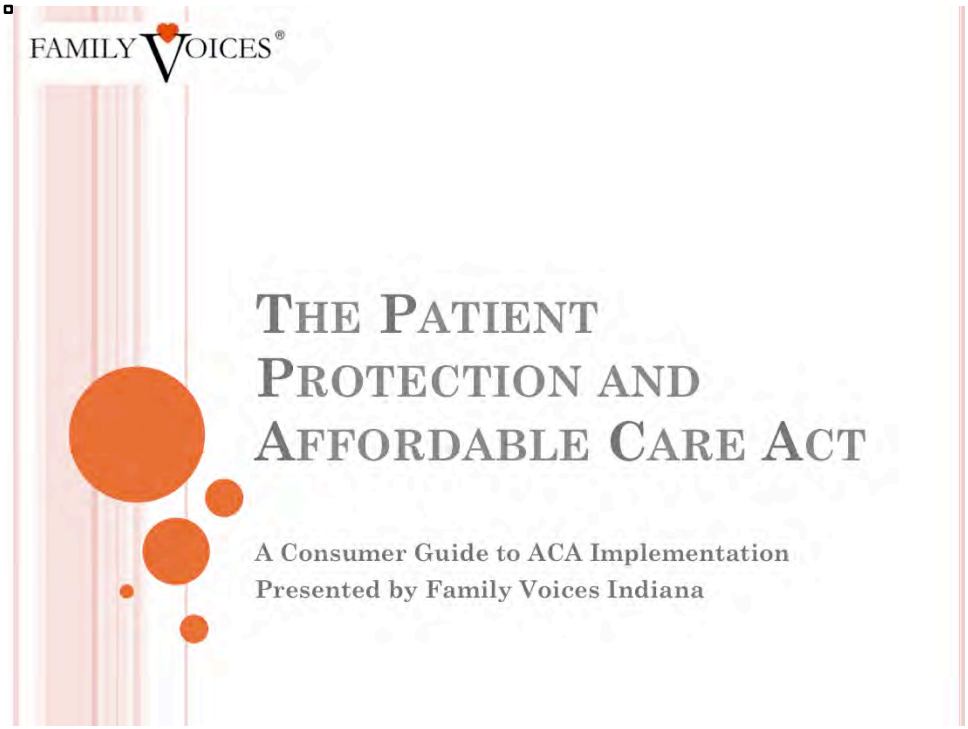
FAMILY VOICES®
THE PATIENT PROTECTION AND AFFORDABLE CARE ACT
A Consumer Guide to ACA Implementation
Presented by Family Voices Indiana

"It's been a wild ride, and it's not over yet. The ACA is not perfect -- I have yet to find any law that is -- but it is a life-changing, life-saving step forward for our country. I am privileged to have felt its personal impacts and to have stood with so many others for whom this is far bigger than sound bites, rhetoric, and politics."

--Rylin Rodgers

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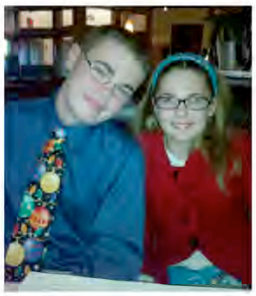
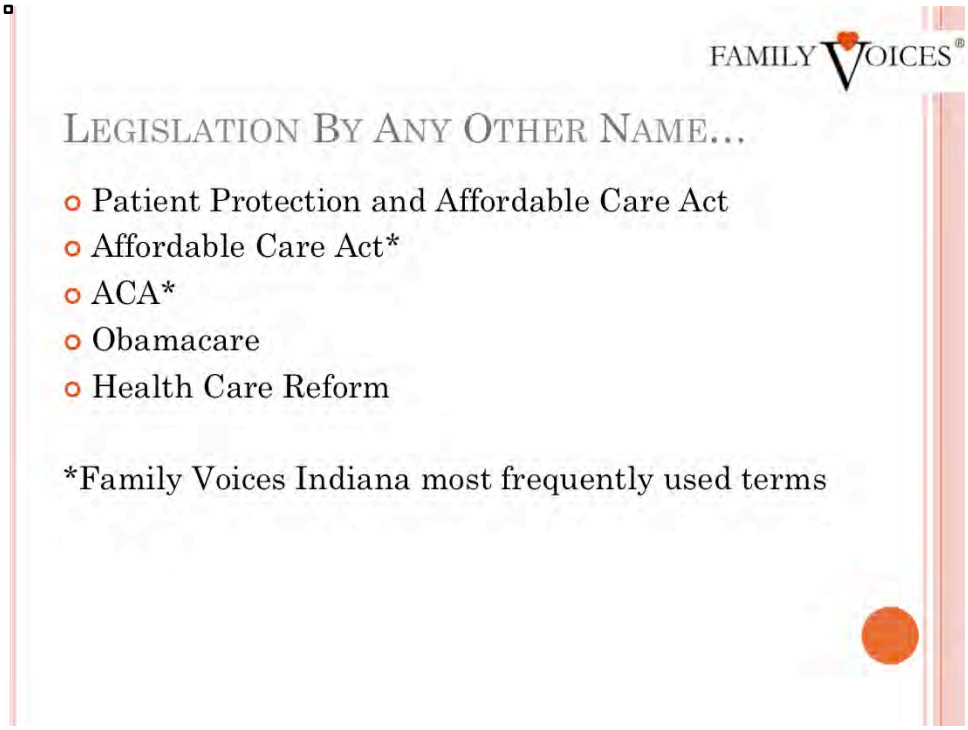
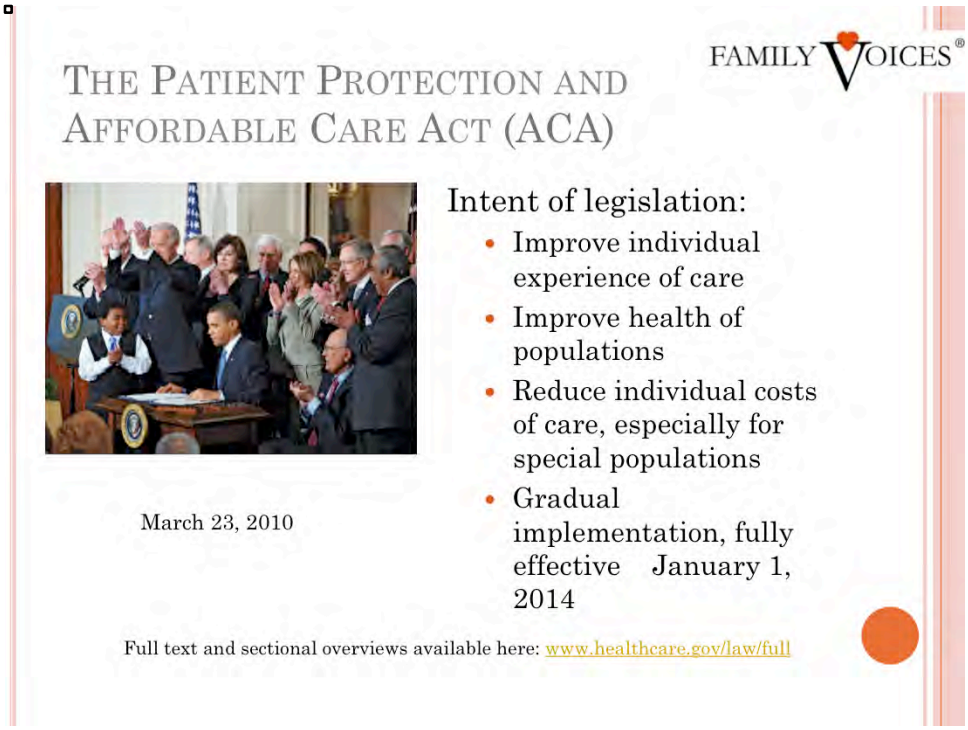


Rylin Rodgers, Family Voices Indiana Director, gave this testimony regarding the ACA: "It's been a wild ride, and it's not over yet. The ACA is not perfect -- I have yet to find any law that is -- but it is a life-changing, life-saving step forward for our country. I am privileged to have felt its personal impacts and to have stood with so many others for whom this is far bigger than sound bites, rhetoric, and politics."

