

Shopping the Marketplace:

What you don't know about the Affordable Care Act will cost you!



2014-2015

The information in this eBook should be used as a general guide. Every situation will be different and results will vary. Use this as a tool with your current insurance advisor. Please call us with any questions or concerns you may have. If you need assistance with the process, we would be glad to partner with you. Do not hesitate to reach out to us.

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What to Look for During Open Enrollment

Open enrollment for “Obamacare”, or the Affordable Care Act (ACA) officially begins on November 15, 2014. Those “shopping” for healthcare will do so in the Marketplace, on the ACA’s official website (www.healthcare.gov). There is a lot of information available, but here is what you’ll need to know:

The plans are tiered: **Bronze, Silver, Gold, and Platinum**. Each tier is based on what is called “Actuarial Value” or AV. The AV is how much a particular plan will cost you expressed as an overall percentage of the claim. For example, a \$100,000 claim, with 100% claim coverage has an AV of 100. While AV is important, it is not a number to focus on; the tier classifications are more important.

Under the ACA, all plans cover preventive care. Preventive care includes services like annual physicals, mammograms, etc. For a full list of preventive care services covered under the ACA you can visit <https://www.healthcare.gov/preventive-care-benefits/>. Other things you will need to know as you shop:

1. What does the plan cover? For example, some plans will include blood work as a part of the deductible. Other plans may stipulate that blood work, up to \$500 per year, will be covered at 100%. That is just one of many examples of how plans differ.
2. How much does the plan cost? Often, people are side-tracked and choose the plan with the lowest premium. However, there are other costs to figure in besides premiums. Lower premiums will often mean higher doctor’s office co-pays. Other things to consider: the deductible, which is the amount you pay before your insurance kicks in, and most importantly, the out-of-pocket maximum. Many family plans under the Affordable Care Act have out-of-pocket maximums that total over \$12,000 per year.

3. Are your doctor and hospital in-network? Due to rising costs, many insurance carriers began to shrink their network of doctors and hospitals to keep the premiums low. You may find that many of the doctors and hospitals previously in-network are no longer an option. Consider this as you shop: if you choose a doctor or hospital that is not in your network, you will incur higher out-of-pocket expenses.
4. Is the plan a HMO, PPO or HSA? With a Health Maintenance Organization (HMO) plan, you will need to get a referral from your Primary Care Physician (PCP) to see a specialist or to have testing done. A Preferred Provider Organization (PPO) plan generally costs more, but you have more flexibility and normally do not need a referral to see a specialist. The Health Savings Account (HSA) is a newer plan. HSAs allow you to tie a savings account to your health plan. The account is then used for medical expenses. HSAs do come with some tax benefits. For more information visit: <http://www.foxbusiness.com/personal-finance/2012/05/03/tax-benefits-opening-health-savings-accounts/>.

Under the ACA, Advanced Premium Tax Credits (APTC) are available. These are more commonly known as federal subsidies. Based upon your household income, these plans are only available for purchase through the Marketplace. To qualify for an APTC, your 2014 Modified Adjusted Gross Income (MAGI) has to be less than:

\$46,960 for an individual
\$62,040 for a couple
\$78,120 for a family of three
\$94,200 for a family of four
\$110,280 for a family of five
\$126,360 for a family of six

If you qualify for a subsidy, you can have that paid directly to the insurance carrier on your behalf. For example, if the cost of your insurance plan is \$1000/month, and you qualify for a subsidy of \$500/month then you would pay \$500/month for the insurance.

Shopping the Marketplace can be confusing; don't forget to contact your "personal shopper" or insurance broker before selecting a plan. Just like clothing, you want to make sure that your insurance plan is a good fit.

Preparing for the Open Enrollment



So, does the thought of open enrollment have you ready to throw your computer against the wall? Not to mention the tears you'll cry as you apply for a tax credit to reduce your premiums. Don't despair; there is a method to the madness, or process. However, without the proper preparation, you'll waste time, and possibly thousands of dollars.

To spare yourself mental anguish, toss out the frameworks of plans you've had in the past, as well as the old rules of healthcare. The rules have changed. Period. It is best to go into the Marketplace with an open mind. The new plans have to be a Qualified Health Plan, or QHP. There are three components to QHPs:

1. Essential Health Benefits
2. Meets the Actuarial Value set by the new law
3. A Metallic Plan

In order to receive a tax credit, you must first complete the qualification process. Here are two items needed to qualify for an APTC:

1. Last year's tax return: The current year is incomplete, but last year's return provides a good baseline. See the figures on page 3 to make sure your household qualifies.
2. A snapshot of what you make in 30 days: If you are self-employed or work on commission, your 30-day income would be the amount you make after deductions (in most cases). If this figure fluctuates find the average, or speak with a CPA or tax professional.

