HEALTH CARE REFORM

ONE YEAR LATER

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HOW DOES THE AFFORDABLE CARE ACT IMPACT YOU? FIND OUT INSIDE.

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Affordable Care Act: The Basics

More than four years after President Obama signed the Affordable Care Act into law, many questions remain about its overall impact on the United States population, economy and future.

The 900-page federal act was developed to expand access to insurance, increase consumer protections, emphasize prevention and wellness, improve quality and system performance, expand the health workforce and curb rising health-care costs, according to the National Conference of State Legislatures.

Whether or not the act has accomplished these objectives depends on who you ask. The White House reported better-than-expected turnouts for its Health Insurance Marketplace signup. Major enrollment gains were made, the White House says, after a tumultuous rollout of the Obamacare website in fall 2013.

On the other side of the coin, only 18 percent of the public say they or their families are better off now that the major provisions of the health care law have been implemented, according to a July 2014 CNN poll.

WHO SIGNED UP?

More than eight million Americans signed up for private insurance through the Health Insurance Marketplace, according to White House estimates. Within that number, 35 percent are less than 35 years old.

BUDGET IMPACT

The Congressional Budget Office has estimates that the ACA will reduce the United States budget deficit by $1.7 trillion over the next two decades. The CBO also projects that lower-than-expected premiums will help the country save $5 billion by 2016.

Since the law passed, health-care spending is estimated to have grown at the lowest rate on record for any three-year period, according to a 2014 White House release.

THE OPPOSITION

Obama has been met with staunch opposition to the ACA, most vigorously within Congress. The health-care law was the focus of a lawsuit House Speaker John Boehner brought against the president in 2014.

A further look into the CNN poll shows that of those opposed to the law, 38 percent say they oppose the law because it's too liberal, while 17 percent believe it's not liberal enough.

Some opponents have brought legal action against the ACA. Though the Supreme Court ruled in 2011 that the law itself was constitutional, some lower courts have issued judgments against certain aspects of the bill, such as the mandate that companies employing more than 50 people must provide health insurance for their employees.

Open Enrollment Explained

Were you confused during the previous open enrollment period? You weren't alone. Thirty-one percent of the population who enrolled in the first rollout of the healthcare marketplace found the process confusing, according to Enroll America.

Much of the confusion was associated with the long delays and glitches in the healthcare.gov website rollout.

A basic way to think about open enrollment is that you have one time period during the year to shop, compare and actually choose a health insurance plan through open enrollment. This means if you lose track of time or decide not to get a plan, you will likely have to wait a whole other year to get insurance – and you'll have to pay a fee known as the individual shared responsibility payment.

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THE NEXT OPEN ENROLLMENT

The open enrollment period for 2015 coverage runs from Nov. 15, 2014, through Feb. 14, 2015. If you haven't enrolled in coverage by then, you generally can't buy marketplace health coverage for 2015 until the next enrollment period, unless you qualify for special enrollment periods outside of open enrollment.

People experiencing special life events may be able to qualify any time during the year if they are:

- Moving to a new state.
- Experiencing certain changes in income.
- Getting married or divorced, or having a baby

Check healthcare.gov to find out if you qualify for a special enrollment period.

