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Guide to the Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act, also known as the Affordable Care Act ("ACA"), or just Obamacare, was signed into law on March 23, 2010, and while some of its provisions have been in place since 2010 (like the coverage of children with pre-existing conditions), many of the biggest changes went into effect, as of January 1, 2014, while others have been delayed to January 1, 2015. While many are familiar with some of the provisions of the ACA, and many have been inundated with political rhetoric from all sides, leading to some confusion, this article is intended to give a straightforward summary of the new law and how it may impact you.

By: Patrick T. Ryan CFP®, Associate

Divorcing Individuals

Perhaps the most significant benefit of the ACA for individuals going through a divorce is the ability to find guaranteed health insurance coverage. Many individuals, particularly those who were insured through their spouse's employers and had a prior history of a health condition(s), had few, if any, options for health insurance coverage. Individual coverage through an insurance company was either unavailable or cost prohibitive. COBRA, if it applied (COBRA does not apply to smaller businesses), only offered coverage for three years. For individuals with pre-existing conditions, this was often only a temporary fix. Many needed to determine how to bridge the gap between the end of that coverage and the opportunity to qualify for Medicare. Even Illinois' Spousal Health Insurance Rights Act (SHIRA), which offered extended coverage benefits for individuals to assist in bridging the gap to Medicare coverage, as well as expanding coverage options for smaller employers not otherwise covered by COBRA, did not provide the blanket coverage that the ACA does. For many, the sheer cost of health insurance, or the prospect of having to go without it, was enough to force them to stay in a marriage that they would otherwise choose to end. Of course, it is always worth exploring one's options from a cost standpoint, but the fact that individuals now have that option is a significant step forward.

Major Changes

Pre-Existing Conditions

Perhaps the biggest change in the ACA is the fact that insurance companies can no longer decline coverage based on a pre-existing condition. Therefore, individuals who had trouble getting insurance because of their past medical history can no longer be denied coverage. Furthermore, this past medical history cannot be used as a basis to charge higher premiums to an individual – which often times had the impact of making health insurance unaffordable, and effectively priced individuals out of the market. Not only can insurers no longer consider your health status and prior medical history in in determining premiums, they can no longer

consider gender either. What insurers can consider is your age, where you live, whether you use tobacco and whether the coverage you are seeking is for you or your family.

Individual Mandate

While no one can be denied coverage, the law now requires everyone to have health insurance coverage, or face a tax penalty. The requirement for individual coverage has become known as the Individual Mandate. This requirement is often seen as the trade-off for the elimination of pre-existing conditions as a basis to decline coverage or charge higher premiums.

Insurance essentially works by spreading the total costs of coverage between healthy and sick people, and balancing the costs between them. When people are healthy, they are subsidizing the costs for those who are sick, and doing so, knowing that when they are sick, their costs will be subsidized by those will be subsidized by those that are healthy. The concept is to broaden the insurance base to provide enough people to balance these costs for the respective insurers, hence the Individual Mandate. The insurance you have though cannot be any old health insurance policy. Rather, the insurance coverage must meet certain minimum standards.

Minimum Coverage Requirements

As part of the ACA, there are certain Minimum Coverage Requirements that must be satisfied by a plan, for it to satisfy the requirements of the Individual Mandate. Not every insurance plan that previously existed satisfied these Minimum Coverage Requirements. For individuals that had catastrophic-only health insurance coverage, those plans would not meet the Minimum Coverage Requirements in order to satisfy the Individual Mandate. As a result, health insurers were cancelling policies that did not satisfy these requirements, and people were required to sign up for a plan that did meet the Minimum Coverage Requirements. This is what the uproar was about regarding President Obama's campaign pledge that "if you like your health insurance, you can keep the insurance you have." It should have noted that you can keep the insurance policy you have, provided it satisfies the Minimum Coverage Requirements of the Individual Mandate. However, the Minimum Coverage Requirements are not such a bad thing, and offer individuals additional coverage. Still, expanded coverage costs more, and while those people with less robust policies (like catastrophic-only coverage) will be required to have more comprehensive insurance, they will have to pay for it. In response to the uproar over this issue, the Obama Administration has allowed health insurance companies to continue to offer these plans to individuals that were previously covered under the "to-be cancelled" plans for another year.

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It should be noted that these individuals, as well as those covered through Medicare, Medicaid and the Children's Health Insurance Program all satisfy the requirements of the Individual Mandate. Many people that have coverage, whether independently or through their employer, also satisfy the Individual Mandate. For those that do not satisfy the Individual Mandate, they will face a tax penalty.

