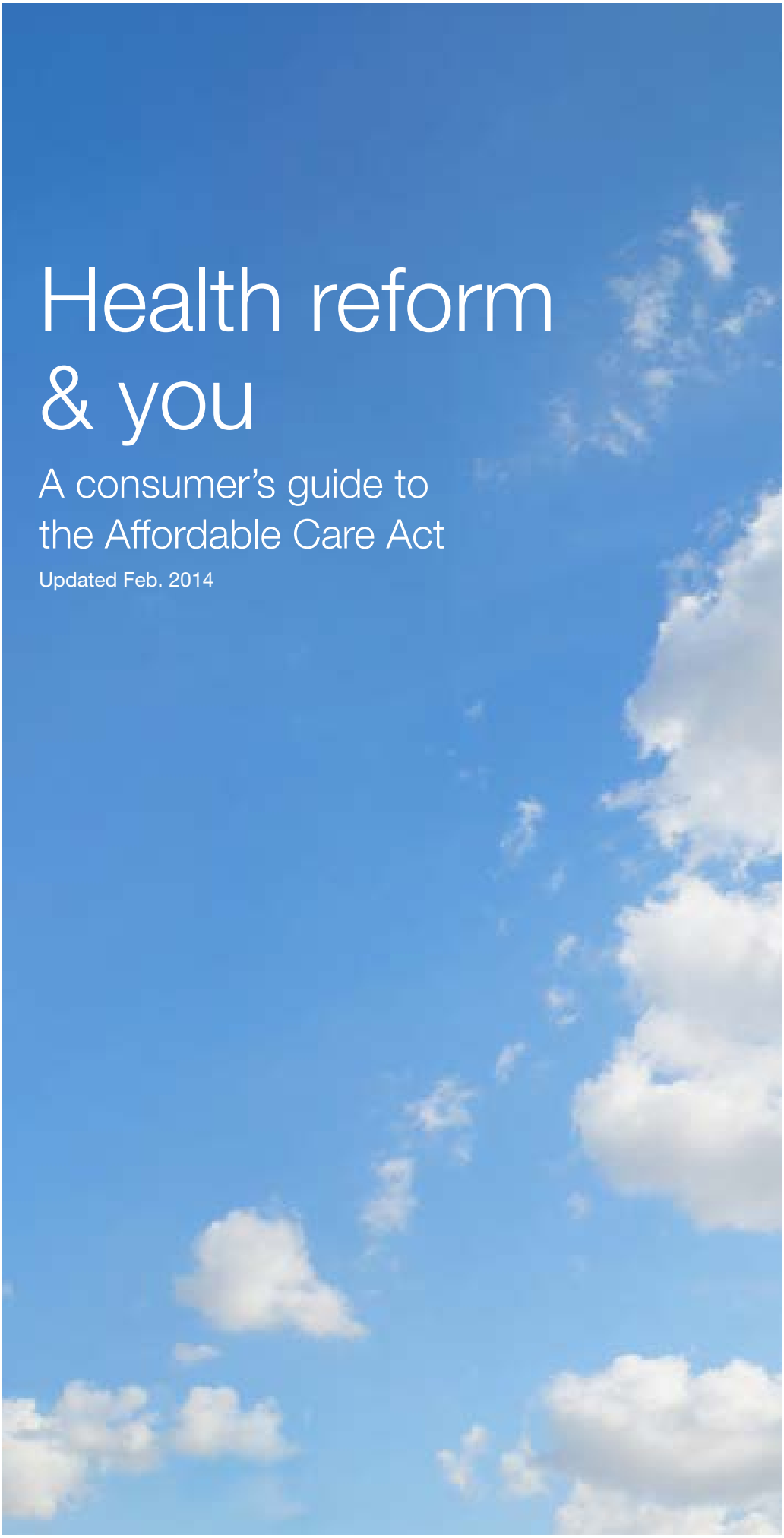


PriorityHealth

Health reform & you

A consumer's guide to the Affordable Care Act

Updated Feb. 2014

U UNINSURED

E EMPLOYER

I INDIVIDUAL

M MEDICARE

C MEDICAID

Contents

About this eBook

The Affordable Care Act is the federal health care reform bill that was signed into law in March 2010. This law is often called "Obamacare." It is one of the largest pieces of legislation to be passed in the United States in a generation. The law itself is more than 1,000 pages long and is quite complicated, even for people in the insurance business. And it affects everyone.

We're here to help

That's why we've created this eBook. Our goal is to clarify what health care reform means for you and your family here in Michigan.

If you still have questions after reading this guide, talk with your employer or your insurance company. If you don't have an insurance company, Priority Health has great plans to choose from. We would love to talk with you! More than 600,000 people in Michigan are already covered by Priority Health plans.

What matters most to you?

To help you find the information that's most important to you, we've labeled each section of this eBook with icons representing people in different situations. Look for the icon(s) that best describe you, and focus on those sections.

Uninsured
I don't have health insurance today

Medicaid
I get health insurance through Medicaid because of my personal status

Individual Buyer
I buy health insurance for myself or my family on my own

Medicare
I get health insurance through Medicare because I am age 65 or older

From Employer
I get health insurance through my employer or my spouse's employer

Get more information

Watch for **orange** *text that links to additional information. Just click on the text to go to a website or another section of this eBook.*

The basics of Obamacare

The Affordable Care Act (ACA) is a set of national health insurance reforms. These reforms began to roll out in 2010 and will continue to take effect in 2014 and beyond.

The main purpose of this law is to increase access to health care for those who don't have insurance. For that reason, the law defines some major changes:

- It requires all Americans to have health care coverage – and then makes that coverage easier to get. An important new way to buy health insurance is through an online system called the Health Insurance Marketplace. More about that later.
- It expands Medicaid coverage to a larger group of citizens by making more people eligible based on their income.
- It changes the coverage that's offered through employers. Smaller employers are now able to let their employees buy health insurance through a small-business marketplace. There are also reforms that affect employees of larger businesses. For example, employers are encouraged to give employees rewards and incentives for healthy living.

