Health insurance and health reform made easy!

The Patient Protection and Affordable Care Act of 2010 provides new avenues for consumers to find and buy health insurance in the individual, non-group market. Use this book to steer yourself on a straight course to health care coverage you can live with (and stay healthy on!).

- **Buying insurance on your own is much easier than you may think** — get in touch with a licensed agent who can fill you in on your options
- **Choose a plan that suits you** — find the plan type and benefits to suit your needs and budget
- **Stay on top of the shrinking Medicare Part D prescription donut hole** — the Medicare Rx coverage gap gets smaller and smaller each year until 2020
- **Don’t let a pre-existing condition keep you from being insured** — join a high-risk pool now and anticipate the end of these exclusions in 2014
- **Take advantage of free prevention screenings** — new health plans guarantee access to certain preventive services at no cost to you

**Open the book and find:**

- An analysis of what reform may mean for you
- Tips on getting the best value for your insurance premium dollars
- An explanation of the proposed “metal” plans — what Bronze, Silver, Gold, and Platinum mean in terms of health insurance starting in 2014
- A timeline of when health care reforms go live over the next few years

**Learn to:**

- Navigate the new health care reform landscape
- Choose the health plan that suits you or your family
- Find self-employed and small-business insurance solutions

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eHealthInsurance.com is the leading online source of health insurance for individuals, families, and small businesses. At eHealthInsurance.com, consumers can research, analyze, compare, and purchase health insurance products that best meet their needs.

Founded in 1997, eHealthInsurance is licensed to market and sell health insurance in all 50 states and the District of Columbia. eHealthInsurance has developed partnerships with more than 180 health insurance companies, offering more than 10,000 health insurance products online. The company’s technology platform is able to communicate electronically with insurance carrier partners, which enables a simpler, more streamlined health insurance application process. This technical connection with the back-office processes of health insurance companies can facilitate rapid approval of applications and real-time communication between carrier and consumer throughout the process.

eHealthInsurance was responsible for the nation’s first Internet-based sale of a health insurance policy and is headquartered in Mountain View, California.
# Table of Contents

## Introduction .................................................................................................................. 1

- About This Book ......................................................................................................... 1
- About You ................................................................................................................... 1
- How This Book Is Organized ....................................................................................... 2
- Icons Used in This Book ............................................................................................ 2

## Chapter 1: So You Want to Buy Some Health Insurance ........................................... 3

- Checking Out the Stages of Reform ........................................................................... 3
- Addressing Insurance Basics ..................................................................................... 4
- Choosing Insurance for Your Family and Your Business ........................................ 5

## Chapter 2: How Health Care Reform Legislation Affects You .................................. 7

- Including Basic Provisions except in Grandfathered Plans ...................................... 7
- Looking at the 2010 Changes ..................................................................................... 8
- Laying Out Changes from 2011 to 2013 .................................................................. 12
- Rolling Out the 2014 Provisions .............................................................................. 14

## Chapter 3: Finding Insurance on Your Own ............................................................... 19

- Buying Health Insurance by Yourself ....................................................................... 19
- Navigating Insurance with a Pre-existing Condition ................................................. 25
- Buying Insurance as a Woman .................................................................................. 28
- Checking Up on Your Health Insurance before Retiring Early ................................ 29

## Chapter 4: Buying Insurance for Your Family or Employees ..................................... 31

- Providing Insurance for Your Family ........................................................................ 31
- Covering Your Business ............................................................................................. 36

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Chapter 5: Ten (Plus One) FAQs about Health Care Reform

Now that health care reform has passed, am I automatically covered? ........................................... 39
Am I required to have health insurance? ........................................... 39
If I don’t buy health insurance by 2014, will I go to jail? .... 40
I’ve been denied insurance because I have a pre-existing condition. Can I get coverage now? ........................................... 40
My neighbor’s insurance was cancelled because of a mistake on his application. Can that happen to me? ...... 40
My child has been denied coverage.
  Can I get her insured now? ............................................. 41
Can I sign up for free health insurance? .................................. 41
I like the health insurance I have now. Can I just keep it? .... 41
Is health insurance cheaper now? ........................................... 42
My current policy has a lifetime limit on the amount it pays. Will insurers be able to keep imposing those limits? ........................................... 42
My kid just graduated college and doesn’t have insurance. Can I get him back on my policy? .............. 42

A Brief Timeline of Health Care Reform ................. 43
Introduction

“E”veryone needs health insurance. These days health care reform legislation is changing the way you obtain that coverage, how you pay for it, and what it costs. As you consider your health insurance alternatives, make sure you understand all your options, especially new options resulting from health care reform.” So says Gary Lauer, chairman and CEO of eHealth, Inc., parent company of eHealthInsurance.