Tax Penalty

For those that opt not to get coverage, you will face a tax penalty in 2014, (technically in 2015 when tax returns are filed); however the full penalty will not go into effect until 2016. Essentially, the penalties are as follows for each uninsured person in the household:

2014 - $95 or 1% of annual household income, whichever is greater

2015 - $325 or 2% of annual household income, whichever is greater

2016 - $695 or 2.5% of annual household income, whichever is greater

Tax Exemptions

Of course there are exceptions to every rule. Exemptions are available for people that do not have health insurance that meets the Minimum Coverage Requirements, including:

- Coverage is unaffordable (It would cost more than 8% of your income)

- Certain financial hardships (like a death in the family or bankruptcy)

- No filing requirement (If your income is so low that you are not required to file a tax return)

- Membership in certain *recognized* groups, (Indian Tribes, Religious groups opposed to insurance)

Subsidies

For some individuals and families with lower income, you may qualify for a subsidy to help with the cost of coverage, now required by the Individual Mandate. The subsidy is in essence, a tax credit that is designed to cover a portion of your health insurance premiums. You can qualify for the credit if your household income is at 133% of the Federal Poverty Line, which for a family of four in 2013 would equate to $31,400. At that level, the tax subsidy would be aimed to insure that the family would not pay more than 2% of their income for a "Silver Plan" insurance premium. The subsidy continues up to 400% of the Federal Poverty Line, or $94,200 for that same family of four, when it is phased out. At that level, the tax subsidy would be aimed to insure that they did not pay more than 9.5% of their income for a "Silver Plan" premium. While the Silver Plan premium is intended to be the benchmark, individuals are not required to purchase a Silver Plan. They can opt for the less expensive Bronze Plan or the more expensive Gold or Platinum Plans.

Levels of Plans

The health insurance marketplace will offer four levels of plans, with each level covering a certain percentage of your healthcare costs:

Bronze – 60% cost coverage
Silver – 70% cost coverage
Gold – 80% cost coverage
Platinum – 90% cost coverage

The premiums will be cheapest for the Bronze plans, as they offer the lowest amount of coverage, and increase as the level of coverage increases.

Similar to traditional insurance plans, different levels of deductibles will also be available within the plan levels, with higher deductibles usually resulting in lower monthly premiums.

Medicaid

Under the ACA, Medicaid benefits were to be expanded to cover individuals earning up to 133% of the poverty line. The expansion of Medicaid benefits are fully funded by the federal government in the first three years, and then decline to 90% by 2020. If your income is not high enough that you can qualify for Medicaid benefits, the insurance marketplace websites will steer you in that direction. However, the Supreme Court ruled that the ACA cannot require every state to expand their Medicare coverage, so the actual coverage varies by state. In Illinois, Governor Quinn signed a law expanding Medicare coverage in accordance with the ACA.

Medicare

For those presently covered through Medicare, there is no need to sign up through the online marketplaces. As noted above, Medicare satisfies the Individual Mandate, and once you are signed up, the ACA does not require you to sign up again. There is also an expansion of preventative services, like mammograms and colonoscopies, through Medicare under the ACA. Perhaps the most significant is the closing of what is known as the "donut hole" (the gap in prescription drug coverage, after meeting the deductible, where seniors were required to pay 100% of their prescription costs before coverage resumed) in the Medicare prescription drug coverage (Medicare Part D). The ACA also takes aim at Medicare fraud and waste, with a goal of lowering these expenses, thereby extending the life of the Medicare Trust Fund.

10 Benefits of Minimum Coverage Requirements (from healthcare.gov)

1. Outpatient care—the kind you get without being admitted to a hospital
2. Trips to the emergency room
3. Treatment in the hospital for inpatient care
4. Care before and after your baby is born
5. Mental health and substance use disorder services: This includes behavioral health treatment, counseling, and psychotherapy
6. Your prescription drugs
7. Services and devices to help you recover if you are injured, or have a disability or chronic condition. This includes physical and occupational therapy, speech-language pathology, psychiatric rehabilitation, and more.
8. Your lab tests
9. Preventive services including counseling, screenings and vaccines to keep you healthy and care for managing a chronic disease.
10. Pediatric services: This includes dental care and vision care for kids

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The ACA and You

How do I get coverage?

If you are an individual looking for coverage, chances are you are already covered by an employer or spouse's employer. However, nothing prevents you from seeking your own individual or family coverage, outside of employer provided coverage, if it makes financial sense.

So where do I go?

getcoveredillinois.gov

This is the Official Health Marketplace for the State of Illinois. Though the website is easy to navigate, it is largely set up to guide you to the appropriate location for insurance, and will redirect you to the appropriate website, whether it is the national healthcare marketplace, SHOP Exchange, Medicaid, or Medicare.

healthcare.gov

This website is now infamous for its initial difficulties during the rollout of the insurance marketplace. However, it has vastly improved in quality and ease of use since that time.

Only 16 states run their own marketplace. 7 others are a "partnership" with the Federal Government (like Illinois) and the Federal Government is running the rest.

Where can I enroll?

Similar to traditional insurance plans, there is an "open enrollment" period for the online marketplaces under the ACA. Individuals have been able to enroll through the online marketplaces since October 1, 2013 and individuals can continue to enroll there through March 31, 2014. If you enroll during this period, you will qualify for coverage beginning in 2014, but your coverage will not begin immediately. If you sign up by the 15th of a month, your coverage will begin on the 1st of the following month. Otherwise, if you sign up after the 15th, you will have to wait until the following month.

