The Affordable Care Act (ACA) made a huge impact on our health care system and the way insurance works. It was designed to make health insurance coverage more fair, affordable and easy to understand. The ACA also expanded Medicaid eligibility to cover more people with lower incomes and created a health insurance marketplace.

The Health Insurance Marketplace is a way for people to shop for, compare and enroll in private or public health coverage. Financial assistance is available if you qualify to help lower the cost of coverage. This website is mainly for:

+ People who don't have insurance through a job or Medicare
+ New Yorkers ages 18-65 years old
+ New York small businesses with 100 or fewer employees

Please visit **nystateofhealth.ny.gov** for more information.

What is commercial or private insurance?

Commercial insurance is managed by private insurance companies and is usually offered through your job. This means your employer shares part of the cost of buying insurance. If your employer does not offer insurance plans, the health insurance marketplace is available for individuals to purchase commercial insurance.

What is public insurance?

Public health insurance includes government supported programs like Medicaid and Medicare. Medicaid helps eligible people with low to medium incomes pay for health insurance. If you are pregnant and under age 18, you can apply for Medicaid regardless of immigration status and income. Please visit **www.health.ny.gov/health_care/medicaid/** for more information.

What are managed care plans?

Managed care plans are health insurance plans that have contracts with health care providers and/or medical facilities to provide care at a lower cost. There are different types of managed care plans such as: HMO, PPO, POS and EPO (see glossary).

What are student health programs?

Students are often required to have health insurance, and colleges may offer health insurance to students called student health programs (SHP). Students may need to enroll in a SHP or prove they have other insurance coverage that is at least as good ("comparable coverage"). Please keep in mind that coverage from SHPs may not be enough if you have chronic medical conditions or take medications regularly.

How can I get on my parent's health insurance?

If your parent has health insurance through their job, you can often stay on their plan until age 26, and in some cases age 29, but this varies by insurance. Unfortunately, the latest that you may be allowed to stay on your family's Medicaid plan is age 19. If you would like to seek confidential sexual and reproductive care, you may be interested in applying for the Family Planning Benefits Program (FPBP) to ensure that these services are billed separately from your parent's insurance. Please refer to the resource page for further information.

What should I consider when choosing a health plan?

+ **Costs:**
  - Monthly premiums: how much you pay every month for the insurance plan
  - Deductibles: how much you pay out of pocket for care before insurance pays
  - Co-insurance and co-pays: your out-of-pocket costs for office visits (primary care and specialty), prescriptions, etc.
+ **Services covered:** consider if mental health, dental and prescriptions are covered
+ **Plan exclusions:** what services your plan doesn't cover
+ How many doctor visits you think you may need during the year (consider if you have any chronic illness that may require regular medical visits)
+ How often you need medication
+ Coverage for your doctors and specialists: in-network vs. out-of-network (see glossary)
+ Availability of a flexible spending account or a health savings account from your employer to help lower any future costs

How does disability impact health insurance?

If you have a disability and are unable to work because of it, you can stay on your parent's private health insurance even after you turn 26 years old. You may need to submit additional documents to complete this process. Please check with your insurance for more information. If you have a disability and are covered under your parent's Medicaid insurance plan, you must switch to your own Medicaid insurance plan at age 19. In order for your parent to communicate with your insurance plan, you must sign a release form.

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A Health Insurance Guide for Young Adults

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What is health insurance?

Health insurance is a way to pay for your health care. It protects you from having to pay the full costs of medical services if you are injured or sick. Each health insurance plan is different and covers different medical costs.

Why is health insurance important?

There are many reasons:

- ***It protects you*** from paying unexpected, high medical costs in full.
- ***It allows you to pay less*** for some health care services that are covered by your insurance plan.
- ***It gives you access to free care*** to prevent certain illnesses**,** like vaccines, check-ups and screenings.

Note: Please check with your insurance provider to see what services are covered in your plan. Some services may be fully covered while others may be partially covered or not covered at all.

Where can I get health insurance?

- Your job/employer
- Your college/university (Student Health Program)
- Health insurance marketplace
  - Commercial health insurance
  - Medicaid
- Your parent/guardian's health insurance

What if I do not have health insurance?