This slim book provides a concise, just-the-facts look at individual health insurance and what recent reform legislation may mean for you. Whether you’re in the market for health coverage for yourself, your family, or your employees, you need to know the facts about health care reform legislation.

About This Book

The book is designed to help average Americans — that’s you! — understand how health reform legislation affects your options for finding and buying health insurance.

What the industry calls “the individual and family (non-group) health insurance market” is composed of people like you who are looking for health coverage for themselves and their families. We also address some of the choices facing small business owners buying group policies for their employees.

About You

The assumptions we make about you are pretty general:

✔ You’re interested in buying health insurance.
✔ You’re either currently uninsured or need (or want) to buy coverage.
✔ You’re curious about the impact of the Patient Protection and Affordable Care Act of 2010 on your choices.
How This Book Is Organized

This short book aims to give you a basic understanding of what the Patient Protection and Affordable Care Act of 2010 means for you if you’re buying insurance on your own.

Chapter 1 starts you off with an overview of the insurance-buying process and gives you a feel for the recent reforms. Chapter 2 offers a rundown of when various reforms become effective. Chapter 3 explores the why and how of buying health insurance on your own, with special attention to the effects of having a pre-existing medical condition when searching for coverage and issues to consider if you’re a woman or thinking about retiring. If you’re interested in getting insurance for your family or your employees, turn to Chapter 4. And, in the For Dummies tradition, the last chapter offers answers to frequently asked questions about healthcare reform. At the very back, we provide a stripped-down timeline of things to come.

Note: Unless otherwise stated, all the studies and surveys cited in this book are the product of eHealth. This book was prepared in May 2011 and doesn’t reflect any changes to the health care reform law made after that date.

Icons Used in This Book

And, what would a For Dummies book be without the little images in the margins? The icons in this book are

- **Important points to keep in mind as you navigate through the world of health insurance get this reminder.**

- **Info that only an insurance geek could love is marked with this icon. If you’re interested, read it, but if you skip it, you won’t miss anything you really must know.**

- **Info next to this bull’s-eye is right on target for helping you make the most of your health care time and money.**

- **Check this icon for tips that can steer you away from danger to your health or to your health care budget.**
Health care reform became a reality as of March 23, 2010. How that new reality affects your reality is something we try to address in this small but meaty book.

If you’re someone who doesn’t work for a company that offers health insurance benefits, or if you do have access to group benefits but can’t afford or aren’t offered the benefits you need, you’re part of what’s called the individual health insurance market and this book is for you. Likewise, if you’re a small business owner who wants to cover yourself and your employees, read on.

Checking Out the Stages of Reform

The provisions of the Patient Protection and Affordable Care Act roll out over several years. Many changes became effective 90 days or 6 months after the act was signed into law on March 23, 2010. Important changes affecting children, young adults, seniors, and those with pre-existing conditions are in place now, and get some tweaks as more reforms roll out in the coming years. New programs including insurance co-ops and online exchanges get established within a few years.
The last of the big, consumer-focused provisions become effective in 2014, which is when the provision called “Promoting Individual Responsibility” goes into effect. This provision requires that most Americans buy health insurance to avoid paying a penalty.

We run through many of the major changes and when they take effect in Chapter 2, and there’s also a brief timeline on the last two pages of the book.

Addressing Insurance Basics

You’ve heard the stories, you know the statistics: Health care costs do nothing but go up, and medical bills are one of the major reasons people in the United States declare bankruptcy. Now, nothing says that having health insurance prevents financial catastrophe, but the fact remains that if you have medical problems, having insurance is much better than not having it.