Big changes in 2014

Many of the ACA's reforms have already taken effect. For example, adult children up to age 26 can now stay on a parent's or guardian's health plan. But 2014 is a big year for introducing new reforms.

Starting Jan. 1, 2014, the following things happen:

- The **Health Insurance Marketplace** (or Marketplace) and the **Small Business Health Options Program** (or SHOP) will open. These two public markets will give you a whole new way to shop for coverage. You can buy insurance through the Marketplace or the SHOP starting Oct. 1, 2013 – but your coverage won't take effect until Jan. 1, 2014.
- People who don't get health insurance will have to pay a penalty. This fee will increase every year.

Get health insurance or pay a fee

Under Obamacare, all U.S. citizens are required to have certified health insurance starting in Jan. 2014. This means that if you don't get insurance through an employer, you will have to either pay for health insurance or pay a penalty. (You won't have to pay the penalty if your income is lower than what is required to file an annual tax return or are a member of a federally recognized tribe.) This requirement to have insurance is called the **individual mandate**.

Here's where the Health Insurance Marketplace comes into play – it makes it easy for you to get coverage that meets the government's minimum requirements for quality and affordability. Plus, insurance companies will no longer be allowed to deny you coverage because of a preexisting condition.

Now, what about that penalty for not having health insurance? Here's what the law says: If you can afford health insurance but don't buy it, you'll have to pay a fee when you submit your federal income tax forms. The penalty starts low and increases year by year.

*The **individual mandate** provision of the health reform law requires citizens to have insurance coverage that meets minimum standards. These standards include guaranteed access to affordable coverage, essential health benefits and other consumer protections. The legislation imposes a tax penalty on individuals (with some exceptions) who do not have coverage.*

In 2014:

The fee is 1% of your yearly income or $95 per adult in the household for the year, whichever is higher. The fee for uninsured children is half the adult fee ($47.50 per child).

In 2015:

The fee is 2% of your income or $325 per adult, whichever is higher.

In 2016:

The fee is 2.5% of your income or $695 per adult, whichever is higher.

***Remember:** Paying the fee doesn't get you health insurance. So, if you don't have insurance, you'll have to pay the fee AND pay for all of your medical care – doctor visits, hospital stays, and so on.*

You do the math

The Jones family has two adults and three children and an annual household income of $70,000. They don't have insurance. Their penalty in 2014 would be 1% of $70,000, or $700 annually. While this is lower than the cost to buy insurance, is it worth the risk? What if a family member needed surgery or was diagnosed with diabetes? The medical expenses could be tens of thousands of dollars. What would you do?

Overview of the Health Insurance Marketplace

The Health Insurance Marketplace, or Marketplace, is a government-sponsored, Internet-based market where individual Americans can buy health insurance plans from private insurance companies. It's meant for people who don't get insurance through an employer or through Medicare or Medicaid.

The Affordable Care Act requires all 50 states to have a public marketplace. Each state decides whether it wants to set up its own marketplace or partner with the federal government in running its marketplace.

The State of Michigan chose not to set up its own marketplace, so our state marketplace is run by the federal government.

Another name used for the Marketplace in the earlier days of health care reform was the American Health Benefits Exchange, or "the exchange" for short. This term is still heard a lot, but in this eBook we use the term Marketplace.

When the Marketplace opens for business on Oct. 1, 2013, you'll be able to submit an application and then see which insurance plans are available to you. You'll also learn whether you qualify for free coverage through **Medicaid** or the Children's Health Insurance Program (CHIP) or for lower-cost coverage through **government subsidies.**

You can apply online, by mail or in person with someone trained to help. More on this later.

These are the basics of the Marketplace. We'll cover more of the details in the **next section.** There we'll also explain the SHOP option for employees of participating small businesses.

A health insurance exchange mechanism (now called the ***Health Insurance Marketplace****) is a key provision of the Affordable Care Act. Its function is to provide a lineup of competing insurers offering a choice of certified health plans. All plans must meet the standards set by the Health Choices Administration. For instance, plans are not allowed to discriminate based on health history or future risk. Competition between insurers is expected to improve the quality and pricing of offered plans.*

Expanded Medicaid coverage

Medicaid is a program of the federal government that provides free health care coverage to millions of individuals and families with low incomes. Today, your eligibility for Medicaid depends on your personal status – for example, whether you're pregnant, disabled or a minor.

In 2014, the rules for Medicaid are changing to make more low-income people eligible – at least in some states. The Supreme Court ruled that each state must decide whether to accept the ACA's requirement to make Medicaid available to more people (based on income). The Michigan Legislature voted in favor of expanding the Medicaid

The **federal poverty level (FPL)** *is the set minimum gross income that a family needs for food, clothing, transportation, shelter and other necessities. This level is set each year by the Department of Health and Human Services. It varies according to family size. Public assistance programs such as Medicaid define eligibility income limits as some percentage of FPL.* **[Go back to "Subsidies for people with low income"]**

continued >

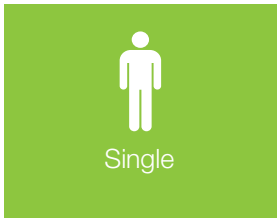
program. Medicaid will now be available to residents whose household income is up to 133% of the **federal poverty level.** That's about $32,000 per year for a family of four. So with the expansion of Medicaid, even if you weren't eligible for Medicaid in 2013, you might be in 2014.

We expect that many low-income people will take advantage of this new opportunity to get free or low-cost health coverage through Medicaid.

The expansion of Medicaid could be helpful for employers too, because as more of their employees enroll in Medicaid, company health insurance costs will go down.