THE PENALTY

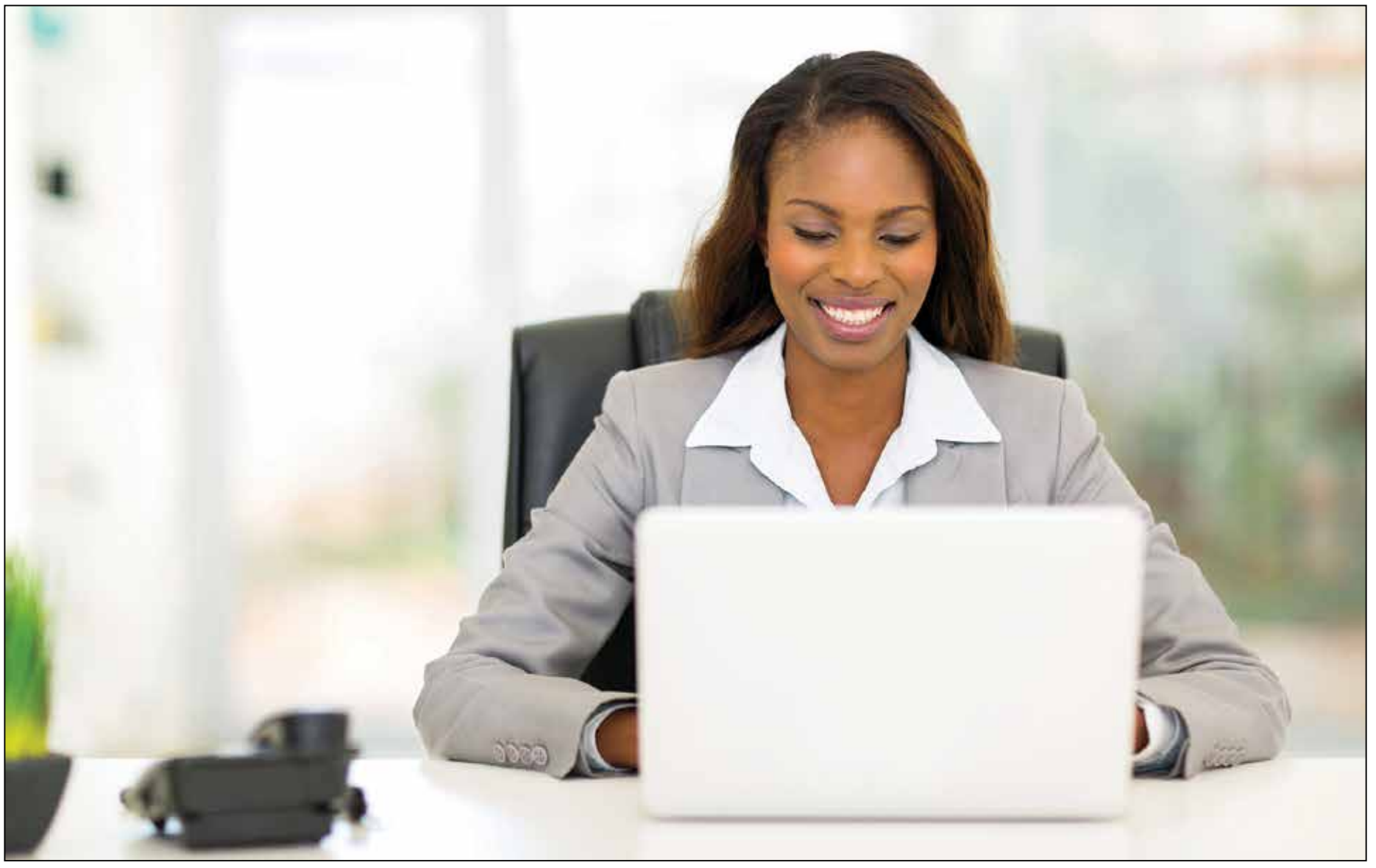
In 2014, the individual shared responsibility payment was set at 1 percent of your annual income or $95 per person for the year, whichever was higher. The fee will continue to increase every year and is scheduled to be 2.5 percent of your income, or a minimum of $695, in 2016. Payments are made when you file your income-tax return each April.

There are exemptions to the payment. See healthcare.gov/exemptions for the full list. You may qualify if:

- You're uninsured for less than three months of the year.
- The lowest-priced coverage available would cost more than 8 percent of your household income.
- You don't have to file a tax return because your income is too low.

Small Business Health Options Program

For the everyday entrepreneur, finding affordable health-care coverage for employees can be downright difficult.



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Through the Affordable Care Act, businesses with 50 or fewer full-time employees can use the Small Business Health Options Program (SHOP) to offer coverage to their employees. What this means as a business owner is you control the coverage you offer and how much you pay toward premium costs.