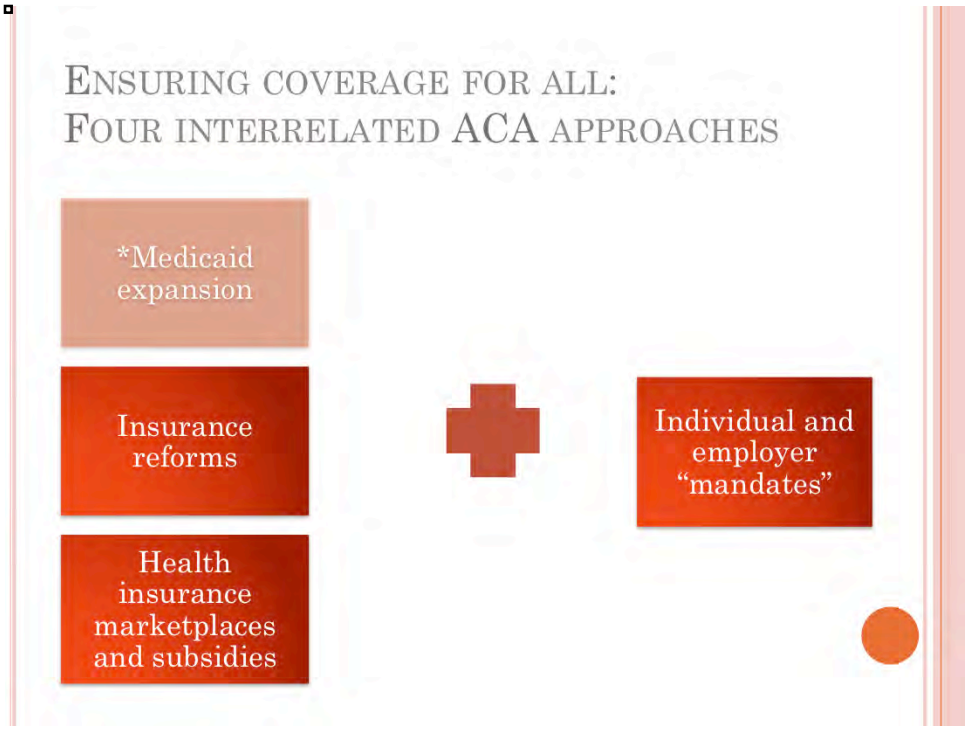
To contact Family Voices, please email info@fvindiana.org or call 317-944-8982. For more information about Family Voices, topics concerning caring for a child with special health care needs, and additional resources regarding the Affordable Care Act and other topics, please visit our website, www.fvindiana.org.




The Patient Protection and Affordable Care Act is referred to by many names, including the Affordable Care Act, ACA, Obamacare, and Health Care Reform. Family Voices Indiana most frequently refers to the act as the Affordable Care Act or the ACA.




President Obama signed the Patient Protection and Affordable Care Act into law on March 23, 2010. The intent of the legislation was to improve the individual experience of care, improve the health of populations, and reduce the per person costs of care for special populations. In an attempt to ease the transition to the new regulations, the law was implemented using a stepwise approach. With the exception of provisions relating to shared employer responsibility, the law was fully implemented on January 1, 2014.
Frequently asked questions, topical overviews and the full text of the law is available at www.healthcare.gov.




The Affordable Care Act was designed with the intent that all Americans would have access to health care coverage. In order to do this, several principles were combined, to include: Medicaid Expansion, the creation of Health Insurance Marketplaces and subsidies, Insurance Reforms, and Individual and Employer Mandates. Let's briefly discuss each of these ideas.

First, we will cover Medicaid Expansion. When the Affordable Care Act was challenged by various states, the US Supreme Court ruled that states could not be required to expand their Medicaid programs. When the law was drafted, it was done so under the assumption that all states would expand their Medicaid programs to provide coverage for all adults whose income was at or less than 138% federal poverty levels. However, since the Supreme Court's ruling, many states, including Indiana, have chosen not to expand their Medicaid programs, despite having the opportunity to do so using federal funds. In states like Indiana, where Medicaid will not be expanded, individuals whose income falls below 100% FPL are now left in a coverage doughnut. That is to say, they are neither eligible for Medicaid nor the Health Insurance Marketplace subsidies. A limited number of Hoosier adults with incomes at or below 100% FPL will be eligible for the Healthy Indiana Plan.

In addition to Medicaid Expansion, the legislation called for insurance reforms, such as coverage mandates and benefits, which we will discuss in greater depth; application of premium dollars to health expenses rather than administrative costs and profits; justification of premium increases, and others.

Next, the legislation mandated the creation of Health Insurance Marketplaces and subsidies. There are three types of health insurance marketplaces: state-facilitated, state and federal partnerships, and federally facilitated marketplaces. Indiana chose not to develop or manage a state-run marketplace or partnership, and therefore, is participating in the federally-facilitated insurance marketplace. The marketplaces are designed such that consumers may apply and shop for health insurance coverage in one location. All of the plans featured on these marketplaces are qualified health plans. That is to say they meet the requirements of the legislation. Further, consumers whose incomes fall between 100 and 400% FPL and who purchase exchange-offered qualified health plans, are eligible to receive tax credits to reduce the costs of premiums. Consumers with incomes at or below 250% FPL are also eligible for cost-sharing subsidies.
Finally, the Affordable Care Act mandated that most employers offer insurance to their employees and that self-employed or otherwise uninsured individuals purchase health insurance. The purpose of these mandates was to create a large and diverse pool of consumers, with the intention of keeping consumer costs low.


Before we discuss the Interrelated ACA Approaches in greater detail, it is important to note that individuals who are covered by "Grandfathered Plans" may not enjoy the full benefits of the Affordable Care Act. Grandfathered plans are plans that were in existence prior to the signing of the legislation on March 23, 2010. There are two types of grandfathered plans. One is a job-based, or employer-sponsored plan. These plans may operate in much the same way as they did prior to the legislation and can continue to do so as long as there is at least one person who has been continuously covered by the plan since the law was signed and only if the plan does not substantially change insofar as benefits or increased consumer costs are concerned. Individual grandfathered plans are those that were purchased prior to the signing of the law and for which consumers decide to maintain their coverage under the same plan. The plans must also remain relatively unchanged. Insurance companies are required to obviously disclose the grandfathered status of a plan.

Grandfathered plans are not required to cover preventative care without cost sharing, do not have to guarantee consumers' right to appeal coverage decisions, are not required to protect consumers' choice of doctors and hospitals and are not required to undergo a rate review when premium costs increase 10% or more. Additionally, individual plans are not required to end yearly limits on coverage nor eliminate pre-existing condition exclusions. Grandfathered plans may make routine changes, including cost adjustments to keep pace with medical inflation, adding new benefits, making modest adjustments to existing benefits, voluntarily adopting new consumer protections under the new law, or making changes to comply with state or other federal laws.