To find out whether you qualify for Medicaid, go to the Marketplace ***(healthcare.gov).*** Create an account and submit an application. The website will tell you for which government programs, including Medicaid, you and your family are qualified.

Medicaid eligibility



Makes less than $15,200

Makes less than $31,300

Guaranteed Issue

Starting in Jan. 2014, being sick won't keep you from getting affordable health care coverage. An insurance company can't deny you coverage even if you have a preexisting condition. This provision has been in effect for children since 2010, but now everyone will have access to coverage, no matter their age, gender, income or health status (including pregnancy). This requirement that you must be allowed to enroll in a health plan is called guaranteed issue.

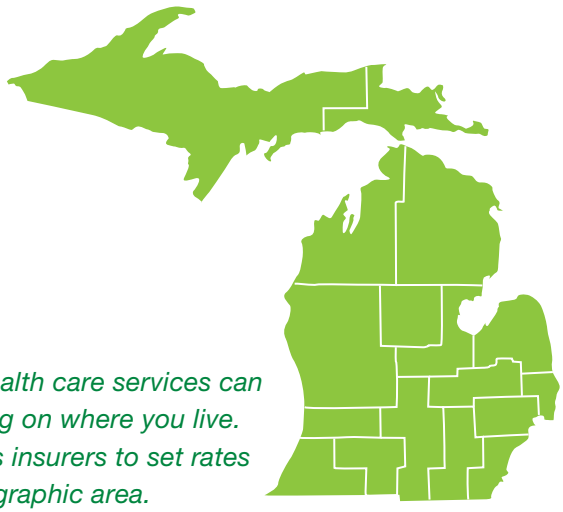
Guaranteed issue also controls how insurance companies can set their rates. In Michigan, rates can be set based on age (but not gender), place of residence, tobacco use and specific benefits. The difference between the highest rate and the lowest rate cannot exceed a 3-to-1 ratio. So if a 27-year-old non-smoking male has a monthly premium of $80, his insurance company cannot charge a 62-year-old male smoker in the same region more than $240 for the same plan.

***Guaranteed issue** laws require insurance companies to issue health insurance to any applicant regardless of the applicant's health status, age or other factors. Policies are guaranteed to be renewed as long as the policyholder continues to pay the premium.*

Age (cannot exceed 3:1 ratio)

Place of residence

Tobacco use



The cost of health care services can vary depending on where you live. The law allows insurers to set rates based on geographic area.

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Health Insurance Marketplace: The details

[Go back to previous section]

Public and Private Marketplaces

The Affordable Care Act required the creation of a public marketplace in each state. This is a way for more people to shop for affordable health insurance – especially people who don't get coverage through an employer, Medicare or Medicaid.

Even though we talk about "the Marketplace," there are actually two public marketplaces in Michigan (and in every state):

- **The marketplace for individuals**: This is the **Health Insurance Marketplace** where you can compare plans and buy health insurance online.
- **The marketplace for small business**: This is the **Small Business Health Options Program** (the SHOP). It's an online market where you can buy health insurance if you work for a participating company with 50 or fewer full-time employees.

In addition to these two public marketplaces, you can also buy directly from a health insurance company or shop at one of several **private marketplaces** such as ***ehealthinsurance.com*** for individuals and ***iSelectcbs.com*** for employers. (Priority Health participates in both.) Eligibility requirements and enrollment periods are the same for the private and public marketplaces.

SHOP delayed

The online SHOP has been delayed until Nov. 2014. Employers should work with their agent or health plan to purchase a SHOP plan.

Health Insurance Marketplace:

The public marketplace for individuals

The Health Insurance Marketplace is a government-sponsored, Internet-based market where individual Americans can buy health insurance plans from private insurance companies. It's a "one-stop shopping" website where you can go to compare and buy coverage.

continued >

The Marketplace will also tell you what **financial help** might be available to you from the federal government. For example, you might be eligible for reduced premiums or cost-sharing subsidies or for government programs such as Medicaid, CHIP and MiChild (a low-cost health insurance program for uninsured children). Because all of this information is available through the Marketplace, you won't have to ask any other government agencies. This makes it easier for you to understand your options.

All health plans sold on the Marketplace and the SHOP beginning in 2014 must include 10 categories of services called ***essential health benefits.***

Who can purchase

Are you eligible to buy health insurance through the marketplace? The answer is yes if:

- You're an adult U.S. citizen who is not incarcerated
- You live in the state that the marketplace serves
- You are not covered by Medicare

About the plans

Plans sold on the marketplace have to meet the government's coverage and affordability requirements.

The plans are divided into four categories:

All plans offer the same set of essential health benefits.
The category you choose will affect:

- The cost of your monthly premium
- What portion of the bill you'll pay for things like hospital visits and prescriptions (copayments)
- How much your total out-of-pocket costs could be per year if you need a lot of care

In general, you'll find this to be true: The lower the premium, the higher the out-of-pocket costs will be when you need care. The higher the premium, the lower the annual out-of-pocket costs.

The marketplace also offers catastrophic plans to people under 30 years and to some people with very low incomes.

Essential health benefits include:

- *Maternity and newborn care*
- *Hospitalization*
- *Prescription drugs*
- *Pediatric services, including dental and vision*
- *Rehabilitative and habilitative services and devices*
- *Mental health and substance use disorder services*
- *Laboratory services*
- *Ambulatory patient services*
- *Preventive and wellness services and chronic disease management*
- *Emergency services*

How to use the Marketplace

You can get started shopping for coverage either by using the website or by calling the toll-free help line (1-800-318-2596). If you don't have access to the Internet, call the help line; a customer service representative will walk you through the process.

If you do have Internet access, **here are the steps to take:**

1. Go to the Marketplace website ***(healthcare.gov)*** and create an account.

2. Review the site and read about the plans that are available. Pay attention to things like premiums, cost-sharing subsidies, benefits, quality ratings and doctor directories. Choose the plan that looks best to you. (Note: To qualify for certain **government subsidies**, you must choose a plan in the Silver category.

