How to Get the Most Out of the Affordable Care Act

A Quick Guide for Michigan Residents

Introduction

Let's face it: Many people still don't understand the Affordable Care Act (ACA). Also known as "health reform," we've had lots of time to get to know the sweeping law since President Obama signed the ACA in March 2010. But it's complex, and *nearly 1,000 pages long*. Most folks find health insurance to be kind of boring and confusing. They just want it to cover them if they get sick or injured. Plus, there's been plenty of bad information out there.

But it's really important for everyone to have some kind of health insurance. You never know when you will find out you have an expensive illness, or suffer an unexpected injury, and not be able to afford your medical bills.

So … we're here to help you sort it all out in a simple, straight-forward manner. Then you'll be able to get the most out of the ACA for you and your family.

Now is definitely the time get started. Whether you were aware of it or not, many parts of the ACA became reality between 2011 and 2013. On Oct. 1, 2013, Michigan's new Health Insurance Marketplace or "Exchange" begins selling health plans on the Internet. On Jan. 1, 2014, key parts of the ACA take effect.

If you get health insurance through your employer, you may not notice many changes or benefits from the ACA, though it definitely provides some important protections for consumers. But if you're someone who buys health insurance directly—or would like to—you may be surprised at all the good things the ACA has to offer you and your family.

And if you don't make much money, you may be able to get some help to assist you in paying for insurance, lowering the cost so you can afford to buy it. You'll find plenty of information in this guide under the following sections:

First, A Little Background

Why We Have Health Insurance

For people who have it, health insurance usually pays for most of the care they receive if they get seriously sick or injured. The main purpose of health insurance is to protect against the risk of a major financial loss. In other words, it's supposed to keep you from going bankrupt because of huge medical bills.

But health insurance can also help you stay healthy. It can pay for regular visits to a doctor who can catch illnesses early. Doctors can help you lose weight, or stop smoking, or deal with asthma, and addressing these conditions early can help you live longer and better, avoid missing work, and have a better quality of life.

Unfortunately, about 48 million Americans (more than 15 percent of all citizens) don't have the protection of health insurance—they're uninsured. That's a big reason why more than half (about one million) of all personal bankruptcies in the United States each year are medical bankruptcies.

But even having health insurance may not protect you from a medical bankruptcy. Read on to see why.

Not All Health Plans are Created Equal

Health insurance in the U.S. comes in two basic flavors: government and private.

Government health plans are actually the rights of specific groups of people to certain health insurance benefits, mostly paid for by taxes. The biggest ones are Medicare for people 65 and older, Medicaid for certain people—mostly children, the disabled, and senior citizens—with low incomes, and TriCare for military veterans. Government health plans don't drop eligible members except for fraud.

Private health plans are products sold by hundreds of insurance companies, both for-profit and nonprofit. These plans are either bought by employers as a job benefit for their workers, or paid for directly by individuals and small businesses.

Where Medical Bankruptcies Come In

People in private health plans offered by an employer usually lose their insurance coverage when they lose or leave their jobs. Often, it's a serious illness or sudden disability that forces them to quit working and lose coverage. People who buy their own private health plans—if they can find one that's affordable in the first place—have often been dropped from coverage because they came down with a serious illness like cancer. And after that, other private health plans wouldn't insure them either.

In fact, even with health insurance, many people with very costly health problems have been wiped out financially. That's because their plans had high deductibles, co-pays, and co-insurance, and they couldn't afford to pay those because the medical bills were so high. Another reason is because of annual and lifetime limits. (If common insurance terms make your eyes glaze over, you'll find some short and sweet definitions at *http://tinyurl.com/85m3kny*.)

Reform is Based on a "Conservative" Concept

Back when Congress was debating health reform in 2009, some groups (mostly "liberals") wanted "universal health coverage" like that in Canada. There, health coverage is viewed as every citizen's right. Health care providers are paid by a "single payer"—the Canadian government, using tax dollars—instead of by insurance companies using money they make selling policies. There are no deductibles for basic care, and copayments are low or nonexistent. In the U.S., this concept was sometimes called "Medicare for all."

