Financial Planning Newsletter

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# Affordable Care Act – Part One

Hello!

With respect to this month's newsletter, this will be the first of a two-part series. Given the recent headlines of the Affordable Care Act (ACA), also known as "ObamaCare", I thought it would be timely to provide some additional details on this as there has been confusion as to who will be affected. There are several components of this Act (the actual bill was over 900 pages long) so this newsletter is not meant to provide a comprehensive review, but rather a summary of the main parts of the Act.

For this month's version, highlights of the Affordable Care Act will be shared as well as the different plan options available to consumers. In next month's newsletter, the effect on employers will be detailed, from small businesses to the large employers.

The Patient Protection and Affordable Care Act (PPACA) was signed into law in March 2010 by President Obama in order to reform our health care system. According to the Census Bureau, in 2012, 15.4 percent of Americans (about 48 million individuals) were uninsured. The Act provides for affordable and qualified private and public health insurance options to be made available to all Americans starting in 2014 through mandated consumer protection guidelines and regulations in the form of insurance exchanges. It is not meant to regulate one's health, but rather, to standardize the health insurance industry and to stop some of the questionable practices that had been taking place by insurance companies.

PPACA is often referred to as the Affordable Care Act (ACA) or ObamaCare and has been controversial from day one, but it was upheld by the U.S. Supreme Court this past June. The Affordable Care Act does not replace private insurance or government-sponsored programs (Medicare and Medicaid). Instead, it creates state-specific health insurance marketplaces (exchanges) where individuals, families and small businesses can purchase subsidized health insurance and determine if they qualify for Medicare, Medicaid, or Children's Health Insurance Program (CHIP).

## Benefits of Affordable Care Act

There are several benefits to consumers that are offered through the Affordable Care Act including:

- Coverage is now being offered to millions of people who were not able to obtain coverage in the past.
- Premium pricing is based on income, not on health history.
- Preventive care, which includes annual checkups, immunizations, screenings, and counseling services must be offered at no additional cost to the insured.
- Beginning in 2014, the following must be included in all health care plans: emergency and laboratory services, preventive care, pediatric care (including dental and vision care), maternity care, outpatient care, prescription drugs, hospitalization, rehabilitative services, and treatment for mental health and substance abuse.
- Those individuals ages 26 and under can remain covered under their parents' plan.
- For those on Medicare, it will provide access to preventive care services at no cost, reduction in the cost of prescription drugs, and help to close what is commonly referred to as the "donut hole" in Medicare Part D.
- There will be limits on out-of-pocket costs on what an individual and family will have to pay for health-related expenses. The current out-of-pocket limits are $6,400 for an individual and $12,800 for a family. For those who have incomes at or below 250% of the Federal Poverty Level

(FPL), their out-of-pocket limits will be reduced. For 2013, 400 percent of FPL for an individual is $45,960 and for a family of four, it is $94,200.

- Health insurance costs are now being subsidized. Cost-sharing subsidies are being offered to those individuals/families with incomes up to 250% of the Federal Poverty Level which will reduce their out-of-pocket costs for covered health-related services.
- Tax Credits
  - Income Tax Credit - eligible for those with incomes up to 400% of the Federal Poverty Level.
  - Premium Tax Credits – this will limit what a person has to pay toward the premium to a specified percentage of income and is available for those with incomes up to 400 percent of the Federal Poverty Level (FPL). To be eligible for this tax credit, individuals must not have access to health coverage through an employer, must not be eligible for military coverage, and must not be eligible for public coverage (Medicare, Medicaid, or CHIP). It is important to note, than an exception to this applies when an employer-sponsored plan does not cover at least 60 percent of covered benefits on average or the employee share of the premium exceeds 9.5% of the employee's income.
- Insurance companies will no longer be able engage in the following practices:
  - Not cover those individuals with pre-existing conditions.
  - Charge higher premium rates for those with less favorable health conditions.
  - Terminate coverage when an individual is ill.
  - Increase rates by unreasonable levels.
  - Charge higher premium rates for women than for men.
  - Have lifetime and annual limits.
  - Charge older individuals more than three times the amount they charge younger adults for the same basic coverage (before, it was five times). They will be allowed to adjust premiums only based on individual versus family enrollment, geographic area, or tobacco use (with limitations).

## Health Insurance Exchanges

The purpose of these was to create a more structured and competitive marketplace for those that are in need of health care coverage. Starting next year, exchanges will primarily be used by individuals purchasing private coverage as well as businesses with up to 100 employees.

It is expected that each state will set up marketplaces, and can choose to organize multiple ones, so long as only one serves each geographical area. The hope is the regional marketplaces will be formed and these can be in the form of government agencies or as non-profit organizations.

## Available Plans

Under each state's Health Insurance Marketplace, there are five plan options available, four of them being referenced to as a metal. For the metal plans, each offers the same consumer benefits, rights and protections, but has different cost-sharing arrangements as well as availability of network providers.

1. Platinum Plans
   - They offer individuals the lowest out-of-pocket costs since 90 percent of covered expenses are paid for by the insurer and 10 percent by the insured, but in turn, have the highest monthly premiums.
   - Potential candidates for these plans include those who have pre-existing conditions, have dependents, or just want to have the plan with the lowest potential out-of-pocket costs in the event they are subject to health care related expenses.

2. Gold Plans
   - With these plans, 80 percent of covered expenses are paid for by the insurance company, and the

remaining 20 percent is the insured's responsibility.
- Those that are looking to have much of their healthcare related expenses covered but don't want to pay the higher premiums related to the platinum plan and are comfortable with taking on 20% of potential out-of-pocket costs would be good candidates for this plan.

3. Silver Plans
   - Expenses in these plans are covered 70 percent by the insurance carrier and 30 percent by the insured. These plans are considered the marketplace standard as premium limits is in effect. The premium cannot be more than 9.5 percent of one's income if they make less than 400 percent of the Federal Poverty Level. In other words, the less one makes, the less their premium cap is.
   - These plans are suitable for individuals and families who tend to use a few basic health services and do not have pre-existing health-related issues.

4. Bronze Plans
   - Of the metal plans, these have the lowest premiums since insurance companies only have to cover 60 percent of one's healthcare expenses while the insured is responsible for the remaining 40 percent.
   - Since these plans only offer basic benefits and have a limited network of medical professionals, this plan would be selected by those who are do not intend on needing any more than basic medical coverage.

5. Catastrophic Coverage
   - This coverage only covers the bare minimum health benefits and has a very limited network. Those with this coverage will be subject to potentially high out-of-pocket costs as well as a high deductible so it is meant to only provide coverage in the event of a protect you if a catastrophic health-related event were to occur.

## Individual Mandate

As part of the Affordable Care Act, all eligible individuals must have what is considered basic health coverage by January 31, 2014 and most employer and government-sponsored health plans as well as those purchased under the Exchange satisfy this requirement. There will be individuals who are exempt from this mandate, including those with incomes below the threshold required for filing taxes, those who pay over 8 percent of their income towards health insurance coverage, and those who would have normally qualified for Medicaid but for the fact that their state did not expand the program.

In the event that coverage is not purchased by January 31, 2014 and the individual is not exempt, he or she would be subject to an "individual shared responsibility fee", which will be assessed each month insurance coverage is not set up and will be considered as part of their taxable income. Individuals are allowed a coverage gap of up to three months in a year and will be exempt from the fee for these months.

## Conclusion

Since the Affordable Care Act was signed into law back in 2010, the number of uninsured individuals has steadily dropped and the Congressional Budget Office (CBO) projects that this number will be reduced further by another 14 million next year.