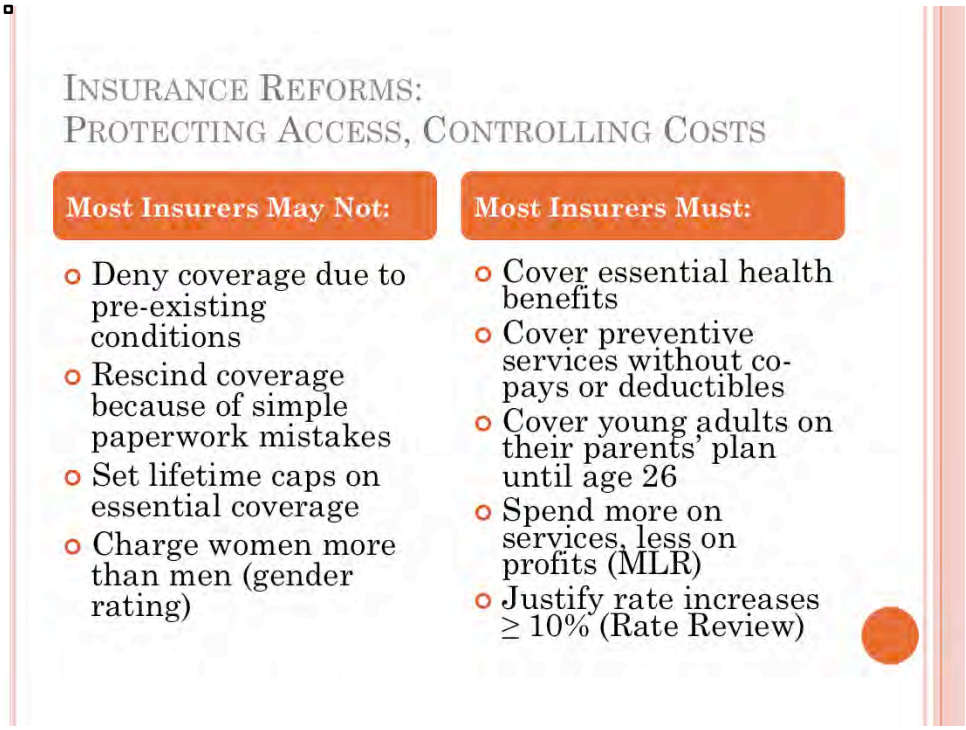
All plans, regardless of grandfathered status, must end lifetime limits on health coverage expenses and must end arbitrary cancelations of policies. All plans must also provide consumers with a summary of benefits and coverage, spend premium dollars on health care, not administrative or other costs, and cover adult children up to age 26 on the parents' policy, if the policy holder chooses.

## Insurance Reforms: Pre-existing Conditions

FAMILY VOICES®

- Individuals may not be denied coverage on the basis of a pre-existing condition.
  - Children first!
    - Applied to children under 19 years of age, beginning September 23, 2010
  - Provision fully effective January 1, 2014
    - Adults and children
    - Eliminates high-risk and pre-existing condition plans

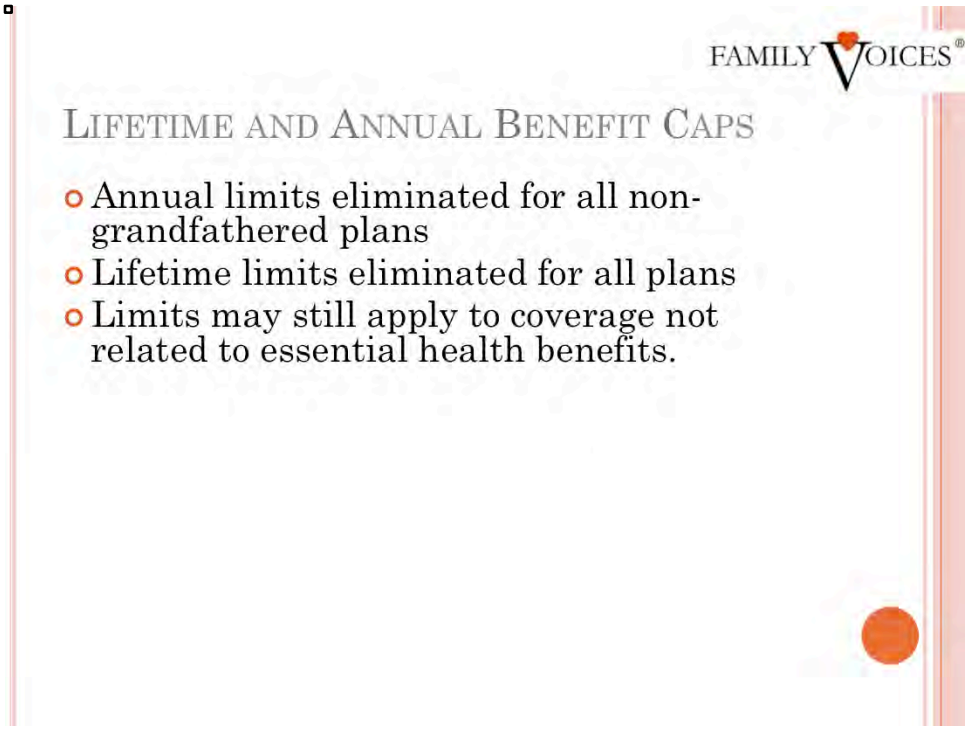

Now, let's discuss the insurance reforms created by the ACA. First, we'll start with pre-existing conditions. The ACA mandated that individuals may not be denied coverage on the basis of a pre-existing condition. That is to say, insurance companies are no longer allowed to refuse treatment or deny benefits due to the fact that you or your children were ill or carried a diagnosis prior to the purchase of the plan. This approach was first applied to children, who enjoyed the protection beginning on September 23, 2010. Beginning January 1, 2014 all individuals, with the exception of those maintaining coverage under a grandfathered plan, will be protected from pre-existing condition exclusions. This protection will eliminate the need for high-risk and pre-existing condition pools and plans, such as ICHIA and PCIPs.




Additional insurance reforms include those designed to protect consumer access to coverage and care while controlling costs. Most insurers may not deny coverage due to pre-existing conditions, may not rescind coverage because of simple paperwork mistakes, may not set lifetime caps on essential coverage, and may not charge women more than men or use gender ratings of any kind to determine premiums. On the other hand, most insurers must cover essential health benefits, which we will discuss in greater detail later, must cover preventative care services and routine screenings without additional costs, and must cover adults younger than 26 years old on their parents' plan. Additionally, the ACA calls for the use of an 80/20 medical loss ratio, which requires the insurers to spend 80% of premium dollars on health care and quality of life expenses, and finally, mandates that insurers justify rate increases of 10% or more through a Rate Review process.

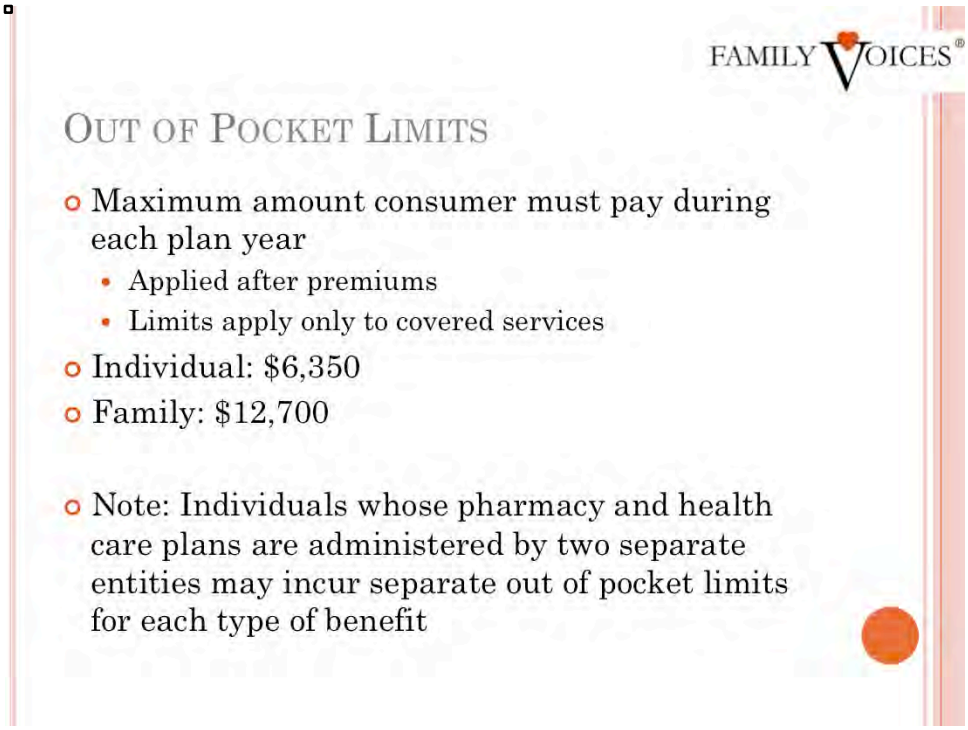

Consumers who have purchased qualified health plans or participate in new employer based plans are guaranteed coverage for certain preventative health and screening services. These services do not incur charges above premium dollars. In other words, there is no cost-sharing or deductible requirement for preventative health services. Preventative health services may include cancer screenings, vaccinations, well checks and annual exams, women's services and others. Preventative care, screening and vaccination requirements are based on the recommendations of Bright Futures, the US Preventative Services Task Force, and CDC guidelines.