Qualifications for APTCs are based on income, filing status and premiums. If you believe you may qualify for a tax credit, speak with a qualified insurance professional. A simple conversation can save hours of wasted time and needless frustration. It may also save that computer you were so ready to throw.

The balance between coverage and cost has shifted. Before current healthcare reform, if you chose a plan with a higher deductible, you could save just enough money to pay for the difference in deductibles. If something happened in the first 12-18 months, you would break even. If nothing happened, however, you would be ahead of the game.

Today, it's the reverse.

Put your budget aside for the moment: there is a financial incentive when you choose a lower-deductible plan. You will not save as much as you would pre-ACA; however, not everyone can afford the higher deductibles.

Moving on to the Bronze, or the HSA-qualified plan: depending upon how they're used, they can save you money. Yes, it is a higher deductible. If you only put away the premium difference in an HSA account, it would cover at least half of your deductible for 12-18 months. If you are a family of 4, you can save enough to cover the individual deductible on the policy in 12 months, give or take a month. This does not include the tax savings you would receive for contributing to an HSA account.

Finally, review your life insurance policy. Since, you are already shopping for healthcare, now is the perfect time to consider this other necessary insurance. For those of you who do not have a life insurance policy: now is the time to acquire one. Life insurance premiums will only go up as you age. Unfortunately, you will never see a "buy one, get one" sale on life insurance policies.

If you have a policy, here are a few key things to look for as you review: sufficient funds to cover income loss, debts and basic necessities.

As always: do your homework and consult with a qualified professional as needed.

Networks of Doctors and Hospitals Change with Healthcare Reform



Across the nation, many doctors are refusing to accept the Affordable Care Act, or what many refer to as “Obamacare”. More than anything else, their refusal is indicative of a lack of education about the ACA. The Affordable Care Act is not actually a plan.

The ACA only changed how policies are bought and sold, and created a Marketplace for easier access to plans. There is no government health plan attached to the ACA. When someone purchases a plan on the Health Insurance Marketplace/Exchange, they are purchasing the plan from the insurance company that is offering the coverage. Any customer service concerns, claims and invoices are handled by the insurance company backing the policy, not the government, or anything called “Obamacare”.

The Affordable Care Act placed new restrictions on the health insurance companies. Under these restrictions they made two major changes: increased costs to cover the required expenses and anticipated claims, and controlled costs on the back end. In order to control costs on the back end, health insurance companies either reduced their network or completely changed it.

These major changes will force some policyholders with a new ACA-compliant plan to choose a new doctor. But why can't you go the same doctor? It's just dollars and cents.

In order for a doctor or hospital to be considered “in-network”, they have to agree to the terms of the insurance company’s contract. This includes agreeing on a reimbursement schedule for seeing patients. Over the past few years, many doctors and hospitals have seen a gradual decrease in the reimbursement schedule. Under ACA terms, more than a few decided that the reimbursement schedule wasn’t worth the trouble, and did not sign the insurance company’s contract. Consequently, they are no longer a part of that particular company's network of doctors and hospitals.

Once a doctor or hospital is removed from the network, this change goes into effect regardless of where a plan is purchased. In other words a plan purchased through the Marketplace, through an insurance broker or directly from the insurance company will have the same doctors and hospitals listed in its network. Note: the only time the doctors and hospitals in network will differ is when they are different countries or particular cities in the U.S.

So what do doctors actually mean when they say that they are not accepting “Obamacare”? What a doctor or hospital is actually saying when they reject the ACA is that they disagree with the new reimbursement schedule offered to them by a certain insurance company. Their language, however, is misleading and confuses patients, policyholders and the general public.

The role of the Health Insurance Marketplace/Exchange is simply to control the tax credit. Those who apply and qualify for a tax credit can begin an application on the Marketplace and finish it while working directly with the insurance company offering the policy. This is done via a special connection between the Marketplace and the insurance company; the process, however, is still controlled by the Health Insurance Marketplace/Exchange, where the tax credit qualification comes from.