Businesses under the 50-employee threshold are not required to offer health coverage but may find the SHOP to match their needs.

DEPARTMENT OF LABOR TIPS

The United States Department of Labor offers several tips for small business owners looking to purchase health insurance plans for their employees, including:

• Self-education: The first step to choosing quality coverage that is aligned with your business' needs is to educate yourself on what is out there. Learn how to compare premiums and out-of-pocket costs across different plans to find out what works best for you.

• Set your budget: Think about how much money you can comfortably spend for group coverage. You will also need to consider your employees' budget for insurance.

• Get organized: Gather and maintain all of the critical information you will need to select insurance, including a list of employees you plan to cover and your tax ID number.

TAX BENEFITS

For employers with low- to moderate-wage workers, the government has made available an expanded Small Business Healthcare Tax Credit. The credit covers as much as 50 percent of the employer contribution toward premium costs.

There is also a built-in feature within SHOP that gives you and your employees a chance to use pre-tax dollars to make your premium payments, leaving more money in your pockets.

HOW TO SHOP WITHIN SHOP

The U.S. Department of Labor recommends you use your existing insurance broker to access the SHOP. You can also select insurance plans on your own. You can review, compare and select a plan that works best for your budget and employees.

Small Business Changes

As business owners continue to navigate through the Small Business Health Options Program (SHOP), new statistics show that many are still unsure of the Affordable Care Act's impact on their operation.

A 2014 Gallup poll revealed that half of U.S. small-business owners thought the ACA would be bad for their bottom lines, compared with 9 percent who said it would be good.

Similarly, 52 percent of owners predicted that the ACA was going to reduce the quality of health care they and their employees receive.

Other numbers from the Gallup poll included:

- Some 55 percent of owners expected the money they pay for healthcare to increase.
- Five percent expected their healthcare costs to decline
- Forty-one percent of small business owners held off on hiring new employees in mid-2013.
- Some 38 percent pulled back on their plans to expand their business.

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2014 NUMBERS

Flash forward to 2014, and many of the concerns voiced by small-business owners have come to fruition. The U.S. Bank Small Business Annual Survey found that in January, nearly half of small business owners with at least five employees said they curbed hiring plans because of the health law. Twenty-nine percent said they were forced to make staff cuts.

Larger businesses are more likely to have cut employee benefits or shifted the cost of higher benefits to employees because of the legislation.

At least three out of five owners with a minimum of $1 million in revenue or five employees say the new healthcare law has resulted in higher premiums for their business.

American Hospital Association

The American Hospital Association has offered both opposition to and approval for various aspects of the Affordable Care Act.

The AHA, which represents nearly 5,000 hospitals and health-care networks in America, has a strong interest in health-care reform. The organization has been steadfast in both praising the act while also calling for repeals of specific aspects.

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OPPOSITION

One of the most contested aspects of the ACA – from the viewpoint of the AHA – is the establishment of an Independent Payment Advisory Board comprised of 15 members appointed by President Barack Obama.

The board's influence on policy and payment decisions means that rate-cutting processes could be implemented against the wishes of the AHA. The AHA released a statement explaining the group's opposition to the board, citing the fact that hospitals have already agreed to have $155 billion of future payments cut and redeployed to pay for coverage of more Americans.

Another key area of AHA contention is aimed at hospital readmissions penalties. Avoiding admissions and reducing readmissions are two of the most effective methods to save on hospital expenses, according to an expansive initiative completed by the Physician Group Practice.

Medicare payments to 2,225 hospitals were reduced as of Oct. 1, 2013, based on penalties applied because of the new AHA enforcement policies aimed at reducing the number of patients readmitted within one month.

APPROVAL

The ACA's efforts to expand coverage to 32 million uninsured individuals by requiring the purchase of a policy has been continually applauded by the AHA.

Other key points that the AHA has stood behind include the provisions preventing denial of care and coverage on the basis of pre-existing conditions and requirements on guaranteed renewability.