What America wound up with is health reform based on the (mostly "conservative") idea that it is the individual's responsibility to be insured. Based on the model used in Massachusetts since 2006, this "individual mandate" was the most hotly debated part of health care reform. Though the courts have upheld it, this is still the least understood aspect of the law. But it actually strengthens private insurance companies and keeps them competing in a free-enterprise system. It does not replace them with a government-run health system.

Health Reform Highlights

Goals of the Affordable Care Act

- Make health coverage and health care available to everyone
- Establish greater consumer protections
- Make it easier for you to shop for and buy affordable health insurance
- Control the cost and increase the quality of health care
- Increase coverage for prevention of health problems

The "Individual Mandate"

Several important pieces of the Affordable Care Act are already in place. Children can now stay on their parent's coverage until they are 26. Insurers are now required to pay 80 percent of every dollar they get on health care and improving quality.

The last major pieces of the Affordable Care Act, including the "individual mandate," take effect on Jan. 1, 2014.

Basically—but with some exceptions—this part of the ACA says that, if you don't already have a government or private health plan, then you must either buy an approved private health insurance policy or pay a relatively small tax penalty.

If you're not one of the exceptions, your deadline for having a health plan is March 31, 2014.

The reason for the "individual mandate" is simple: The whole idea of insurance is to spread the cost of protecting against major risks among a large number of people. That way, the protection is affordable for just about everyone. And when medical calamities strike a predictable fraction of the group, there's enough money set aside to cover their losses on health care bills.

The ACA is not a single-payer "government medicine" program. It doesn't even create an option for people to join a Medicare plan that competes with private insurance plans. By requiring people to buy health plans from private companies, the ACA should increase business for those companies.

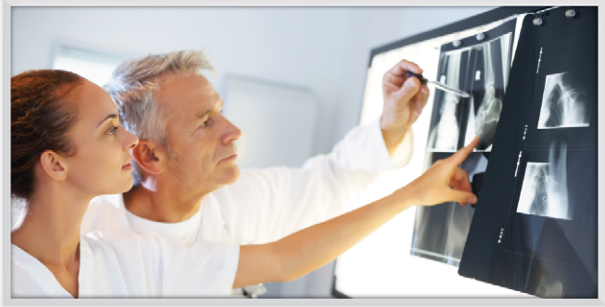
"Minimum Essential Health Benefits"

The ACA says ten "essential health benefits" must be included in all private health insurance plans sold to individuals, families and small businesses after Jan. 1, 2014:

- Patient office visits
- Emergency care
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Laboratory services
- Preventive and wellness services, and chronic disease management
- Pediatric services, including oral and vision care
- Rehabilitative services and devices

Is Your Health Plan "Grandfathered" or Not?

If you are in a "grandfathered" private health plan (one that was in place before March 23, 2010, when the Affordable Care Act was signed into law) it is not required to provide the "minimum essential health benefits." Nor must it offer some of the other benefits of health reform. So, it's important for you to determine whether or not your health plan is "grandfathered." If you get health insurance through work, ask your employer. If you bought a plan yourself, check with your broker, agent, or insurance company.



Note that the ACA does not say health plans must offer 100 percent coverage of these services. For most, insurance companies are permitted to use "cost-sharing" devices like copays, deductibles, and co-insurance to "share" part of the cost with you.

Some of these services are so extensive that we list them under separate headings below.

Tax Penalties for Lack of Coverage

Most people who don't have health insurance as of Jan. 1, 2014, will pay a tax penalty on their income tax returns:

- In 2014, the tax penalty for each uninsured adult in the household is $95 or up to 1 percent of income, whichever is greater, but no more than $285 per household.
- In 2015, tax penalty rises to $325 per uninsured adult or 2 percent of income, but no more than $975 per household.
- In 2016, the tax penalty per uninsured adult will be $695 or 2.5 percent of income, whichever is greater, but no more than $2,085.

Note, too, that for people under 18 the tax penalties are half the adult amounts.

Exceptions from the Mandate

People who are exempt from the ACA requirement to have coverage include:

- Those who are not required to file taxes
- Citizens living outside of the United States
- Members of Indian tribes
- Prison inmates
- People earning less than the poverty level
- Those who have a legitimate religious reason for not believing in insurance
- People who can't afford it (the cost is "unaffordable" if it is more than 8 percent of the household's income)
- Those with a coverage gap of less than three months during the year (and therefore not required to report it on their tax returns)
- People with a hardship waiver (due to unusual circumstances such as a natural disaster)

In addition, people under 30 years old may buy a policy that only pays for catastrophic medical costs, but it must allow for at least three primary care visits a year.