Assessing costs

Once you start shopping around, you may realize that the cost of purchasing health insurance on your own (at least in most states) is less than you expected, and certainly less than what you’d owe if even one person in your family faces a lengthy hospital stay or ongoing treatment for a chronic condition.

The truth is that the cost of office visits and other medical services is lower for people with insurance, because insurance companies can negotiate with health care professionals for lower rates for their customers. It’s true; good old uninsured you walks in with no negotiating position and pays lots more — sometimes twice as much — than Mr. Insured standing right next to you for the very same care. You want to get on Mr. Insured’s team if you can.

Shopping for options

As you explore the world of health reform, you naturally have a lot of questions — questions about health insurance in general and questions about what you need in an insurance policy.
You need to think about what kinds of benefits suit you best before you go insurance shopping. Do you need prescription coverage or can you save money by not choosing that option? If you’re a woman of childbearing age and plan to get pregnant, you need to focus on getting a policy that covers you and your baby throughout the gestational process. If you’re nearing the end of your career, explore options for insurance before you’re out the door to be sure that you don’t eat up your retirement savings paying for health expenses.

And if you have an ulcer, or get migraines, or have any of a number of other so-called “pre-existing medical conditions,” you need to know what’s in the realm of possibility for insurance coverage (probably more than you think) and how to take advantage of government-assistance programs and health reform provisions designed with you in mind.

Then, of course, there’s the part where you have to pay. The new reforms do a lot to curb insurance-company practices, but they may or may not lower your premiums. There’s no free ride, there’s no single-payer government-sponsored public option for everyone, but there is some subsidy money (eventually, in 2014), if you can’t afford to pay for insurance. And there are reforms that enforce good business practices for insurers — an insurer can’t drop your coverage for unintentional errors in your application and has to spend a large portion of the money it gets from you and other clients on services related to health care and wellness.

**Choosing Insurance for Your Family and Your Business**

When you come right down to it, health insurance offers financial stability for you, your family, and your business. Insuring your kids gives you peace of mind; insuring yourself gives those who love you and depend on you — your family and employees — peace of mind.

If you have children, you know that your children’s well-being comes first. You want your kids to have the best of everything, and with some of the reforms in the Patient Protection and Affordable Care Act, providing the best health care coverage got a little easier for parents who don’t have employer-based
group health insurance. According to the health care reform law, children under age 19 can no longer be denied coverage solely due to the presence of a pre-existing medical condition. However, to get a plan of their own, some children may need to be enrolled during special open enrollment periods. Requirements vary from state to state, so contact your state’s insurance department for complete information.

As your children grow, their insurance needs can change. But if they reach a point in their early adult years when they can’t get insurance on their own, you may be able to keep them on your policy (or add them back onto it) until they turn 26 — it depends on their health, their medical history, and your policy’s rules.

Then there’s your business family. If you’re an employer, it’s smart business to offer insurance coverage because it’s a benefit many workers look for. Health insurance also gives some security to your business. If a key employee has medical problems and doesn’t have insurance, the stress of that can certainly have an impact on how that person performs, which can affect your small business in ways you can’t anticipate.

As the owner of a small business, you certainly need to have insurance yourself. You don’t want to jeopardize your whole operation and put all your employees at risk of losing their livelihood if your business goes under in the wake of paying unforeseen medical expenses of your own.

The bottom line is that health insurance is good for your bottom line.

Plus, provisions in the health care reform law offer tax incentives if you employ more than 25 people but fewer than 50, pay at least half of your employees’ premiums, and meet certain other requirements. Check out Chapter 4 for more information on the benefits of small business insurance.
How Health Care Reform Legislation Affects You

In This Chapter
▶ Understanding what’s changed
▶ Previewing what’s around the corner
▶ Eyeballing the final phase

So, Congress passed legislation and the president signed it into law, but what does the Patient Protection and Affordable Care Act do for you?

The short answer is that it does several things, but not all of them immediately. Adjustments to the current system are spread out over a number of years. Some provisions are in effect now, more come online in the next couple of years, and the last major ones that affect you happen in 2014 although provisions continue to kick in through 2020.

In this chapter, we explain certain changes the law makes and when they come into effect. Along the way, we offer tips and info on how to prepare for upcoming changes or take best advantage of current provisions.