Restrictions on physician-owned hospitals also are supported by the AHA. Why? Because the group claims that for-profit hospitals leave important but money-losing services such as emergency departments and burn units to community hospitals.

The AHA has a deep history with this subject, including the successful lobbying to Congress to impose a multi-year ban on the construction of physician hospitals in the mid-2000s.

Women and the ACA

Beginning in 2012, about 47 million women gained guaranteed access to additional preventive services without paying more at the doctor's office, according to the U.S. Department of Health & Human Services.

Previously, one in five American women skipped well-woman visits and other preventive services because of cost. The Kaiser Women's Health Study in late 2013 uncovered other telling numbers, including:

• Twenty-two percent of women reported skipping prescription medicines in the past because of cost.

• A parent's plan is now the leading way that women under age 26 get their coverage (45 percent).

• Most women (70 percent) report discussing diet and nutrition with a provider in the past three years, but less frequently about smoking (44 percent), alcohol or drug use (31 percent) or mental health (41 percent).

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PREVENTIVE SERVICES

With the inception of the Affordable Care Act, women are now guaranteed preventive services that were recommended by the independent Institute of Medicine and based on scientific evidence.

As of 2012, all new health plans must cover myriad women's preventive services without cost sharing. In short, cost sharing can include copayments, co-insurance and deductibles.

The following preventive services are endorsed by the Health Resources and Services Administration:

• Breastfeeding support, supplies and counseling.

• Screening and counseling for interpersonal and domestic violence.

• Screening for gestational diabetes.

• DNA testing for high-risk strains of HPV.

• Counseling regarding sexually transmitted infections.

• Screening for HIV.

• Contraceptive methods and counseling (though the Supreme Court ruled in June 2014 that some "closely held" companies do not have to offer certain contraceptives because of religious beliefs).

• Well-woman visits.

• Mammograms every one to two years for women older than 40.

• Cervical cancer screening every three years.

• Smoking cessation programs for adults.

• Wide range of prenatal screenings and tests.

• Diabetes and blood pressure screening.

• Depression screening for adolescents and adults.

Essential Health Benefits

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As of Jan. 1, 2014, the Affordable Care Act began requiring that all insurers meet mandates that include a set of essential health benefits for their new policies under "Obamacare."

A 2013 study by HealthPocket revealed that this provision was much needed, as only 2 percent of existing individual health plans provided all 10 essential benefits. Here is a look at the list:

• Ambulatory patient services: Also termed as outpatient care, this is the most common form of healthcare.

• Prescription drugs: All individual and small-group plans cover at least one drug in every category and class in U.S. Pharmacopeia, the official publication of approved U.S. medications.

• Emergency care: Under the reform law, emergency visits do not require pre-authorization, and you cannot be charged extra costs for an out-of-network visit.

• Mental health services: Plans are required to cover mental and behavioral health services. Check your state's bylaws, because some set limits on the number of therapy visits per year.

• Hospitalization: You may still have to pay 20 percent of a hospital bill if you haven't reached your out-of-pocket limit, but your insurer must cover your hospitalization under the law, according to the American Association of Retired Persons.

• Rehabilitative and habilitative services: Rehabilitation services include therapies to relieve pain and help you regain your ability to speak, walk or work after a serious injury. Habilitative services aim to help overcome long-term disabilities.

• Preventive and wellness services: The law instructs insurers to provide all 50 preventive services recommended by the U.S. Preventive Services Task Force.