Big Rewards for Individuals & Families

Reward #1: Guaranteed Coverage

If being forced to buy insurance coverage rubs you the wrong way, you'll like what you get in return: For starters, guaranteed coverage, even if you are in poor health.

Beginning in 2014, it becomes illegal for insurance companies to discriminate against anyone for being seriously ill or having a disability. You can't be excluded from coverage or charged a higher premium because you have such a "pre-existing condition"—or because you are a woman, as has happened in the past.

Another valuable new consumer protection in 2014 is that your health coverage cannot be cut off or capped with an annual or lifetime dollar limit (which did happen previously).
It continues regardless of how sick you may get or how much the insurer has spent on health care to help you get better.

Need Medicaid Coverage Before the Exchange Opens?

If you have a low income and need health coverage for yourself and your children, you may already qualify for no-cost or low-cost health insurance through Medicaid and MIChild (our state's version of the Children's Health Insurance Program). Find out by calling Michigan Enrolls at *1-888-ENROLLS* (or 1-888-367-6557). You can also apply for MIChild coverage online at *http://tinyurl.com/mfkqqz*.

Reward #2:
Michigan's Health Insurance Marketplace

Beginning in October 2013, Michigan residents will be able to buy coverage on our state's new Health Insurance Marketplace. Also known as the "Exchange," it will be operated by the U.S. Dept. of Health and Human Services, since state lawmakers rejected the option of having Michigan run it.

Families and individuals who don't already have health care through an employer have the chance to use Michigan's Exchange to buy health plans directly. If you fit this description, you'll have more health plans to choose from and, it is expected, at lower prices than you could before—similar to a big business.

You'll be able to compare and select plans online, the same way you might do with airline tickets. The plans will be grouped into four tiers—platinum, gold, silver, and bronze. There will be other options for young adults, and stand-alone dental plans for sale.

Also, Michigan's Health Insurance Marketplace will help you figure out if you're eligible for Medicaid. If so, it will enable you to apply for Medicaid online, instead of buying a private health plan. Medicaid eligibility is generally based on your household income in relation to the *federal poverty guidelines*, as well as other factors such as age, disability, and whether or not you have a dependent child.

The Affordable Care Act gave states the option to expand Medicaid eligibility to non-elderly citizens whose incomes are as high as 138 percent of the poverty level. Michigan's legislature is currently debating whether or not to do this.

Reward #3: New Tax Credits to Cut the Cost

Starting on Jan. 1, 2014, people with incomes of up to four times higher than the federal poverty level (400% of FPL) will be eligible for a new kind of tax credit that reduces the monthly cost of health insurance instantly. The tax credits will be available to individuals earning up to $43,000 a year, and families making up to about $88,000. The tax credit amounts will be based on a sliding scale: The less you earn, the bigger the credit you'll receive.

The purpose of these credits is to lower the cost of buying a private health insurance plan. To take advantage of this, you'll just need to purchase the health plan through Michigan's Health Insurance Marketplace. When you submit your insurance application through the Exchange, you'll immediately see the amount of any tax credit for which you're eligible.

Then, at the time you buy a health plan through the Exchange, your tax credit can be sent directly to your insurance company, which will cut your premium cost accordingly. That way, you pay less out of pocket when the company bills you each month.

Caution: Be Accurate About Your Income When Buying Coverage through the Exchange

The amount of tax credit you're eligible for depends on how much income your family expects to earn. When you apply for coverage through the Exchange (enrollment starts in October 2013), it's important to make sure your income estimate is accurate. Otherwise, if the amount you list is a lot less than your actual income, you'll get too big of a tax credit and may have to pay part of it back at the end of the year.

New Consumer Protections

As of Jan. 1, 2014, these rules apply to all group health plans and individual health insurance policies created or sold after March 23, 2010, when the Affordable Care Act was signed into law. However, not all of these rules apply to "grandfathered health plans."