3. **Before** you fill out your application, **gather** some basic information:
   - Social Security numbers for all household members (or document numbers for legal immigrants)
   - Employer information for each family member who needs coverage
   - Income information – see your W-2 form, a current pay stub or your tax return
   - Policy numbers for any current health insurance plans covering any family members
   - A completed **Employer Coverage Tool**, a form that needs to be filled out for each job-based insurance plan someone in your household is eligible for

4. Once you've completed and submitted your application (via the website, phone or mail), the Marketplace will process your request and determine whether you're eligible for government programs such as Medicaid, CHIP or MiChild, or for government subsidies.

5. Once your eligibility is confirmed, the Marketplace will notify your chosen health insurance company and send them your enrollment files. You will then receive communication from your insurance company.

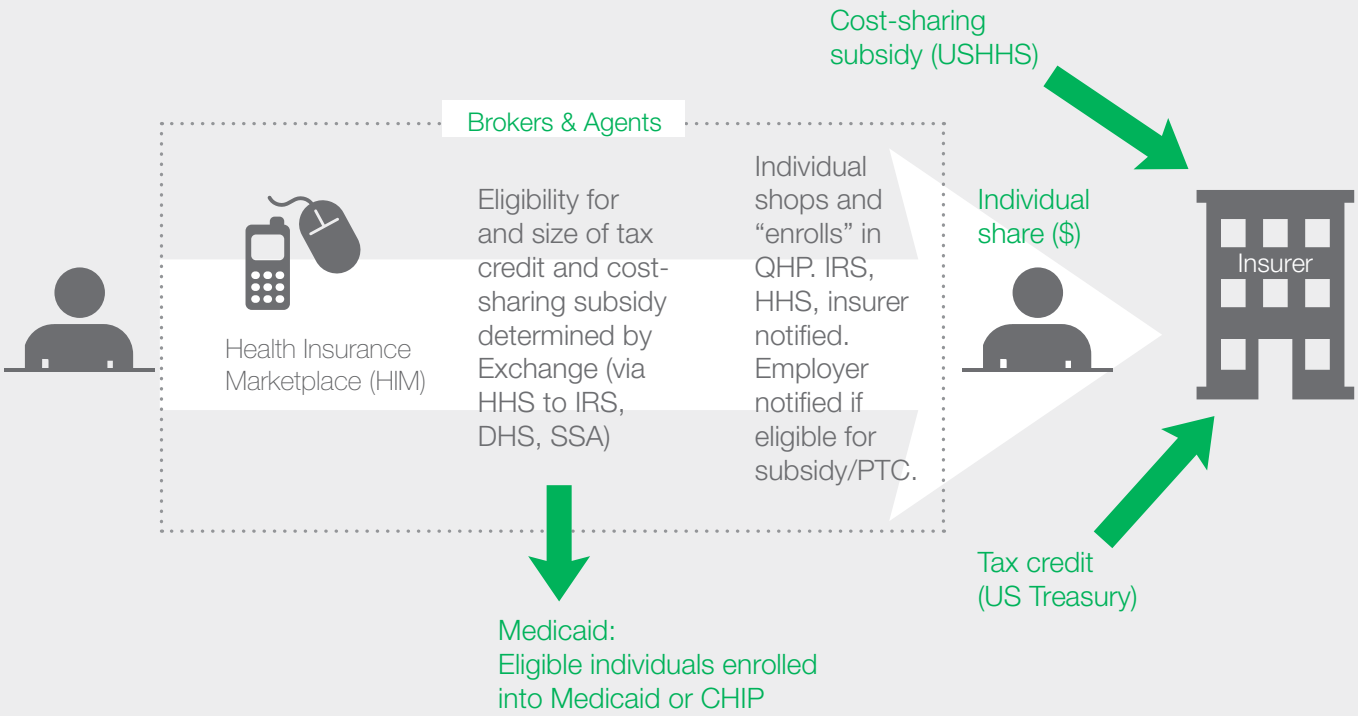
6. If you are employed full time, the Marketplace will notify your employer that you have purchased insurance (and perhaps received a federal subsidy).

7. If you received federal financial subsidies, your health insurance company will collect payments from **three sources**:
   - You
   - Department of Health & Human Services (HHS)
   - Internal Revenue Service (IRS)/U.S. Treasury

Health Insurance Marketplace

MyPriority is a Qualified Health Plan on the Health Insurance Marketplace

How to enroll in the Marketplace



How to get answers

If you find yourself confused while shopping for coverage and can't find the answers on the Marketplace website, you can use the Marketplace's 24/7 online chat service or call the 24/7 toll-free call center (1-800-318-2596). **Find more information.**

In addition, the government has formed a new customer support team called Navigators. Navigators are individuals and organizations who have expertise in enrollment and benefits. They will provide free, impartial help in selecting a plan and getting enrolled. You can talk with them in person at various locations around the state. Navigators can be located at Medicaid offices, labor unions, chambers of commerce or social service agencies. **FInd a list of navigators in your area.**

First year

The first open enrollment period for the individual marketplace begins Oct. 1, 2013, and ends March 31, 2014. About 50 million uninsured people across the U.S. will have the chance to shop for coverage on the marketplace during this initial six-month period. This first open enrollment period is longer than the open enrollment periods will be in later years. This is to give people time to learn the new process.

If you sign up for coverage before Dec. 23, 2013, your insurance will take effect on Jan. 1, 2014. You can sign up for coverage through March 31, 2014 but the effective date of your coverage will depend on when you enroll.