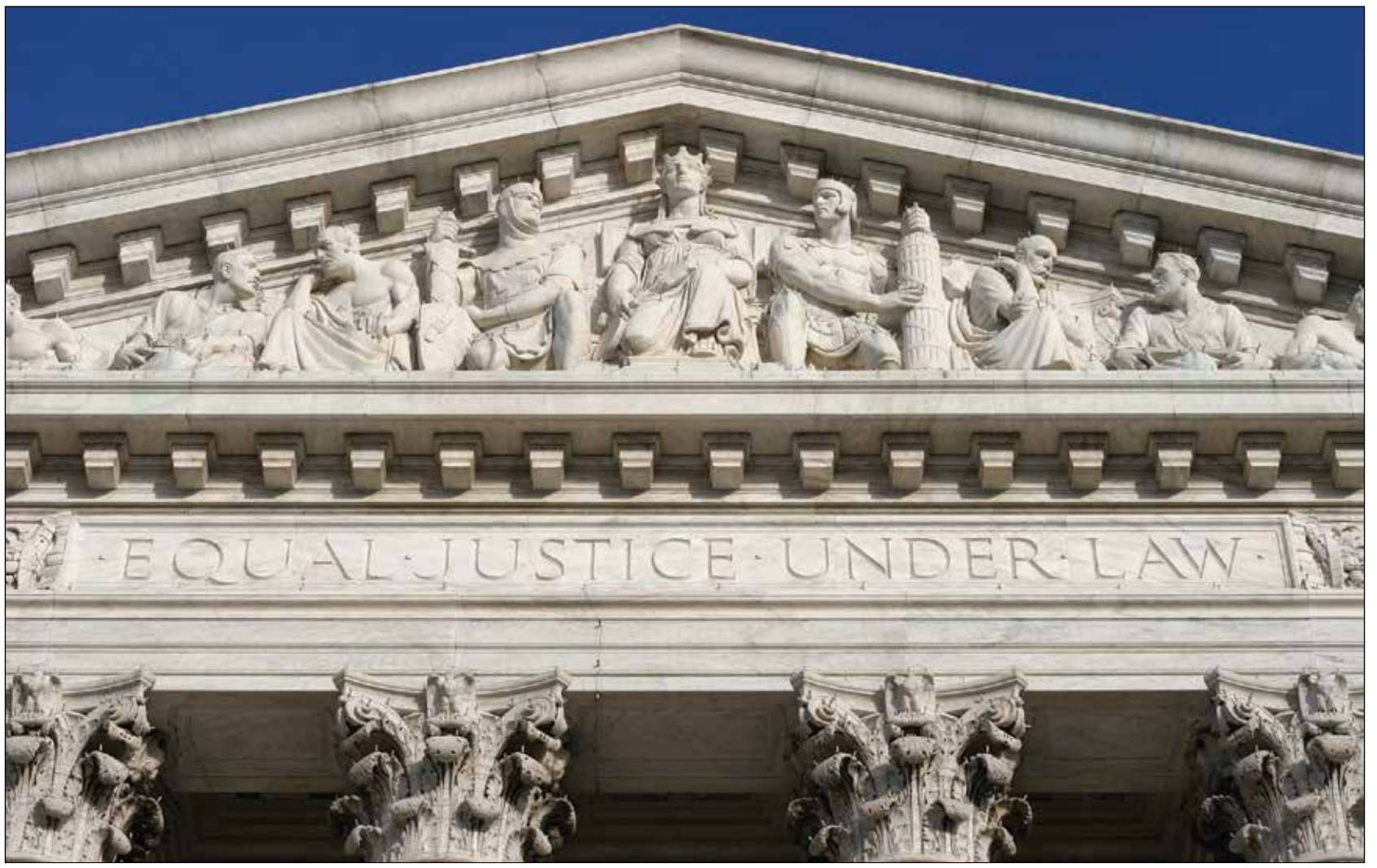
• Laboratory services: This essential benefit includes a full set of preventive screenings tests, including prostate exams and Pap smears.

• Pediatric care: Children ages 19 and younger can now receive X-rays, fillings and medically necessary orthodontic work.

• Maternity and newborn care: The law classifies prenatal care as a service that must be provided at no extra cost.

While these essential health benefits apply to most new insurance policies, the Affordable Care Act allows for two exemptions. One is for policies that were in existence before March 23, 2010, which are considered "grandfathered in" and do not have to meet these new standards.

The other exemption is for companies that self-insure, which means they pay for their own employees' health care and are not required to offer the same benefits as traditional insurance policies. Your insurance provider can give you more information on which benefits your policy covers.