The ACA mandates that qualified health plans cover essential health benefits. Those benefits include:
Outpatient services
Emergencies services
Hospitalization
Maternity and newborn care
Mental health and substance use disorder services, including behavioral health treatments
Prescription drugs
Rehabilitative and habilitative services and devices
Laboratory services
Preventative and wellness services
and Pediatric services.
The extent to which these benefits are covered vary by category, state and plan. That said, each state was required to designate a benchmark plan from which minimum levels of coverage for these benefits were drawn.



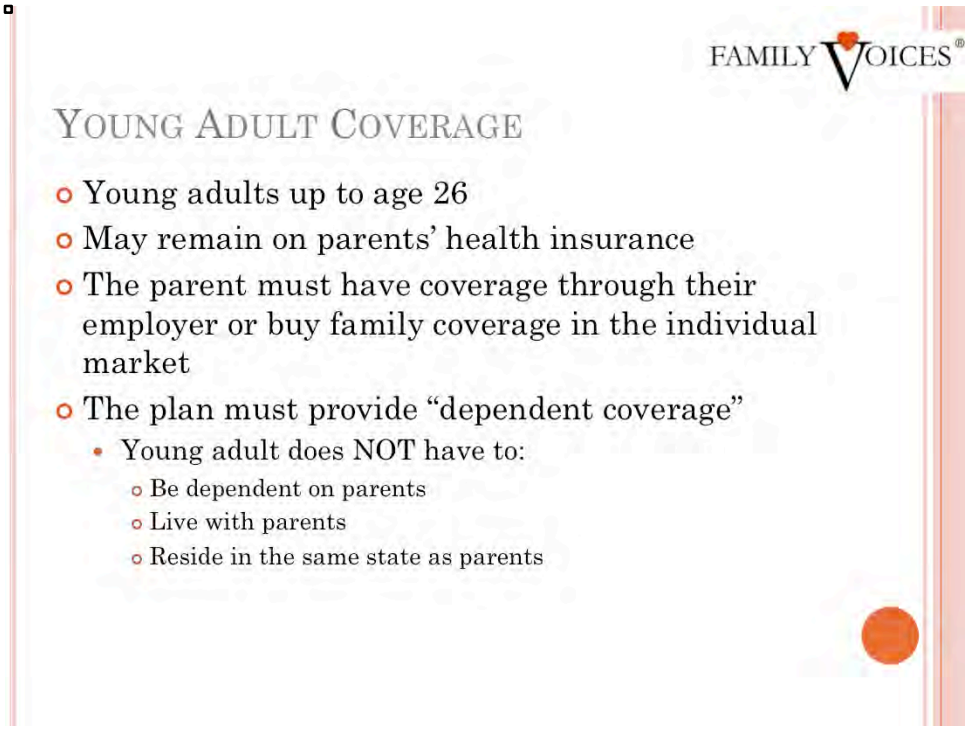

The ACA also eliminated annual and lifetime benefit caps for all individuals. That is to say, the insurer may not refuse to pay for covered services that exceed a certain cost threshold. Grandfathered plans may still have annual limits but all plans have eliminated lifetime limits.

Coverage limits may still apply to services that do not fall under one of the essential health benefit categories.

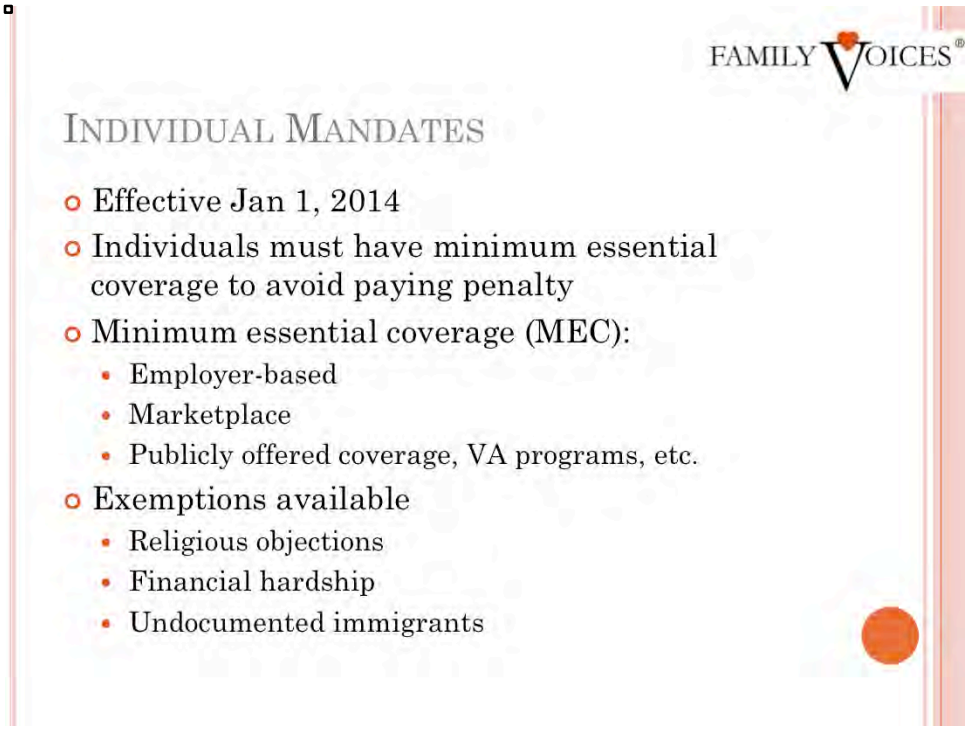



To ensure the affordability of care, the ACA also established out of pocket limits, which are the maximum dollar amounts that consumers may pay for covered services after premium dollars. Each plan may apply these limits in a slightly different manner, and it is important for consumers to be aware of how the out-of-pocket limit is applied to their plans. Out-of-pocket limits are as follows: for individuals, $6,350 per plan year and for families, $12,700 per plan year.

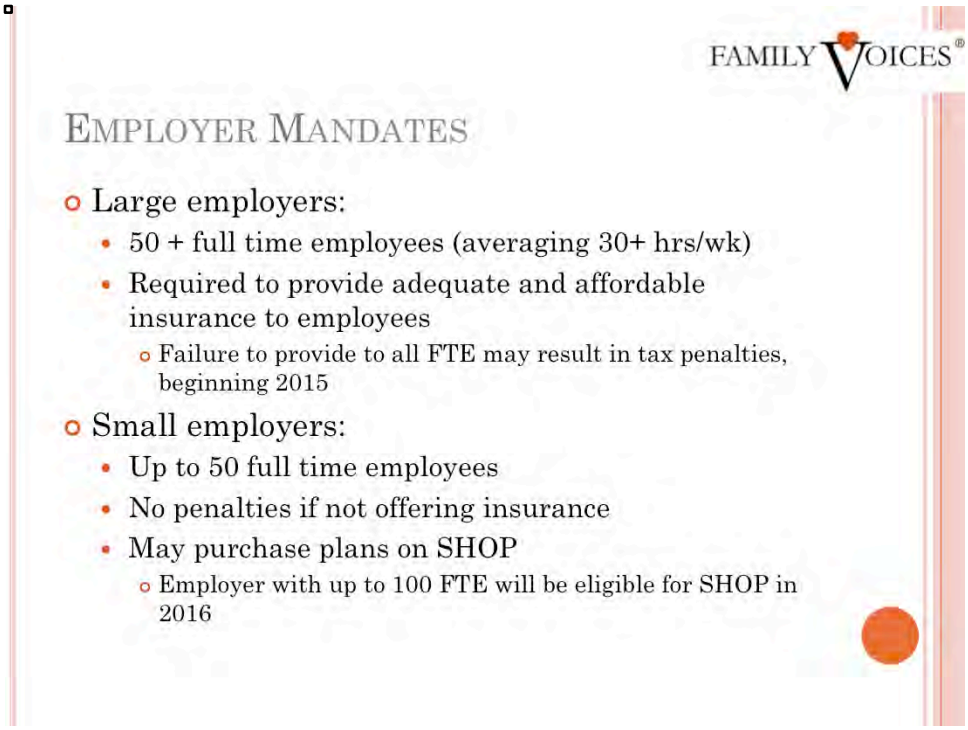
It is important to note that some individuals may incur two separate out of pocket limits during 2014. This occurs when the pharmacy and health care coverage benefits are administered by two separate administrators and is most commonly encountered with employer-sponsored plans. This loophole will be closed beginning 2015.