This is no different than when you purchase a product from the store. You cannot request service or a refund on the product unless you go back to the store that you purchased it from.

Look carefully at the available network of doctors and hospitals with any insurance plan you consider. Several major insurance companies have multiple networks to choose from. Often, they will charge more for policyholders to have access to a larger network of doctors and hospitals. You can avoid this by simply choosing a smaller network and finding a doctor there. As always, seek help from a licensed professional, such as an insurance broker, to find the best option for you.

Simplifying Health Insurance Shopping



In the past, choosing a healthcare plan to fit the needs of an individual or his or her family was difficult. There were endless premiums, co-pays and deductibles to consider. The ACA, however, has changed the design of the plans in an effort to make comparison and plan choices clearer. By now you're thinking that the process is about as clear as mud, right? The good news is, it's really not that hard to figure out.

Making sense of health insurance has never been so easy. At least that is what the government thinks. The industry has gone through dramatic changes and there have been considerable delays in getting the Marketplace off of the ground. This is another reason why it is best to work with a subject matter expert.

There are several easy ways to understand the new plans (Bronze, Silver, Gold and Platinum) going into 2015:

Each tier and its corresponding metal essentially tell you if a plan is rich or lean. For example, at the end of the year, the maximum deductible one could pay is either \$6,350 for an individual, or \$12,700 for a family. There still is co-insurance (cost-sharing) when the individual maximum out-of-pocket is \$6,350. Depending

on the carrier, that figure can be multiplied three times for a family's maximum out-of-pocket. In this example, that would be \$19,050. This is a rare example of a particularly bad year. The chances of this happening to a family are similar to their chances of winning the lottery.

4. Platinum plans - Typically less than \$3,000 max out-of-pocket per person (\$1,500 max on some plans), with co-pays for first dollar coverage. This is very rich and the premium will be unaffordable for most.
5. Gold plans - Roughly \$3,000 out-of-pocket max per person, including your deductible (this can vary depending on the insurance company). A deductible could be as low as \$500 or as high as \$3,000. This plan will also typically include co-pays at the doctor's office, specialist referrals and a prescription drug plan. The co-pay amount will vary by carrier, service and/or tier.
6. Silver plans - About \$6,000 out-of-pocket max per person, including your deductible (varies depending upon the insurance company). Your deductible could range anywhere from \$2,500 to \$6,350 per person. Silver plans typically include co-pays similar to Gold plans.
7. Bronze plans - Often referred to as a low-level plan, but there is nothing wrong with this plan type. In fact, it is very similar to the old Health Savings Account (HSA) plans. Bronze plans are high-deductible, and most services apply towards that figure. The only services covered by this plan are the preventive and wellness exams (check individual policy for details). If an individual is comfortable with the maximum out-of-pocket, isn't worried about co-pays, and/or qualifies for a premium reduction, then this is a great alternative to the other tiers. Bronze plans have maximum out-of-pocket costs totaling \$6,350 for the individual and \$12,700 for a family. This will vary depending on the insurance company.

8. Catastrophic plan - This plan is for the young. It mirrors the Bronze plans, but it has a doctor's office co-pay attached. Catastrophic plans are an alternative for the young—they are affordable, and include a co-pay for “first dollar” doctor visit coverage. There are age limits to this plan; however, with demonstrated financial hardship, those over the age limit may also qualify.

Those who qualify for an APTC may also qualify for a cost-sharing credit. A cost-sharing credit reduces your out-of-pocket expenses on any Silver plan. There are several variables that determine how much of a reduction in deductible and out-of-pocket expenses you may be eligible for. See an insurance advisor for more details.

All of the above plan types have “first dollar” preventive and wellness coverage. This means that the insurance company covers annual exams. Annual exams are the same for most individuals and are listed specifically under a plan's covered services. Beware: simply putting the words “preventative” or “wellness” before an exam's title does not mean that it will be billed as such by your insurance company. Everything comes down to the billing code that is used when an invoice is sent to the insurance company. A short list of covered annual exams/services include:

4. Routine lab work
5. Pap Smear/Mammogram
6. PSA Screening
7. Colonoscopy
8. Immunizations

Use this as a guide, but carefully review your particular plan. Each health insurance company has their own definition of what constitutes preventive and wellness care. Furthermore, each state will have certain mandates that may differ from the information provided above. Plans frequently change, and along with

many of the other delays that have already occurred and will occur with the Affordable Care Act (ACA), you should seek advice from a qualified individual to make educated decisions.