Consumer Rights Created by the ACA

- Your health insurance policy must be written in plain language. You must be given access to simple summaries of your health plan's benefits and costs that help you understand your coverage and compare coverage options.
- If you are a young adult under 26 years old, you may be eligible for coverage under a health plan belonging to one of your parents.
- You are entitled to choose any primary care doctor you want who's part of your health plan's network and is accepting new patients. This includes OB-GYN specialists and pediatricians.
- You can get emergency care at a hospital outside your health plan's network without prior approval. Your insurance company cannot charge you higher co-payments or co-insurance for out-of-network emergency room services.
- Your insurance company cannot impose annual or lifetime dollar limits on your coverage for essential health benefits.
- Your insurance company cannot discriminate against anyone by limiting or denying benefits—or charging you more—due to a "pre-existing condition." This includes newborns with health problems, people with disabilities, those with chronic conditions such as diabetes, and people who have life-threatening illnesses such as cancer.

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Consumer Rights Created by the ACA *(continued)*

- If you are a woman, your insurance company cannot discriminate against you by charging you higher premiums because of your gender, or by denying coverage because you are or have been pregnant.
- Your insurance company can no longer cancel your coverage because you made an honest mistake on your application.
- Your insurance company must spend 80 or 85 cents of each of your premium dollars on health care. Insurance companies call this the "medical loss ratio." Your company can spend no more than 15 to 20 cents of your premium dollar on administrative costs, marketing and overhead.
- Insurance companies must publicly justify to a Michigan rate-review body increases of 10 percent or more in the average premiums it charges to individuals or small businesses.

You have a right to ask your insurance company to reconsider any denial of payment for services you believe were covered. If you still disagree with the company's coverage decision after that, you have a right to appeal to an external authority.

If you have questions or need help, there's someone to help

You have direct access to help through a new Consumer Assistance Program (CAP) if you experience problems with your health plan or have questions about your coverage. Michigan's CAP is run by the state's Department of Insurance and Financial Services. You can contact it by calling *(877) 999-6442* or by email through this website: *http://www.michigan.gov/HICAP*.

New Benefits for All Adults

Under health reform, you won't be charged a copay or co-insurance, or have to meet a deductible, in order to receive free preventive services—so long as they are delivered by a physician or other health care provider in your health plan's network.

As of Jan. 1, 2014, a large number of preventive services will be covered at no cost to you by most private health plans (but not necessarily by grandfathered plans).

Covered Preventive Services for Adults

1. Abdominal aortic aneurysm one-time screening for men of specified ages who have ever smoked
2. Alcohol misuse screening and counseling
3. Aspirin use for men and women of certain ages
4. Blood pressure screening
5. Cholesterol screening for adults of certain ages or at higher risk
6. Colorectal cancer screening for adults over 50
7. Depression screening for adults
8. Type 2 diabetes screening for adults with high blood pressure
9. Diet counseling for adults at higher risk for chronic disease
10. HIV screening for adults at higher risk
11. Immunization vaccines for adults (doses, recommended ages, and recommended populations vary):
    - Hepatitis A
    - Hepatitis B
    - Herpes Zoster
    - Human Papillomavirus
    - Influenza (flu shot)
    - Measles, Mumps, Rubella
    - Meningococcal
    - Pneumococcal
    - Tetanus, Diphtheria, Pertussis
    - Varicella (chicken pox)
12. Obesity screening and counseling
13. Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
14. Tobacco use screening and cessation interventions
15. Syphilis screening for all adults at higher risk

New Benefits for Women

The Affordable Care Act takes extraordinary steps to help improve women's health and access to health care services.

Women under age 65 are now guaranteed access to preventive services, such as mammograms and birth control, with no out-of-pocket costs. Essential benefits required in new plans (but not grandfathered plans) include the following preventive services.

As of Jan. 1, 2014, a large number of preventive services will be covered at no cost to you by most private health plans (but not necessarily by grandfathered plans).