In order to minimize the number of young adults without insurance coverage, the ACA mandated that young adults may remain on their parents' insurance policies until the adult child turns 26 years old. In order to do this, the parent must have employer-sponsored dependent coverage and/or must purchase a family plan on the marketplace. Adult children may be employed and do not have to be dependent upon their parents or reside with the parent in order to qualify for coverage. Please note, adult children who remain on their parents' policy but reside in a different state should ensure that the policy is a multi-state plan.

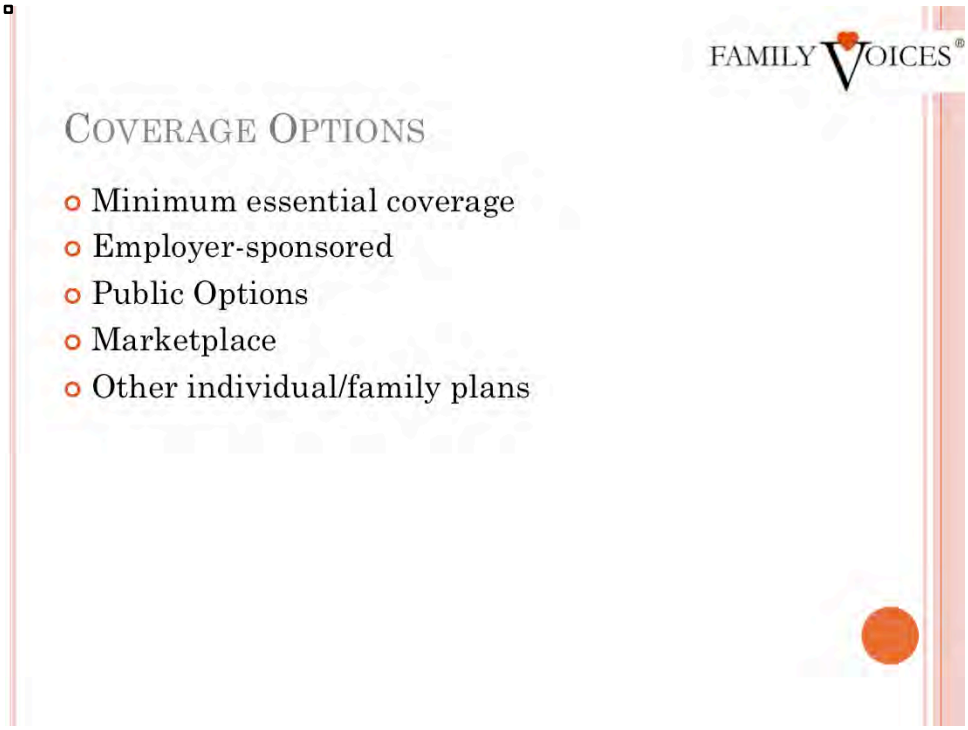



The ACA includes an individual mandate by which Americans must obtain minimum essential coverage, including employer-based insurance, plans purchased from the Marketplace, or public assistance programs, such as the Healthy Indiana Plan or Medicaid. Additionally, individuals who receive Medicaid waiver services, such as the Family Supports Waiver, are considered to have minimal essential coverage.
This provision of shared responsibility is aimed at reducing the overall costs of care by eliminating large pools of uninsured individuals, whose health care costs are later covered by other consumers. Some individuals are exempt from these provisions, and those include individuals or groups with religious objections, such as the Amish who typically do not draw on other government-funded benefits, those for whom obtaining insurance would create a significant financial hardship, and undocumented immigrants.




The ACA also places mandates on employers. Beginning in 2015, large employers with 50 or more full time employees must provide adequate and affordable insurance to their full time employees or pay penalties. For the purposes of the legislation, full time is defined as an employee who works an average of 30 or more hours per week.

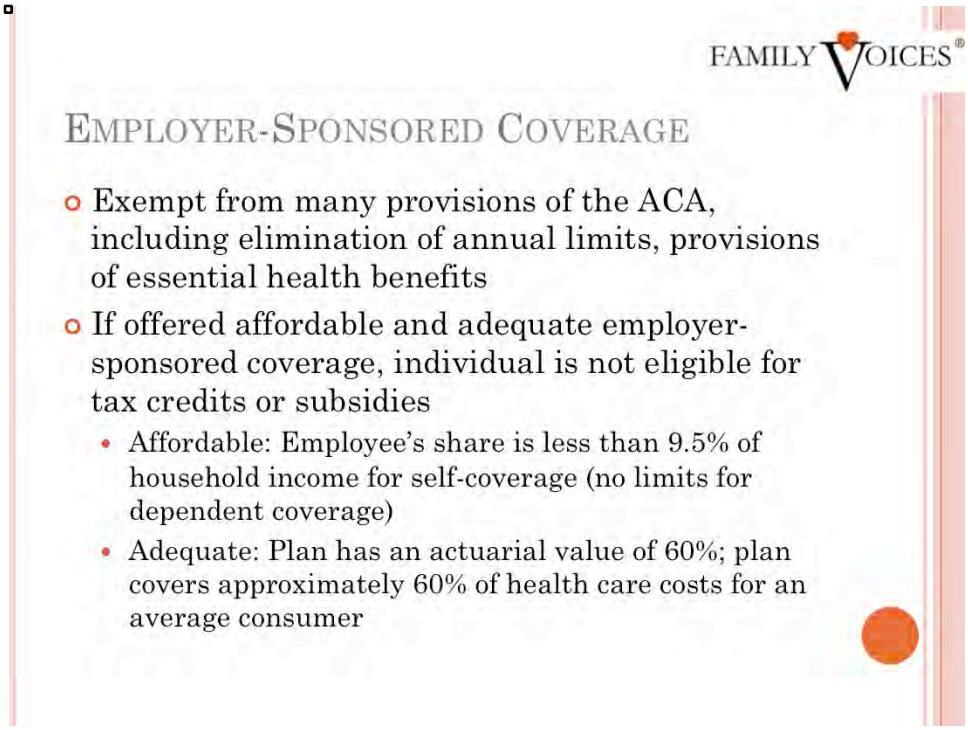
Small employers are not required to provide health coverage benefits to employees but may choose to do so via SHOP, which is the small business Marketplace. This Marketplace was designed to give small employers more competitive benefit options for their employees. In 2016, small businesses with up to 100 full-time employees will be eligible to use SHOP.