“Obamacare” is the Law of the Land, Not a Health Insurance Policy

“Obamacare” is simply the nickname for the Affordable Care Act (ACA) signed into law by President Obama in March of 2010. Some people are offended by the term as it was often used as a slur by parties opposed to the law. However, the President actually endorsed the term. With his endorsement, we should no longer view this nickname as negative.

The ACA or “Obamacare” created an infrastructure and Marketplace (formally the Health Insurance Exchange) for potential policyholders to purchase plans, and for insurance companies to sell them. That's it! They built an online marketplace similar to Amazon's. The Marketplace hopes to create competition among the health insurance companies; the belief is that competitive prices and plans are better for potential policyholders. At the time of this publication, however, health insurance companies are not required to participate in the Marketplace. Without mandatory participation, the Marketplace lacks the true level of competition intended by its creators.

An insurance company can choose NOT to participate in the Marketplace and continue to sell plans outside of it. Their plans must include all healthcare reform mandates, but their overall processes will not change.

Unfortunately, we still have mud on our windshield. The old system of shopping for plans was convoluted and bloated with terms, acronyms and tedious comparison. While the Marketplace's infrastructure created a series of health plan models and tiers to simplify the process for consumers, it is still confusing.

In the Marketplace, as a consumer is reviewing health plans, they can compare plans easily. Each carrier has differing co-pays, co-insurance amounts and out-of-pocket expenses. The compare-and-contrast approach will, in theory, make the shopping experience easier.

The playing field has changed. Change, as we know, “can do you good”, but it also creates short-term turmoil. “Obamacare” is a prime example of this.

The Marketplace is the only place where an individual or family can receive a tax credit for purchasing a health insurance plan. You must meet certain qualifications, however, to be granted a health insurance tax credit.

Your eligibility depends on what is indicated on your tax return—income, family status and age. There may be other requirements that determine your eligibility status, for a full list visit www.healthcare.gov. As stated before, you will still be applying for coverage with the carrier that you choose, not the government website.

It is not required to purchase a health insurance plan inside of the Marketplace. This is a HUGE misconception. If an individual, or family, does not qualify for a tax credit, then there is absolutely no reason to purchase a plan inside the Marketplace.

Outside of the Marketplace, you have a few more options to choose from, along with the same plans you would find inside the Marketplace. Identical plans inside and outside of the Marketplace have the same premium. There is no difference in coverage or cost.

“Obamacare” is the law of the land, nothing more, or less. There are no health plans sold through the federal or your state’s government. The ACA simply changed the rules concerning what would be required by insurance companies. The ACA was created to protect everything that you’ve worked so hard for.

Do I Have to Buy in the Health Insurance Exchange?



Healthcare reform is moving at full throttle to be ready for November 15, 2014. Some are still unaware that healthcare reform was even signed into law, and most are confused as to how things will pan out. The Health Insurance Exchange is in place, but you need to know your options before diving in.

The media and your next door neighbor are probably doing a good job keeping you up-to-date on healthcare reform. They may tell you that you have to buy inside the Health Insurance Exchange, but aren't sure why.

For small businesses, the S.H.O.P. has been delayed and will not be ready in time for 2014's open enrollment date. However, individuals and families working for companies that do not offer health insurance can easily go to the Health Insurance Exchange, which opened October 1, 2013 with an effective date of January 1, 2014. Going the Exchange route, you may find that you qualify for the tax subsidy to offset your premiums and out-of-pocket expenses. Of course, not everyone will qualify for the subsidy. The tax subsidy takes into account factors such as family filing status, income, etc. If you qualify for the subsidy, the Exchange would be

beneficial to you. If your income is higher, however, and you do not qualify for the subsidies, then there is no added value if you use the Exchange.

None.

Buying outside the Exchange will give you more options. The plan options are more flexible and allow you more control over your health plan coverage. This extra level of control and flexibility can help you manage your personal interests and stay within your budget.

Inside the Exchange, you will only be looking at five different plan levels from each carrier. The only difference between the carriers is the monthly premium, as long as you are comparing the same plan. They are cookie-cutter plans, to say the least. You are limited to the five plan levels and available carriers.

Reviewing plans outside the Exchange with a health insurance broker can be advantageous for you and your business. The flexibility of plans and pricing options are empowering for small business owners. Now you can turn off the news and stop listening to your neighbor. You are in control.

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