If enroll from	Effective date
Oct. 1 to Dec. 23, 2013	Jan. 1, 2014
Dec. 16, 2013 through Jan. 15, 2014	Feb. 1, 2014
Jan. 16, 2014 through Feb. 15, 2014	March 1, 2014
Feb. 16, 2014 through March 15, 2014	Apr. 1, 2014
March 16, 2014 through March 31, 2014	May 1, 2014

Following years

When open enrollment is over, you'll have to wait several months before you can enroll or change your coverage. In 2014 and following years, your chance to enroll is between Oct. 15 and Dec. 7 (pending federal guidance). So, if you decide not to buy coverage, you'll have to wait until the next year's open enrollment period to buy coverage. And at income tax time, you'll have to pay the penalty for not having insurance.

Note: *The Oct. 15 – Dec. 7 open enrollment period also applies to the private marketplaces.*

Exceptions

Like almost everything in health care reform, there are exceptions. So, if you lose employer-sponsored coverage, have a life-changing event (such as a marriage, birth or adoption) or have a major change in household income, you will be able to sign up outside of the regular enrollment period. In these cases, you'll still be able to buy coverage from the Marketplace, whether you need it for the short term or the long term. And if you move to another state, you'll be eligible to purchase coverage from that state's Marketplace. (If you lose your job, you may be able to keep your job-based plan by buying COBRA continuation coverage for a limited time, though this option is often quite costly.)

SHOP enrollment

Enrollment in your employer's plan on the SHOP is scheduled by your employer. The dates vary by employer.

Open enrollment in the Marketplace

When can you enroll? For both the individual Marketplace and the SHOP marketplace, there's a specific time period when you can buy coverage. This period is called open enrollment.

Proposed open enrollment period for coverage in 2015 is Nov. 15, 2014 — Jan. 5, 2015. Federal guidance is pending.

Help for people with low income

[Go back to "Overview of the health insurance marketplace"]

[Go back to "Details of health the insurance marketplace"]

[Go back to "The public marketplace for individuals"]

[Go back to "How to use the marketplace: steps"]

Because the main goal of health care reform is to make it easier for more Americans to get health insurance, the ACA added a few ways to reduce the cost of health coverage for low-income individuals and families.

Starting in 2014, the federal government will offer financial assistance, or subsidies, to help people pay for insurance **purchased through the Marketplace**. These subsidies will especially help you if your household income is between 100% and about 200% of the **federal poverty level (FPL).** (If you live at less than 100% of the FPL, you'll get better coverage for a lot less money through Medicaid.)

The government offers three types of subsidies, depending on income and family size:

1 Reduced premiums through tax credits:	2 Out-of-pocket maximums:	3 Copayment, deductible and coinsurance subsidies (cost-sharing reduction):
You will qualify for these tax credits if your household income is **between 100% and 400% of the FPL**. These credits essentially limit the cost of your premiums to 2% of household income (for the lower income levels) or 9.5% (for the higher levels). The U.S. Treasury will pay these credits to your insurer.	Again, if your household income is between 100% and 400% of the FPL, the government will put a cap on what you'll have to spend on your deductible and copayments for the year. Those who earn 200% of the FPL will pay less than $3,000 out of pocket. (For reference, the out-of-pocket maximum for Medicare recipients today is $6,700.) But to qualify for these savings, you must choose a Silver plan in the Marketplace.	If your household income is between 100% and 250% of the FPL, the government will cover part of your copayment, deductible and coinsurance fees. So, a $30 copayment could be reduced to $10 or a $500 deductible may be reduced to $250. Again, to qualify for these savings, you must choose a Silver plan.

Two examples

To understand how these subsidies might work, let's look at the case of Michael, a 26-year-old single male living at about 200% of the FPL.

1% penalty for not buying insurance in 2014:	**$220**
2% penalty in 2015:	**$440**
2.5% penalty in 2016:	**$695**
Premium tax credit:	$1,447.74
Cost-share subsidy:	87%

If Michael doesn't buy health insurance, he will have to pay a penalty. But the federal government is willing to help him out with a premium tax credit, an out-of-pocket cost limit and a cost-sharing subsidy.

The fourth row of the table shows how Michael's premium tax credit will work. The most an individual making $22,000 will pay is 6.3% of household income for coverage through an individual marketplace. This means that Michael's total premium costs will be capped at around $1,400. For just over $100 per month, Michael can get a plan with great coverage. Plus, his overall plan coverage improves from 70% coverage to 87% coverage through cost sharing.

This means that when Michael buys a silver plan, his cost-sharing subsidies reduce the amount he is responsible for paying. That makes his 70% plan feel like an 87% plan.

But what about a family of four? Let's see what help the Richardson family will be able to access in 2014:

1% penalty for not buying insurance in 2014:	**$470**
2% penalty in 2015:	**$940**
2.5% penalty in 2016:	**$1,175**
Premium tax credit:	$2,967.30
Cost-share subsidy:	87%

With a household income of $47,000 per year, the Richardsons will pay roughly $200 per month for excellent coverage. Plus, their out-of-pocket costs are reduced. The family can breathe a sigh of relief.

Now, it's true that if we're just comparing costs, it is less expensive for someone to pay the penalty and go without coverage. This is even true for those with the lowest incomes and the highest levels of subsidization. But then the individual or family takes on the financial risk of being uninsured. And the cost of a cancer diagnosis, for example, can break a family financially. Even a small unplanned medical procedure can cause a large financial strain.

How to apply for subsidies

You'll see the amount of savings you're eligible for when you fill out and submit your Marketplace application beginning Oct. 1, 2013. Prices shown for insurance plans will reflect any premium reductions and cost-sharing subsidies.

Seven scenarios

1 U

I'm not employed. What are my options?

Is your family income less than or equal to 133% of the poverty level? **(Here's a handy chart.)**

Yes → Your family is eligible for Medicaid; you should apply for it.

No

Then is your family income less than or equal to four times (400% of) the poverty level?

Yes → Your family is guaranteed coverage through the Marketplace and is eligible for a premium tax credit. Or you could use a private market.