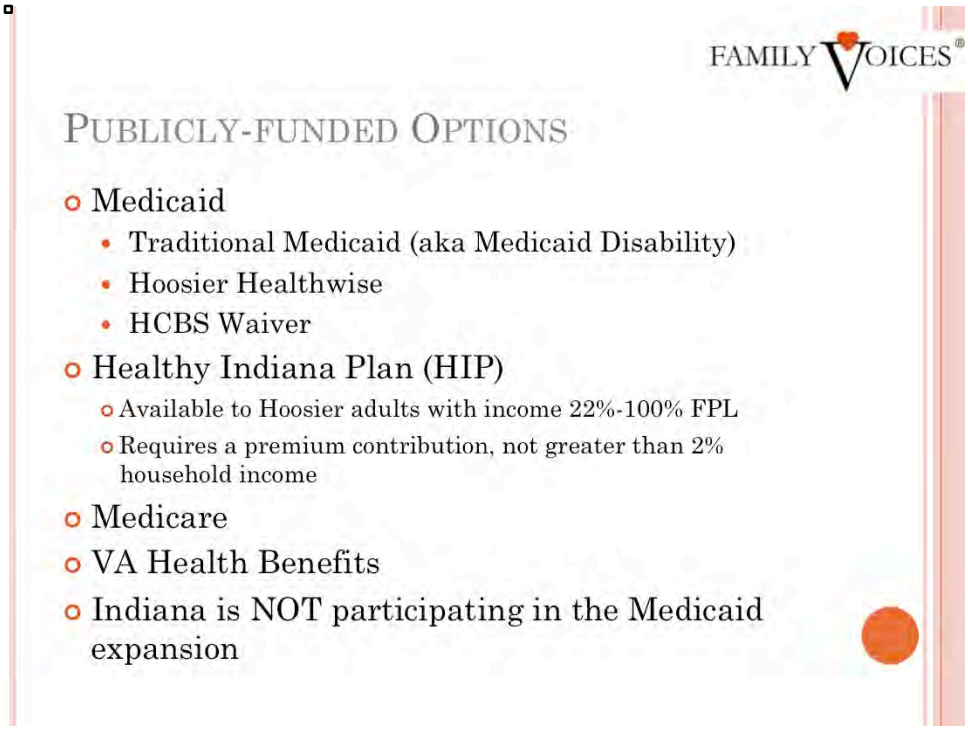

We will now discuss coverage options in greater detail. As previously mentioned, the individual mandate requires the vast majority of Americans to obtain minimum essential coverage. MEC is defined as insurance coverage with an actuarial value of 60% or represented as the metal bronze on the exchange. Bronze plans are designed to pay for 60% of costs incurred by accessing services covered by the plan for the average consumer. Individuals who receive minimal essential coverage outside of the Marketplace are not eligible for premium tax credits or otherwise subsidized coverage. That said, it is important to note that there may be cases where members of a family may have access to minimal essential coverage but other family members do not. In those cases, the family members without MEC may qualify for subsidized coverage via the exchanges.

There are several coverage options available, and many people will be eligible for more than one option. Presently, individuals may obtain coverage via an employer, by accessing public options, such as the Health Indiana Plan and Medicaid, and/or may shop for an individual or family plan on the Marketplace.

To be clear, individuals may continue to purchase plans directly from insurers or via insurance agents. That said, only plans purchased from the Marketplace qualify eligible individuals for premium tax credits and cost sharing subsidies.




While employer-sponsored coverage may be exempt from several of the ACA provisions, it is still a viable and appropriate option for many individuals. Generally, individuals who are offered employer-sponsored coverage are not eligible for tax credits and premium subsidies if they choose to purchase an insurance plan via the Marketplace exchange. That said, if the employer-sponsored coverage does not meet both affordability and adequacy standards, an individual may be eligible for subsidized plans on the Marketplace. To be affordable, the employee's contribution to an employer sponsored plan must be less than 9.5% of the household income for self-only coverage. Dependent coverage may exceed 9.5% of the household income. To be considered adequate, the plan must pay 60% of covered health care expenses for the average individual.




Many publicly funded coverage programs do provide Minimal Essential Coverage. Those programs include various Medicaid programs, the Healthy Indiana Plan, and Medicare.

Individuals with low incomes or who have disabilities may qualify for one of several public options offered in the state of Indiana. Some individuals may qualify for Medicaid, either income- or disability-based. Income-based eligibility differs by program. Individuals who qualify for pregnancy-only, family planning, and other limited services do not have minimum essential coverage. More information about these programs is available on the Medicaid fact sheet found on our website.

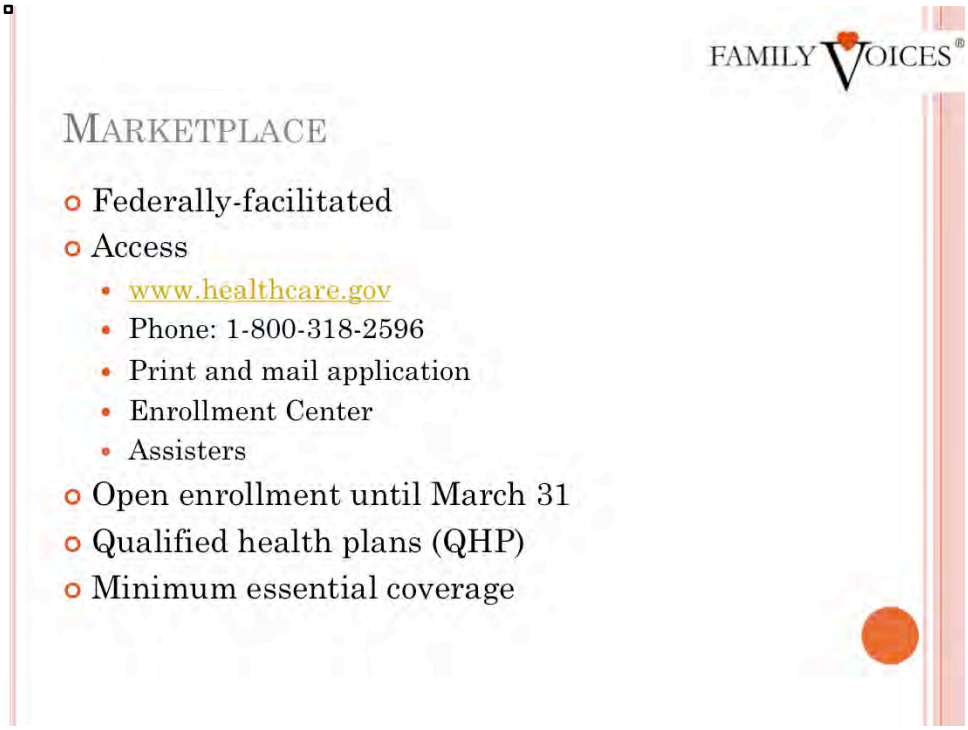
Individuals who receive disability based services, such as traditional Medicaid without a spend down or HCBS waiver services, do have minimal essential coverage.

In addition to Medicaid programs, Indiana offers the Healthy Indiana Plan for a limited number of low income adults, aged 19-64, whose incomes fall between 22% and 100% FPL. HIP does require premium contributions of up to 2% of the household income and acts as a high deductible plan for covered individuals.

Adults who are 65 years or older generally participate in Medicare and should not access the exchange for additional coverage.

Veterans receiving comprehensive VA health benefits do have MEC. Those with limited benefits or questions, should contact the VA for more information.

Indiana is one of several states that is not expanding Medicaid to include all adults with incomes up to 138% FPL. Advocacy efforts are ongoing to take advantage of the largely federally-funded opportunity to expand coverage to more Hoosiers.