The Constitutional Question

The United States Supreme Court ruled in the summer of 2012 that the Affordable Care Act was constitutional, but that doesn't mean all debate on the subject has ended.

In fact, the question over the constitutionality of Obamacare's enforcement — or lack thereof — is raising even more questions that are politically polarizing on this hot-button issue.

GOP LAWSUIT

The most obvious example is the decision by House Republicans to sue President Obama over the executive branch's selective enforcement of the law.

The seriousness of that lawsuit depends entirely on one's political viewpoint.

From the Republican perspective, the president is not doing his job, which is to enforce the laws of the United States. The Obamacare legislation includes a variety of penalties and deadlines that the executive branch has waived, even though the legislative branch never authorized those changes to the law.

Since the president is not doing his constitutional duty, they say, the lawsuit was justified.

From the Democrats' perspective, the GOP filing a suit against the president is nothing but a political stunt to get support from conservatives. The president should have wide latitude to decide how laws are enforced, Democrats say, and there is no constitutional authority for Congress to sue the president. Deciding constitutionality rests with the judicial branch, not the legislative branch, as they see it.

When it was filed in mid-2014, this lawsuit showed how divided the nation remained over health care reform as its effects continued to be rolled out nationwide.

OTHER QUESTIONS

Additional cases over the Affordable Care Act continue to work their way through the federal court system. While their effects are not likely to be as wide-ranging as the 2012 Supreme Court ruling that authorized Obamacare to proceed, they could continue to bring changes to aspects of the law over time.

Obamacare: Will it be Repealed?

The Affordable Care Act is the most controversial law enacted in recent American history, and it remains unpopular in some political circles.

Conservative Republicans in the House of Representatives, in particular, have vowed to do everything they can to repeal the law entirely. Whether they will realistically be able to is another matter.

While repealing a law is always possible if the president, House and Senate all agree on it, most political watchers say that is highly unlikely — if not impossible — given today's realities. Here are three reasons why.

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PULLING BENEFITS

Once a government benefit has been offered, history shows that these benefits are rarely taken away because it would involve too much political fallout.

The officials who vote to eliminate an entitlement would face enormous opposition from the people who are currently receiving that entitlement. People generally don't want to see their benefits yanked away.

In the case of the Affordable Care Act, millions of Americans are currently getting benefits in the form of health care insurance, Medicaid coverage, additional coverage under their current plans and subsidies to help pay for it all. While the law remains deeply divisive, it's believed that the people who have benefitted from its changes would actively and vocally oppose their benefits being removed.

NO CONSENSUS

Another issue is that there is no consensus on Capitol Hill, much less within the White House, for repealing the measure in the short term.

Congress has spent recent years in gridlock over relatively minor issues, with Republicans controlling the House and Democrats in charge of the Senate and White House. Even if the GOP controlled both the Senate and White House after 2016, reaching a consensus to overturn the law completely would be difficult because of the potential for political fallout as mentioned above.

INDUSTRY SUPPORT

The third reason is a bit cynical but noteworthy nonetheless: the powerful health care lobby doesn't want to repeal Obamacare.

Insurance and health care companies played a role in shaping the Affordable Care Act to begin with, and so far, none of the most powerful industry players in Washington have called for its repeal.

Granted, that doesn't mean the health care industry universally supports Obamacare. There are parts of it that various groups have vociferously opposed and continue to oppose, but they're largely calling for reforms to the law instead of an outright repeal of it.

In the end, that is the route that most Washington insiders think the Affordable Care Act will take. Repeal is always a possibility, but as of right now, that possibility seems remote, with continued reforms and refinements to improve the law over time a much more likely possibility.

Types of Health Plans

From HealthCare.gov

The health plan category you choose determines how you and your plan share the costs of care. These categories have nothing to do with the quality or amount of care you get.