No

Your family is guaranteed coverage through the Marketplace, perhaps with cost-sharing subsidies. Or you could use a private market.

Of course, if you're under 26 years of age, you may qualify to join your parent or guardian's health plan. If you're 65 or over, you'll qualify for Medicare.

2 U I

I'm employed part time (less than 30 hours per week with any employer).

What are my options?

You have the same options as those who are unemployed. Please see #1.

3 U I

I'm self employed.

What are my options?

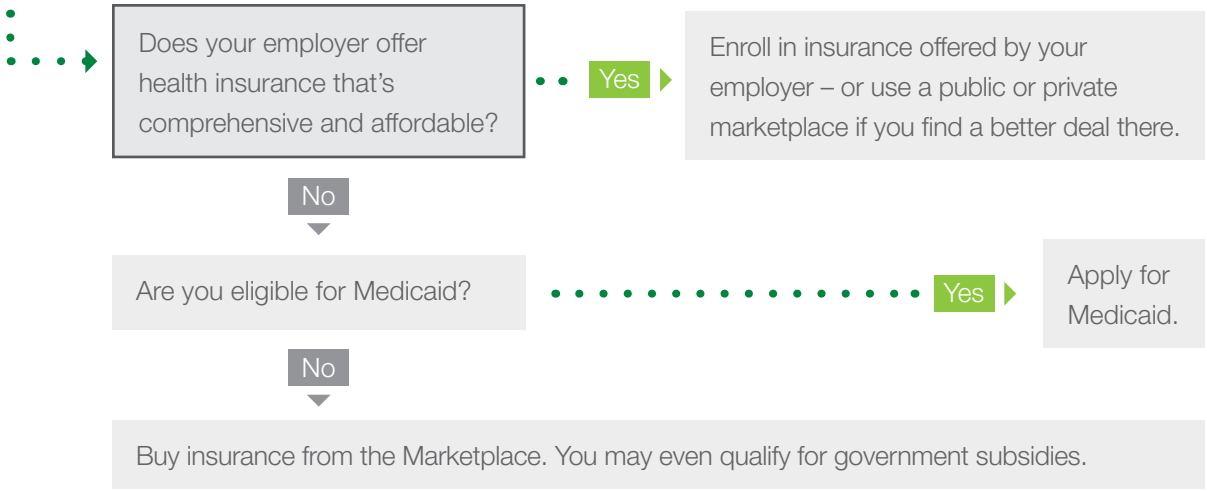
You have the same options as those who are unemployed. Please see #1.

continued >

4 E

I'm employed full time with a large company.
What are my options?

The law says that large employers (those with more than 50 employees) must offer full-time (30-plus hours per week) employees and their dependents an opportunity to enroll in coverage that is affordable and that meets essential coverage standards. Large employers that don't offer affordable, quality coverage for full-time employees will pay a penalty. (Your employer will also pay a penalty if your share of premiums exceeds 9.5% of your wages as reported on your W-2 form, or if the employer-sponsored health plan doesn't pay at least 60% of the total cost of medical services in a year.)



Of course, if you're under 26 years of age, you may qualify to join your parent or guardian's health plan. If you're 65 or over, you'll qualify for Medicare.

5 E I

I'm employed full time with a small business.
What are my options?

Of course, if you're under 26 years of age, you may qualify to join your parent or guardian's health plan. If you're 65 or over, you'll qualify for Medicare.

continued >

6 M

I'm on Medicaid. How does this affect me?

If you're already on Medicaid, you don't have to make any changes. However, if your income goes up and you're no longer eligible for Medicaid, you can apply for coverage through the Marketplace or get it through your employer.

7 C

I'm on Medicare. How does this affect me?

If you are 65 or older and have Medicare, you don't have to make any changes. The good news is that your benefits will actually improve. Under Obamacare, senior citizens can get preventive care without paying deductibles or copayments. The law also phases out the "doughnut hole" of prescription coverage – a gap in coverage that forces people to pay some prescription drug costs out of pocket. The donut hole will be closed completely by 2020.

Frequently asked questions

Q *Will I pay less for health care under the new law?*

A It's possible but not likely. The answer depends on your situation, but the Affordable Care Act is more focused on getting people insured than on lowering costs overall. The hope is that costs will start to go down over time because when more people are covered, the overall cost of health care will decrease.

Q *What will change about my current coverage?*

A The ACA has already put in place a number of changes: required coverage for children up to age 26, elimination of preexisting condition exclusions for kids, elimination of lifetime coverage caps, coverage of preventive care, coverage of birth control for women, improved preventive care coverage for Medicaid recipients and more.

In 2014, many new reforms will take effect:

- Medicaid will expand to cover more people
- Individuals will be required to have health insurance (or pay a penalty)
- Health insurance marketplaces will be up and running
- Guaranteed issue, essential health benefits, employer requirements and other provisions will kick in

How all of these changes affect you depends on your situation.

Q *What if I don't have health insurance today?*

A There are almost 50 million Americans who have no coverage, but in 2014 you'll be required to have coverage. Every state will have a marketplace where individuals can shop for health insurance, and if you meet certain income requirements you'll qualify for subsidies to help you pay for coverage. If you are at or below 133% of the federal poverty level, you will be eligible for Medicaid coverage.

If you don't have coverage now and need it before the marketplace plans take effect on Jan. 1, you can buy from an insurance company such as Priority Health, either directly or by working with an insurance agent.

What does the Oct. 2013–March 2014 open enrollment mean for me?

If you're one of the 150 million Americans who get their health insurance through an employer, your organization probably has coverage in place, so this open enrollment period for the Health Insurance Marketplace won't affect you much. However, you will see a few changes:

- The bad news: Your health insurance will probably be more expensive than last year. That's because your employer is paying more for coverage than last year and is passing some of the costs on to you.
- The good news: Many employers are offering rewards for healthy behaviors like quitting smoking or losing weight. If you make these kinds of health improvements, you'll pay less in premiums, and both you and your employer will see lower long-term costs.
- Starting in 2013 employers are required to give employees a health care summary that clearly defines things like preventive care coverage and prescription drugs. This helps you compare different plans and understand which one is best for you and your family before you sign up.