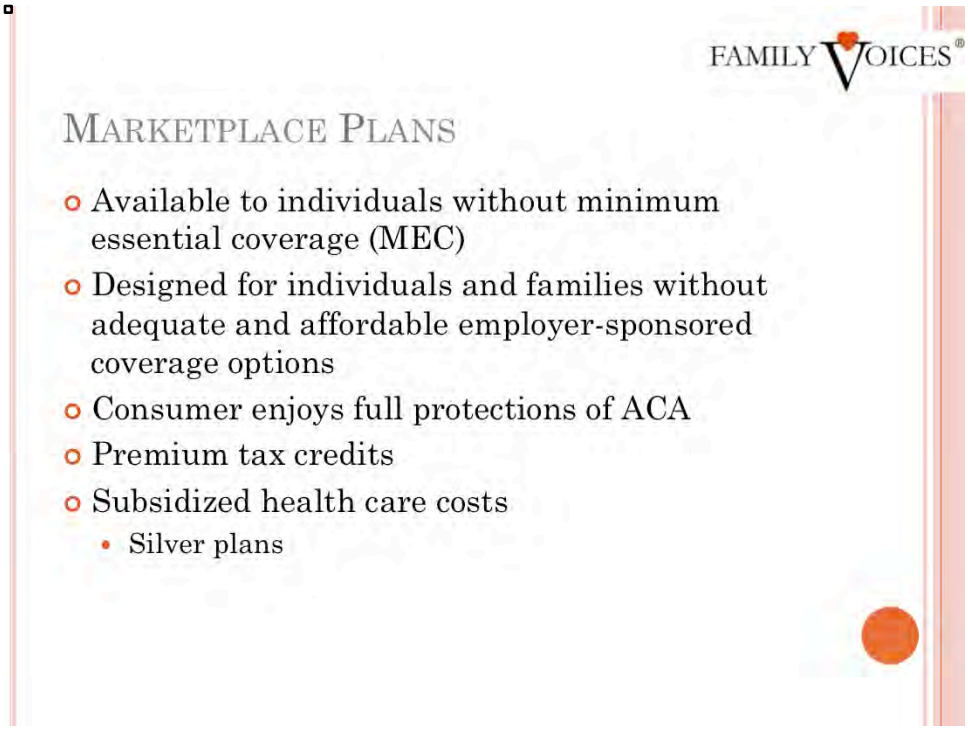



Indiana is participating in the federally-facilitated Marketplace exchange. Consumers may access the Marketplace online at www.healthcare.gov, where they may complete and application and enroll in a plan. Alternatively, they may call, visit the website to print a paper application, which may be submitted via post, or they may visit an Enrollment Center and work with a Certified Application Counselor to apply for and select a plan.

There are a variety of assisters available to help consumers as they navigate the Marketplace. Assisters include Navigators, Certified Application Counselors, Champions for Coverage, and insurance agents. Please review our ACA update to learn more about the role of these assisters. Family Voices Indiana is a Champion for Coverage assister.

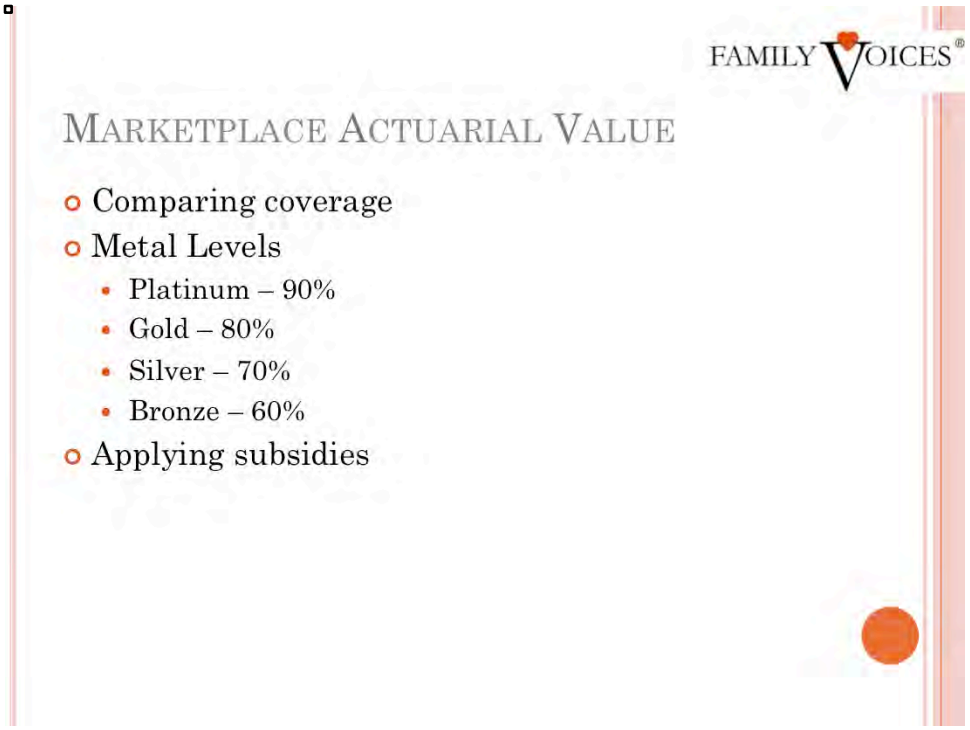
Individuals still looking to purchase insurance on the exchange must do so during the open enrollment period, which ends on March 31, this year. Individuals who experience a qualifying life event, including marriage or birth of a family member, loss of employment or employer-sponsored coverage, and others may access the Marketplace at the time of the event. Additionally, individuals who experience a significant change in income should access the exchange to update income information and review credit and subsidy information.

All plans sold on the exchange are qualified health plans and do include minimium essential coverage.




The Marketplace offers health plans designed for individuals and families who are not offered minimum essential coverage and do not have access to adequate and affordable employer-sponsored coverage options. Because all of the plans sold on the exchange are qualified health plans and none are protected by grandfathered status, consumers who purchase coverage via the exchange receive full protection of the ACA. Additionally, premium tax credits are offered to individuals and families with incomes between 100% and 400% FPL to defray premium costs. These credits may be applied in advance, in which case the credit is directly disbursed to the insurer, partially in advance, in which case a portion of the credit is disbursed to the insurer with the remaining portion offered to the consumer as a tax credit, or entirely as a tax credit offered to consumers when they file their income tax returns. In the event that income is either over or under reported at the time of purchase, tax credits will be reconciled when consumers file taxes each year.

In addition to premium tax credits, individuals with incomes between 100% and 250% FPL may be eligible for cost-sharing subsidies. Essentially, these subsidies will increase the actuarial value of the plan while lowering the overall costs of care. We will discuss actuarial value in greater detail on an upcoming slide. To apply cost-sharing subsidies, consumers must purchase silver-level plans.

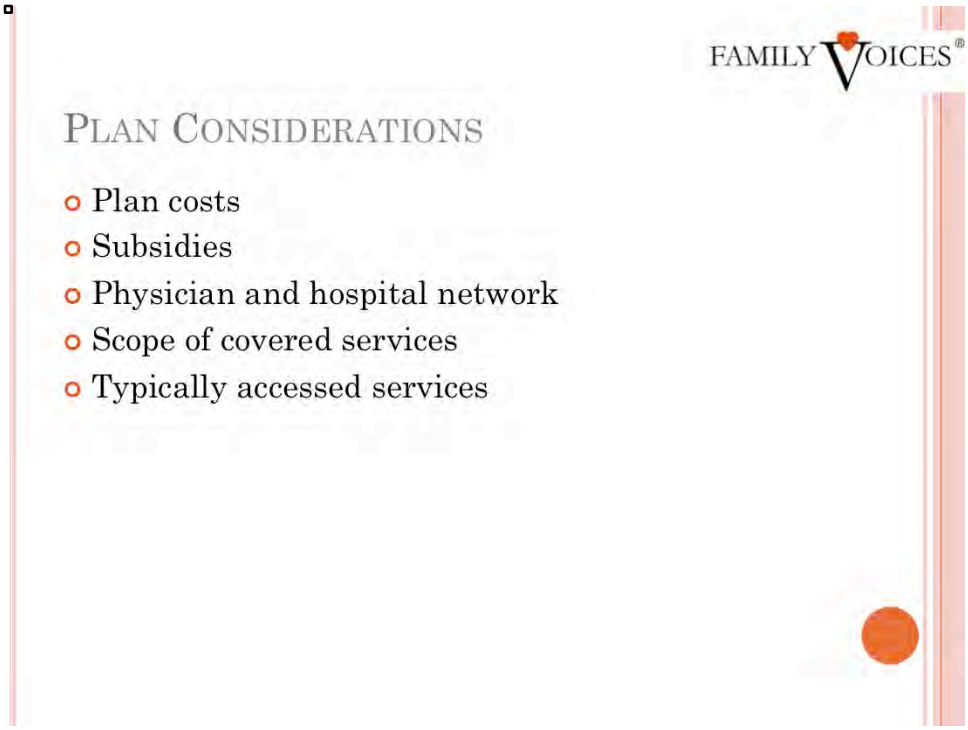



To help consumers compare plans, all Marketplace plans are classified by actuarial value. The actuarial values are represented by the metals platinum, gold, silver, and bronze, such that platinum plans have an actuarial value of 90% and bronze plans have an actuarial value of 60%. The actuarial value corresponds with the amount the plan pays toward covered benefits for the average consumer. In other words, if a consumer purchases a platinum plan, he can expect that approximately 90% of costs incurred from accessing covered benefits will be paid by the insurer leaving the consumer with approximately 10% of costs after premium dollars are paid.