There are five categories or "metal levels" of coverage in the Marketplace. Plans in each category pay different amounts of the total costs of an average person's care. This takes into account the plans' monthly premiums, deductibles, copayments, coinsurance, and out-of-pocket maximums. The actual percentage you'll pay in total or per service will depend on the services you use during the year.

- Bronze: Your health plan pays 60% on average. You pay about 40%.
- Silver: Your health plan pays 70% on average. You pay about 30%.
- Gold: Your health plan pays 80% on average. You pay about 20%.
- Platinum: Your health plan pays 90% on average. You pay about 10%.
- Catastrophic: Catastrophic coverage plans pay less than 60% of the total average cost of care on average. They're available only to people who are under 30 years old or have a hardship exemption.

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WHAT TO CONSIDER WHEN CHOOSING A PLAN CATEGORY

Think about your health care needs when choosing a category of Marketplace plan.

If you expect a lot of doctor visits or need regular prescriptions: You may want a Gold plan or Platinum plan. These plans generally have higher monthly premiums but pay more of your costs when you need care.

If you don't expect to use regular medical services and don't take regular prescriptions: You may want a Silver, Bronze, or Catastrophic plan. These plans cost you less per month, but pay less of your costs when you need care.

If you qualify to save on out-of-pocket costs: Silver plans may offer the best value. You may qualify for lower out-of-pocket costs based on your household size and income. If you do, you can get these out-of-pocket savings only if you enroll a Silver plan. If you make this choice you'll basically get the lower out-of-pocket costs of a Gold or Platinum plan while paying a Silver plan premium.

If you're under 30 or have a hardship exemption and want low monthly premiums: You may want to choose a catastrophic plan designed to protect you from worst-case scenarios, like serious accidents or diseases.

Of course, it's impossible to predict all your health care needs for the year ahead. Pick a plan that fits your budget and meets your and your family's expected needs.

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Don't Have Coverage? Here Are the Fees

From HealthCare.gov

If you don't have health coverage in 2014, you may have to pay a fee. You also have to pay for all of your health care. The fee is sometimes called the "penalty," "fine," "individual responsibility payment," or "individual mandate."

2014 FEES

The penalty in 2014 is calculated one of two ways. If you or your dependents don't have insurance that qualifies as minimum essential coverage you'll pay whichever of these amounts is higher:

- 1% of your yearly household income. (Only the amount of income above the tax filing threshold, $10,150 for an individual, is used to calculate the penalty.) The maximum penalty is the national average premium for a bronze plan.
- $95 per person for the year ($47.50 per child under 18). The maximum penalty per family using this method is $285.

The way the penalty is calculated, a single adult with household income below $19,650 would pay the $95 flat rate. A single adult with household income above $19,650 would pay an amount based on the 1% rate. (If income is below $10,150, no penalty is owed.)

The penalty increases every year. In 2015 it's 2% of income or $325 per person. In 2016 and later years it's 2.5% of income or $695 per person. After that it's adjusted for inflation.

If you're uninsured for just part of the year, 1/12 of the yearly penalty applies to each month you're uninsured. If you're uninsured for less than three months, you don't have to make a payment.

You'll pay the fee on your 2014 federal income tax return. Most people will file this return in 2015.

MINIMUM ESSENTIAL COVERAGE

To avoid the penalty you need insurance that qualifies as minimum essential coverage. If you're covered by any of the following, you're considered covered and don't have to pay a penalty:

- Any Marketplace plan, or any individual insurance plan you already have.
- Any employer plan (including COBRA), with or without "grandfathered" status. This includes retiree plans.
- Medicare.
- Medicaid.
- The Children's Health Insurance Program (CHIP).
- TRICARE (for current service members and military retirees, their families, and survivors).
- Veterans health care programs (including the Veterans Health Care Program, VA Civilian Health and Medical Program (CHAMPVA), and Spina Bifida Health Care Benefits Program).
- Peace Corps Volunteer plans.
- Self-funded health coverage offered to students by universities for plan or policy years that begin on or before Dec. 31, 2014.

Other plans may also qualify. Ask your health coverage provider.