Now, if you don't already have insurance, open enrollment means big changes for you. You'll need to go through the process of choosing a plan and signing up – but then you'll have the peace of mind that comes with knowing you're covered if you or someone in your household gets sick or injured.

How will my taxes change?

There are a handful of tax changes in the ACA, including a Medicare surcharge on high-income taxpayers (effective in 2013) and a 40% tax on high-end health plans (effective in 2018). If you don't have insurance, you may have to pay a penalty beginning in 2014.

What if my employer decides to not offer coverage and chooses to pay the penalty instead?

Then you have the option of shopping on the Marketplace or find coverage elsewhere (through a private marketplace or from an insurer directly). Plus, you may be eligible for **federal subsidies**.

What if I choose not to use my employer-sponsored health plan because it is more expensive than a plan I can buy through the Marketplace?

The law allows you to do this. If the amount you pay for self-only coverage in your employer's plan exceeds 9.5% of your wages, you may be eligible for federal help to purchase coverage in the Marketplace. However, if your employer's plan meets the federal requirements, you'll be responsible for paying for the entire cost on your own without help from your employer.

Q **A** *What if health insurance is still too expensive for me?*

If your household income is below the threshold required to file an annual income tax return, you won't be penalized for not having coverage. Nor will you be penalized if the cost of purchasing coverage exceeds 8% of your household income. However, if you can't afford coverage, there are still ways you can reduce what you pay for health care. Consider going to a clinic instead of the emergency room. Talk to your doctor about the possibility of a sliding scale for services (where you pay based on what you can afford.) If you are under age 30, consider a catastrophic plan that will offer some peace of mind should you have a serious health condition.

Q **A** *How do I know if I'm getting the right plan for me and my family?*

Be sure to read the fine print! Many health plans offer low rates, BUT they come with a very limited network that restricts access to just one hospital system and/or medical group. These same plans often require a referral to see a specialist, and even a prior authorization from your insurance company. Remember too that the premium you pay is just one part of the total cost of health care. Beyond the monthly premium, consider the deductible, co-pays, and co-insurance, as well as the annual out-of-pocket limit you're responsible for. These things can add up and sometimes cost more than the savings you get with a lower monthly premium.

That's it.

Everything you need to know about health care reform.

Well, not exactly, but it's a pretty thorough overview. Still, if you have questions about how this law applies to your situation, call your agent and ask.

If you don't have a health plan, Priority Health is here to help. We know that these changes pose challenges for all of us – individuals, families, businesses and government. That's why we're staying on top of all the developments in health care reform and interpreting how the law affects you.

If you want to know more about Priority Health and the types of plans we offer, visit us on the web at ***priorityhealth.com/getcovered***.

Appendix A: Health care reform provisions

Following are our explanations of a few provisions of the ACA:

Automatic enrollment: Employers with 200 or more full-time employees must automatically enroll new employees in coverage. Employees may opt out if they choose. This provision is pending.

Dependent coverage extension: Health plans must offer coverage to dependents on their parents' plan(s) until the dependent turns 26. Benefits offered must be the same as for other dependents and can't cost more.

Emergency services coverage: All health plans must cover emergency care at out-of-network hospitals at the same copayment or coinsurance level as in-network hospitals. Health plans cannot require prior authorization or a referral for emergency services. However, out-of-network providers may bill patients for the difference between their standard charges and what the patient's health plan pays. This is called "balance billing." That's why you may want to seek services from an in-network emergency department when possible.

Essential health benefits: All individual and small business health plans must include 10 categories of services beginning in 2014. These include hospitalization, outpatient services, maternity care, emergency services, preventive services, prescription drugs and other services. The amount of cost-sharing you can be charged for these services is restricted.

Flexible spending account (FSA) limits: Pretax employee contributions to a health care FSA are now limited to $2,500. Before 2013, there was no limit.

Lifetime and annual limits: In the past, most health insurance policies had lifetime limits, or caps, on the benefits they would pay. Patients rarely exceeded that limit, but when they did, they faced major financial trouble. The new law prohibits lifetime limits and restricts annual limits on essential health benefits. But insurance companies can still put annual and lifetime dollar limits on spending for health care services that are not defined as essential health benefits.

Preexisting condition exclusions: Starting Jan. 1, 2014, the ACA prohibits preexisting condition exclusions for all plans. That means if a doctor has treated you in the past for asthma, for example, you will be covered for any asthma-related care or treatment under your new health plan, with no waiting period.

Premium rebates: Insurers must spend at least 80% of premiums they collect on client medical expenses. (This number is 85% for large employers.) When a health insurer fails to meet this standard, known as the medical loss ratio (MLR) standard, the insurer must repay the difference to the individual or the employer. This rule is designed to protect consumers.

Preventive coverage: Insurers must cover preventive care without deductibles, copayments or coinsurance. Covered services include those that are intended to prevent disease or to identify disease while it's more easily treatable. The list of services is evaluated annually by federal agencies. Services meeting the unique health needs of women, such as coverage for contraception and breastfeeding supplies, were added in 2012.

Primary care provider (PCP) selection: Health plans must allow participants to choose any participating PCP, as long as the doctor is accepting new patients. Under the law, women can select an OB/GYN as their primary care provider and cannot be required to seek a referral or prior authorization to see an in-network OB/GYN specialist. Parents can select a pediatrician as their child's PCP.

Summary of benefits and coverage (SBC): Insurers must provide a clear, easy-to-understand summary of benefits and coverage using a standard format developed by the federal government.