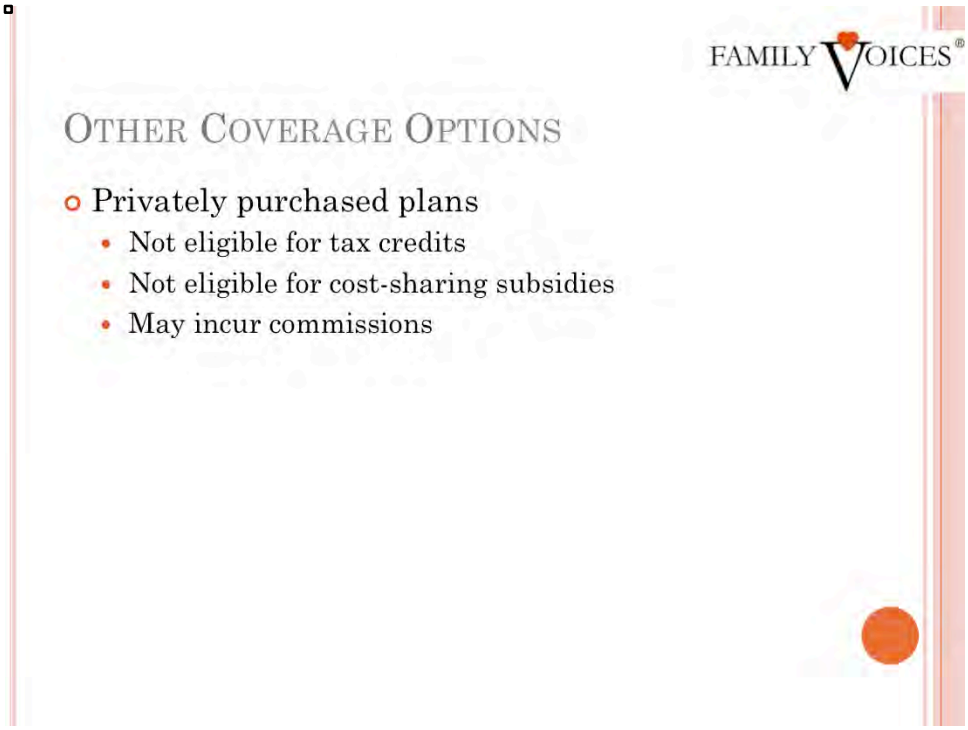
Generally, plans with a higher actuarial value will have higher premiums but lower deductibles and out of pocket expenses. On the other hand, bronze plans often carry the lowest premiums but have the highest deductibles and out of pocket expenses. When deciding which plan to purchase, the consumer should weigh the pros and cons of each plan by carefully considering the amount and type of services typically accessed.

Premium tax credits may be applied to any plan but cost-sharing subsidies may only be applied to silver plans. Many people who qualify for cost-sharing subsidies will find that the subsidy will bring the actuarial value up to or above that of a gold or platinum plan.

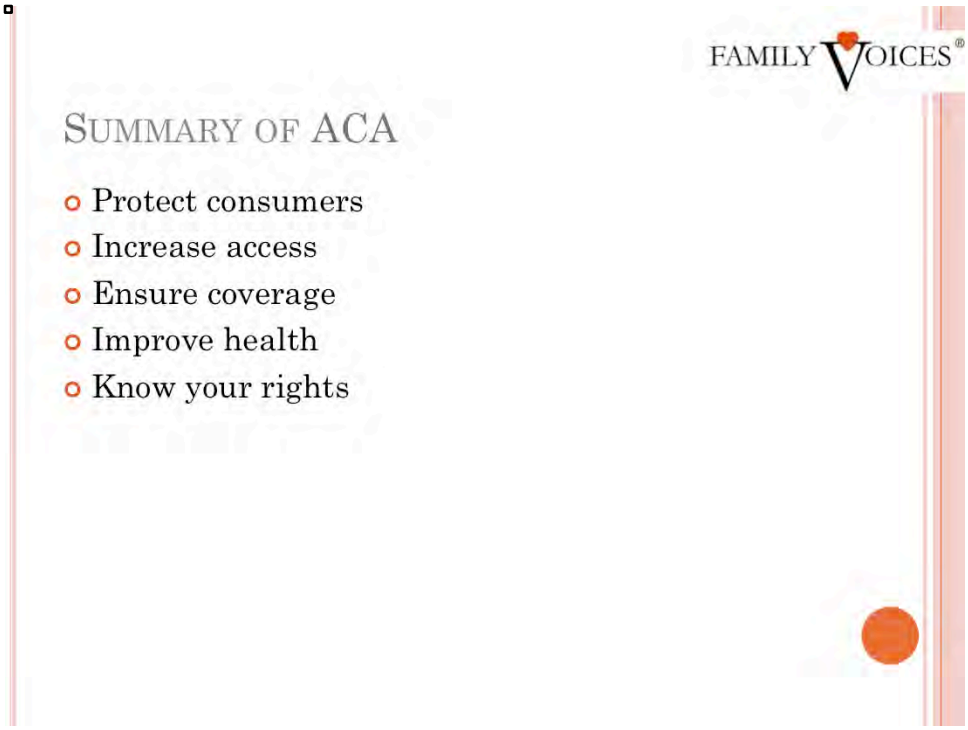
Regardless of the actuarial value of the plan, all Marketplace plans offer preventative services without cost-sharing or fulfilling deductibles, and the maximum out-of-pocket limit for covered services cannot surpass that determined by the ACA, $6350/individual and $12,700/family.




When purchasing a plan, it is important for consumers to consider many factors. Those factors not only include plan costs and subsidies but also factors regarding the actual delivery of care. Consumers should review provider directories and in-network hospitals and clinics to ensure they are able to stay with current or move to other desired providers. Further, consumers should thoughtfully review prescription needs and coverage in order to find the most satisfactory match. Additionally, one should consider the scope and frequency of services covered. While all plans must include the essential health benefits, the amount of services covered may vary with plan. For example, limits to the number of therapy appointments may apply. For this reason, we advise consumers to consider which services they typically access and find the plan that will most adequately cover those needs.




While the individual mandate of the ACA does require individuals to obtain minimum essential coverage, it does not mandate where the coverage is purchased. Therefore, consumers are still able to purchase plans outside of the Marketplace. Insurance companies and agents may sell plans to individuals. These plans are not eligible for tax credits or cost-sharing subsidies, and it may be more difficult to do side-by-side comparisons of available plans. It is important to note that consumers may pay commissions on plans purchased from insurance agents.




In summary, the ACA is a very extensive piece of legislation that was designed with the intent to protect consumers, increase access to affordable health care, ensure coverage and improve the health of all Americans. The legislation is now fully effective, with the exception of the shared employer responsibility provisions, which will be effective 2015. During these times of change, we encourage all consumers to know and exercise their rights as active and competent self- and family-advocates.


If you have questions about how the Affordable Care Act affects you, or if you have questions or concerns about accessing and navigating various systems or services, please contact Family Voices Indiana. We are Indiana's family-to-family health information center. All of our staff members are parents of children with special health care needs, and we are eager to serve individuals, families, and professionals as they journey on their unique paths.