier, Medicare has Part A (hospitals, skilled nursing facilities), Part B (health care professional services), Part D (prescriptions), and Part C (a plan purchased from a private health insurance company). Most people do not have to pay a monthly premium for Medicare Part A because the premium is covered by the taxes an individual paid when working.

Most people do have to pay for Part B and for Part D. Currently (in 2013), the standard monthly premium for Part B is \$104.90 (Social Security Administration, 2013). The amount a specific individual must pay is based on his or her modified adjusted gross income and is calculated from the individual's income tax return. More information for higher-income earners can be found online ([www.ssa.gov/pubs/EN-05-10536.pdf](http://www.ssa.gov/pubs/EN-05-10536.pdf)).

### *Medicaid and CHIP*

The services available and the amount of cost sharing for those services vary by state. More information is available on each state's Medicaid and CHIP websites.

### *Veterans' Benefits*

The benefits a veteran receives and the amount he or she pays are determined by the **priority group** to which he or she is assigned when enrolling for benefits. For a description of each of the eight priority groups, go to [www.va.gov/healthbenefits/resources/priority\\_groups.asp](http://www.va.gov/healthbenefits/resources/priority_groups.asp).

### *Employer-Sponsored Insurance*

As discussed earlier, these plans vary greatly in terms of covered services and cost-sharing provisions (i.e., deductibles, co-pays, and co-insurance). Generally, monthly premiums for employer-sponsored health insurance plans are deducted from your paycheck. The employer's human resources officer will be the best person to provide information on the options available.

### *Health Insurance Marketplace*

Insurance plans on the marketplace will differ by cost sharing. In general, bronze plans have the lowest monthly premiums but require cost sharing at 40 percent for the consumer. Platinum plans have the most generous coverage benefits and only have 10 percent cost sharing by the consumer, but also have high premiums. An individual will have to balance the need for medical services, premium affordability, and anticipated cost sharing to determine which plan is best.

For those with low incomes, tax credits and subsidies are available to make health insurance more affordable. Premium tax credits will be provided on a sliding scale, meaning those with lower incomes will receive larger tax credits that can be applied to an individual's monthly premium. Consumers with incomes at or below 250 percent of the FPL will also be eligible for cost-sharing subsidies to help with out-of-pocket costs. Cost-sharing subsidies will be provided on a sliding scale. When a consumer applies for health insurance on the marketplace using the standardized application, the application will also help identify any premium tax credits and cost-sharing subsidies available to the patient.

## CONCLUSION

The world of health insurance will change on January 1, 2014, when all U.S. residents will be required to have health insurance or pay a penalty. We believe that easy-to-understand and easy-to-use tools are needed to provide clear information about how those changes affect consumers and providers. Two such tools are available: (1) slide sets that can be used to provide information for health care providers and students in health professions training and (2) a consumer guide. This paper summarizes information from those tools, information that can be used to help start a conversation between providers and consumers about how to get and use health insurance under the ACA. Additional details can be found in the discussion paper "Helping Consumers Understand and Use Health Insurance in 2014" ([click here for paper](#)) (Patel et al., 2013).

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