For coverage in 2015 and beyond, the marketplaces will begin open enrollment on November 15, and carry through to January 15. Similar to traditional health insurance coverage, there are also exceptions to the open enrollment periods for "qualifying life events," like the birth of a child, marriage or divorce.

What if I need help?

If you need help signing up online, there are people available to help individuals with the enrollment process. Known as "Navigators," these are individuals certified as part of a larger program that the states are required to establish in order to help individuals enroll in the online marketplaces. Per the Illinois website: "The role of Navigators also includes outreach and education efforts, providing unbiased and accurate information, and helping individuals apply for coverage." The Navigators are typically individuals from community based organizations and non-profits, who offer help for free (they are not allowed to receive compensation from individuals or health insurers for signing people up). You can find a local Navigator by going to localhelp.healthcare.gov.

Keep in mind though, that Navigators are only supposed to help you sign up for coverage. If you have questions regarding which policy is best for you and your family, you should consult with a traditional insurance broker, financial planner or similarly qualified advisor. These individuals may charge you, or be otherwise compensated, for their services.

Key Consideration

When obtaining insurance through your employer, the monthly premiums can be, and typically are, deducted directly from your paycheck. This enables the entire amount to be paid with "pre-tax" dollars. When paying for your own policy out of pocket, you are not able to deduct the full amount. Rather, you are only allowed to deduct the premiums you pay, along with all other qualified medical related costs, to the extent that those costs exceed 10% of your Adjusted Gross Income (presently 7.5% for those 65 and older). So if you have the option of coverage through your employer, don't just look at the premium cost on the online marketplace. Being able to pay with "pre-tax" dollars offers a significant savings, and should be considered when looking at your insurance options.

The Employer Mandate

Under the ACA, larger business owners (those with 50 or more "full time" employees) are required to provide coverage to their employees, or face increasing fines. These provisions are considered to be the most complex provisions for business owners, both big and small, to understand, and more importantly, implement effectively. Citing these very reasons, on July 2, 2013, the Obama Administration delayed enforcement of the ACA's provisions regarding larger employers for a year, to January 1, 2015.

SHOP Exchanges

Smaller businesses were exempt from the coverage requirements of the Employer Mandate, but the ACA will set up online insurance exchanges for smaller employers, known as SHOP ("**S**mall Business **H**ealth **O**ptions **P**rogram) Exchanges. SHOP Exchanges are designed to give small business owners (those with 25 or less "full time" employees in 2014, 50 or less in 2015, and 100 or less in 2016), their own online marketplace to compare and purchase plans for their employees. However, on November 27, 2013, the ability to enroll online in the SHOP Exchange was suspended for a year, to November of 2014.

The additional details of the ACA and Employers, including SHOP Exchanges, the "Cadillac" tax, and what it means to be a "full-time" employee will be covered in the next installment.

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Navigating Healthcare.gov

After hearing about all of the issues and problems with the online marketplace, I decided to try it out for myself to see what the fuss was about. I found my experience to be easy, and did not run into the issues that I had heard so much about – likely due to the intensive repairs to the website. It did not take me long to navigate through the website to see what my options were.

I started at getcoveredillinois.gov under the "How To Get Covered" Tab. I answered 8 simple questions and was directed, via a link, to the healthcare.gov website. There I chose Illinois as my state for coverage, and answered some additional background questions, like name, address, type of coverage and the personal information of those I was seeking coverage for (my wife and daughter), as well as whether or not I used tobacco. (*If you are applying for family coverage, be sure to have everyone's SSN. While you are not required to submit it, it is much easier than the other options for establishing U.S. citizenship of those that will be covered*). I was then given a total of 65 plan options, from 6 different insurance companies, and asked to choose which level of coverage I might be interested in. I was able to see all 65 options if I wished, or any combination of Plan Level options, but instead I chose Gold (80% coverage), and it gave me 19 options through 6 different insurance companies. I was able to sort these options by the monthly premium amount (lowest to highest), Maximum Out-of-Pocket (lowest to highest), or the Health Plan Name (A-Z or Z-A). From there I was given the following information from each plan option:

- Plan Name (including insurance provider)
- Monthly Premium
- Deductible Amount
- Out-of-Pocket Maximum
- Co-Payments/Co-Insurance (Primary, Specialist, and Generic Prescription)
- Whether or not it included Dental, and for who in my family (i.e. my child)

It also offered links to the Plan Brochure, the Summary of Benefits and the Provider Directory, which all opened new pages on the respective insurance company websites.

From there I could select which plans I wanted to compare, and by clicking on a simple "Compare" tab, it laid out side-by-side comparisons, with additional detailed information, for me to review. I was then able to narrow my choices down to three plan options with varying costs, based on the monthly premium, deductible and out of pocket maximum, to determine which would be the best fit for my family. I ultimately decided to stick with my employer's plan, but it was very insightful to easily compare options on the marketplace.