- You will be responsible for covering some, if not all, of your health care costs.
- You may be required to make a payment if you do not have minimum essential coverage or a coverage exemption when you file your tax return. To find out if you will need to make a payment or qualify for an exemption, please visit: **www.irs.gov/affordable-care-act/individuals-and-families/aca-individual-shared-responsibility-provision-calculating-the-payment**

Resources

Family Planning Benefits Program (FPBP):
A public health insurance program for New Yorkers who need family planning services, but may not be able to afford them **www.health.ny.gov/health_care/medicaid/program/longterm/familyplanbenprog.htm**

NYC Health + Hospitals:
New York City Health + Hospitals resource center for insurance
www.nychealthandhospitals.org/paying-for-your-health-care/

Youth Health Website:
A website for adolescents for additional resources on health care
www.nycyouthhealth.org/html/index.shtml

Medicaid Website:
The official New York Medicaid website
www.health.ny.gov/publications/0548/medicaid.htm

Tax Penalty Information:
A website for more information on tax penalties and exemptions
www.healthcare.gov/fees/fee-for-not-being-covered/
nystateofhealth.ny.gov/exemptions.html

Healthcare.gov:
A wealth of general information, including a glossary health care of terms
www.healthcare.gov/ www.healthcare.gov/glossary/

"Age 29" Law Information:
Information about continuing coverage under your parent's insurance past the age of 26 years old **www.dfs.ny.gov/consumers/health_insurance/cobra_and_premium_assistance**

If you do not have insurance and/or are unsure of how to get it, the following resources may be helpful:

NY State Health Insurance Marketplace:
The state-based health insurance marketplace that makes shopping for affordable health coverages easier for individuals, families and small business in New York. **nystateofhealth.ny.gov/**

Health Care for All: A public organization that provides information on accessing health-care, legal support, community organizing and public education. **hcfany.org/**

Glossary

Chronic Illness: A medical condition that is expected to last more than 3 months and usually requires ongoing care.

Co-insurance: Amount that you are required to pay for health care services, after a deductible has been paid. Co-insurance is often specified by a percentage of the total cost. For example, you may pay 20 percent toward the cost of a service and your insurance company may pay 80 percent.

Co-pay: A fixed amount you pay for covered health care services usually at the time of your visit. Generally, plans with lower monthly premiums have higher co-payments and plans with higher monthly premiums usually have lower co-payments.

Deductible: Amount that you must pay for health care expenses before insurance covers the costs. Often, insurance plans are based on yearly deductible amounts.

Exclusions: Conditions, treatments and other services that a health plan will not cover. These must be clearly spelled out in materials given to you about your plan.

Exclusive Provider Organization (EPO): A managed care health insurance plan where services are covered only if you use doctors, specialists, or hospitals in the plan's network (except in an emergency).

Family Planning Benefits Program (FPBP): The FPBP is a public health insurance program for New Yorkers who need family planning services, but may not be able to afford them. It is also intended to increase access to confidential sexual and reproductive health services. See resources page for more information.

Flexible Spending Account (FSA): An account you set up through your employer to pay for most medical expenses that are not covered by your insurance. Your employer will automatically deduct a pre-tax amount (the amount will vary) from your paycheck. However, if you do not use all the money in the account by the end of the year, you will lose it.

Health Maintenance Organization (HMO): A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. HMOs often provide coordinated care and focus on prevention and wellness.

Health Savings Account (HSA): Similar to flexible spending account, except if you do not use the money at the end of the year it will roll over into the following year.

In-Network Providers: Doctors who have a contract with your health insurance plan, so you pay less out of pocket to see them.

Out-Of-Pocket Maximum/Limit: The most you will have to pay for covered services in a plan year. After you spend this amount on deductibles, co-payments, and co-insurance for in-network care and services, your insurance plan pays 100% of the costs of covered benefits.

Out-Of-Network Providers: Doctors who do not have a contract with your health insurance plan, so you may pay more or be responsible for the entire bill to see them.

Preferred Provider Organization (PPO): A type of health insurance plan where you pay less if you use providers in the plan's network. You can use doctors, hospitals, and providers outside of the network without a referral for an additional cost.

Premium: Amount you pay to be a member of a health plan, usually paid monthly.

Point of Service (POS): A type of health insurance plan where you pay less if you use doctors, hospitals, and other health care providers that belong to the plan's network. POS plans require you to get a referral from your primary care doctor in order to see a specialist.