W-2 reporting requirement: Employers must report the cost of employer-sponsored health coverage on their employees' W-2 forms. This requirement began with the 2012 forms. The amounts reported are not taxable. The requirement seeks to provide employees with greater transparency into health care costs.

Waiting period for new hires: Job-based health plans cannot impose a waiting period (for the start of health coverage) longer than 90 days from the date of full-time employment (defined as 30-plus hours per week).

Appendix B: Glossary

Following are our explanations of a few terms of the ACA:

A

Affordable Care Act (ACA)

The term used to refer to the final, amended, federal health reform legislation signed into law on March 23, 2010 by President Obama. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010.

American Health Benefit Exchange (AHBE)

See Exchange.

C

Catastrophic plan

These plans are designed to protect policyholders in the case of an emergency. You're responsible for all of your medical expenses up to the first $6,350 for a single person. ($12,700 for a family). The plan covers up to three visits to your primary care provider though a copayment may apply. However, the deductible must be met before coverage applies for any other services. Originally intended for young people under the age of 30, a catastrophic plan may be available for those who demonstrate they can't otherwise afford health coverage.

Children's Health Insurance Program (CHIP)

Insurance program that provides health coverage to low-income children and, in some states, pregnant women in families that don't qualify for Medicaid but can't afford to purchase private health insurance. Program is jointly funded by state and federal government.

Coinsurance

A consumer's share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. For example, if the health insurance or plan's allowed amount for an office visit is $100 and a consumer has met their deductible, the coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

Copayment

A fixed amount (for example, $15) you pay for a covered health care service, usually when you get the service. The amount can vary by the type of covered health care service.

D

Department of Health and Human Services (HHS)

One of the federal agencies charged with administering the Affordable Care Act.

E

Employer Coverage Tool

A form that identifies an individual's eligibility for employer-sponsored health insurance. The tool is a component in a Health Insurance Marketplace application.

Exchange

A resource where individuals, families and small businesses can learn about their health coverage options; compare health insurance plans based on costs, benefits and other important features; choose a plan; and enroll in coverage. The Marketplace also provides information on programs that help people with low to moderate income and resources pay for coverage. This includes ways to save on the monthly premiums and out-of-pocket costs of coverage available through the Marketplace, and information about other programs, including Medicaid and the Children's Health Insurance Program (CHIP). The Marketplace encourages competition among private health plans, and is accessible through websites, call centers and in-person assistance. In some states, the Marketplace is run by the state. In others it is run by the federal government.

F

Federal poverty level (FPL)

A measure of income level issued annually by the Department of Health and Human Services. Federal poverty levels are used to determine eligibility for certain programs and benefits.**[Go Back to "Expanded Medicaid coverage"]**

G

Guaranteed issue

A requirement that health insurers must permit consumers to enroll in coverage regardless of health status, age, gender or other factors that might predict the use of health services.

H

Health Choices Administration

Created by the Affordable Care Act, this federal agency is charged with overseeing the law's provisions, including the establishment of health plan benefit standards, establishment and operation of the health insurance exchanges and administration of individual affordability credits or subsidies.

Health insurance exchange

See Exchange.

Health Insurance Marketplace

See Exchange.

I

Individual mandate

The requirement that U.S. citizens must have insurance coverage that meets minimum standards or pay a penalty for failing to do so. This provision of the law was upheld by the Supreme Court. **[Go Back to "Overview of health insurance marketplace"]**

Internal Revenue Service (IRS)

A United States government agency that is responsible for the collection and enforcement of taxes. One of the federal agencies charged with administering the Affordable Care Act.

M

Marketplace

See Exchange.

Medicaid

A state-administered health insurance program for low-income families and children, pregnant women, the elderly, people with disabilities, and in some states, other adults. The federal government provides a portion of the funding for Medicaid and sets guidelines for the program. States also have choices in how they design their program, so Medicaid varies state by state and may have a different name in your state.

Medical loss ratio (MLR)

A measurement used to evaluate the percentage of medical costs vs. non-medical costs that a health insurer pays from premiums it collects. If an insurer uses 80 cents out of every premium dollar to pay its customers' medical claims and activities that improve the quality of care, the company has a medical loss ratio of 80%. A medical loss ratio of 80% indicates that the insurer is using the remaining 20 cents of each premium dollar to pay overhead expenses, such as marketing, profits, salaries, administrative costs, and agent commissions. The Affordable Care Act sets minimum medical loss ratios for different markets, as do some state laws.

Medicare

A federal health insurance program for people who are age 65 or older and certain younger people with disabilities. It also covers people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).

MiChild

MIChild is a health care program administered by the Michigan Department of Community Health. It is for the low-income uninsured children of Michigan's working families. Beneficiaries receive a comprehensive package of health care benefits including vision, dental and mental health services.

MLR

See Medical loss ratio.

N

Navigator

An individual or organization that's trained and able to help consumers, small businesses and their employees look for health coverage options through the Marketplace. Navigators must be unbiased and cannot charge for their services.

O

Open enrollment

The period of time during which individuals can enroll in a Marketplace plan. For 2014, the Open Enrollment Period is Oct. 1, 2013–March 31, 2014. For 2015 and later years, the Open Enrollment Period is Oct. 15 to Dec. 7* of the previous year. Individuals may also qualify for Special Enrollment Periods outside of Open Enrollment if they experience certain events. (*Subject to federal confirmation.)

P

Patient Protection and Affordable Care Act (PPACA)

See Affordable Care Act.

Preexisting condition

A health problem that exists before a consumer applies for a health insurance policy or enrolls in a new health plan.

Primary care provider (PCP)

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provision

A requirement within a law that something must be done.

S

Small Business Health Options Program (SHOP)

A marketplace to purchase employee health benefits for business owners with fewer than 50 full-time employees. Beginning in 2017, the SHOP will be available to employers with up to 100 full-time employees.