Covered Preventive Services Just for Women

1. Anemia screening on a routine basis during pregnancy
2. Bacterial urinary tract or other infection screening for pregnant women
3. BRCA counseling about genetic testing for women at higher risk of breast cancer
4. Breast cancer mammography screenings every 1 to 2 years for women over 40
5. Breast cancer chemoprevention counseling for women at higher risk
6. Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women
7. Cervical cancer screening for sexually active women
8. Chlamydia infection screening for younger women and others at higher risk
9. FDA-approved contraception methods, sterilization procedures, and patient education and counseling, not including abortion-causing drugs
10. Domestic and interpersonal violence screening and counseling
11. Folic acid supplements for women who may become pregnant
12. Diabetes screening for women 24 to 28 weeks pregnant and others at high risk
13. Gonorrhea screening for all women at higher risk
14. Hepatitis B screening for pregnant women at their first prenatal visit

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Covered Preventive Services Just for Women *(continued)*

15. Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women
16. Human Papillomavirus (HPV) DNA testing every three years for women with normal cytology results who are 30 or older
17. Osteoporosis screening for women over age 60 depending on risk factors
18. Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk

19. Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users
20. Sexually Transmitted Infections (STI) counseling for sexually active women
21. Syphilis screening for all pregnant women or other women at increased risk
22. Well-woman visits to obtain recommended preventive services

In addition, the ACA includes grants to states to pay for healthcare workers to visit new mothers at home and to pay for postpartum depression services.

The law requires employers with more than 50 workers to provide accommodations for nursing mothers, including mandatory break time and a private area to pump breast milk. Employers for whom this would be an "undue hardship" can request to have this requirement waived.

New Benefits for Children & Youth

The Affordable Care Act makes a wide range of preventive services fully covered benefits for kids, including vaccinations and regular well-baby and well-child visits. The essential benefits that new health plans must provide (but not grandfathered plans) include newborn care, and vision and dental coverage for children.

Covered Preventive Services for Children & Youth

1. Alcohol and drug use assessments for adolescents
2. Autism screening for children at 18 and 24 months
3. Behavioral assessments for children of all ages
4. Blood pressure screening for children
5. Cervical cancer screening for sexually active females
6. Congenital hypothyroidism screening for newborns
7. Depression screening for adolescents
8. Developmental screening for children under age 3, and surveillance throughout childhood
9. Cholesterol screening for children at higher risk of lipid disorders
10. Fluoride chemoprevention supplements for children without fluoride in their water source
11. Gonorrhea preventive medication for the eyes of all newborns
12. Hearing screening for all newborns
13. Height, weight and body mass index measurements for children
14. Hematocrit or hemoglobin screening for children
15. Hemoglobinopathies or sickle cell screening for newborns
16. HIV screening for adolescents at higher risk

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Covered Preventive Services for Children & Youth *(continued)*

17. Immunization vaccines for children from birth to age 18 (doses, recommended ages, and recommended populations vary):
    - **Diphtheria, Tetanus, Pertussis**
    - **Haemophilus influenzae type b**
    - **Hepatitis A**
    - **Hepatitis B**
    - **Human Papillomavirus**
    - **Inactivated Poliovirus**
    - **Influenza (flu shot)**
    - **Measles, Mumps, Rubella**
    - **Meningococcal**
    - **Pneumococcal**
    - **Rotavirus**
    - **Varicella**
18. Iron supplements for children ages 6 to 12 months at risk for anemia
19. Lead screening for children at risk of exposure
20. Medical history for all children throughout development
21. Obesity screening and counseling
22. Oral health risk assessment for young children
23. Phenylketonuria (PKU) screening for this genetic disorder in newborns
24. Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk
25. Tuberculin testing for children at higher risk of tuberculosis
26. Vision screening for all children

What if you're in a grandfathered plan?

"Grandfathered" health plans are those that existed before March 23, 2010, when the Affordable Care Act became law. They can legally keep providing the same coverage as they did before. They are subject to some, but not all, of the coverage and consumer protection requirements of the ACA.

So, if you're in a grandfathered plan, you probably don't have the same benefits as people in newer health plans. For example, grandfathered health plans don't have to provide preventive services at no out-of-pocket cost to you. Nor must they cover all of the benefits considered "essential" under the ACA.

On the other hand, grandfathered plans do have to comply with the ACA's ban on coverage with annual or lifetime dollar limits, as well as coverage denials based on pre-existing conditions.

How can you find out if the health plan you're in is a grandfathered plan? If you get health insurance through work, just ask your employer. If you bought coverage yourself, ask your agent, broker or the insurance company.

Note that no health insurance plans created after March 23, 2010, will ever be grandfathered plans.