Including Basic Provisions except in Grandfathered Plans

Many of the provisions of the Patient Protection and Affordable Care Act of 2010 apply to all insurance policies.
The Act dictates that a policy that becomes effective after March 23, 2010, must have certain provisions, including

- No lifetime coverage limits on essential health benefits.
- No coverage cancellation unless you commit fraud or intentionally misrepresent relevant facts. And, your insurance company must give you 30 days’ notice if they plan to rescind your coverage so that you have time to appeal.
- The option to cover your children under age 26 under your plan — with certain restrictions that we cover more fully in the upcoming “Changing things up for young and old alike.”
- If you exceeded your policy’s lifetime coverage limit and lost your health coverage but still qualify for the plan, your insurance company must notify you that you’re eligible to re-enroll in the same plan or a new plan if the same one isn’t offered.

However, if an insurer doesn’t make significant changes to a policy in effect before March 23, 2010, it can keep the annual dollar limits already in place and isn’t required to provide recommended preventive services or share those costs — these plans are grandfathered. Grandfathered plans don’t have to offer some services such as guaranteed access to pediatricians and OB-GYNs, either.

But, if an insurer alters certain terms of a policy — for example, reduces benefits or raises deductible, co-insurance, or co-payment costs beyond proscribed limits — the policy no longer receives grandfathered status.

Looking at the 2010 Changes

At least one provision of the new health reform law was retroactive. The bill became law on March 23, 2010, but small businesses became eligible for tax credits to help provide insurance to employees as of January 1, 2010.

Other provisions continued to roll out throughout 2010. The government opened a new Website — www.healthcare.gov — to provide information on the new provisions and available plans and insurers. The site includes a timeline of when provisions take effect from 2010 through 2014, offers a glossary of insurance-speak terms, and gives you the opportunity to offer feedback. (The last pages of this book offer a brief timeline of major provisions as well.)
Chapter 2: How Health Care Reform Legislation Affects You

Browsing to health-reform resources

You can find information about anything on the Internet, and health reform is certainly no exception. Tap into any of the resources in the following list and search for health reform if need be to get a view of the big picture and perspective on details of the 2010 legislation.

✓ www.healthcare.gov: This government website is designed to educate people about health reform and provide them with info on the health insurance products available in their area.

✓ healthreform.kff.org: The Kaiser Family Foundation site offers consumer resources for health reform education.

✓ blog.eHealthInsurance.com: This blog covers health reform issues and other issues of broad consumer interest relating to researching and purchasing health insurance.

Changing things up for young and old alike

The first-year provisions of health care reform include benefits that affect everyone from children to those in their senior years. A list of these provisions in order of the age of the groups affected follows:

✓ Kids get better access to coverage. Under the new law, insurers can’t decline coverage for a child under the age of 19 because of a pre-existing condition, although parents may have to wait for special enrollment periods to sign junior up for a new plan.

✓ Older children can stay on a parent’s policy. Your adult children can stay on your policy until they’re 26, whether they’re still in school or not. Maybe you can use insurance as an inducement to get them into their own place and out of your house: “If you move out, you can take your bedroom furniture, and I’ll pay your insurance premiums.” You may have to pony up first and last month’s rent as well, but it’s worth a try.

Most health insurance plans starting on or after September 23, 2010, must include a provision to allow children under 26 on a parent’s policy. However, if you’re a parent with a non-group policy, your pretty-much-an-adult child may
need to undergo medical screening and can be denied coverage for pre-existing conditions. Also, if your child is gainfully employed and can get insurance through her employer, your insurer doesn’t have to offer this coverage.

✓ The donut hole gets smaller for Medicare beneficiaries. If you’re part of the Medicare nation, you may have heard about — or even experienced — the donut hole. It sounds sweet, but it isn’t. The donut hole indicates a gap in prescription drug benefits: After Medicare pays a certain amount, the program pays nothing more until you reach a threshold classified as “catastrophic.” So, at the point when you need more medications, you get no help paying for them.

But here comes the new law. For 2010, those in the donut hole receive checks for $250 to help pay their prescription costs. (The hole gets filled in even more in subsequent years; see “Tweaking prescriptions, prevention, and payment options in 2011” later on.)

Preventing problems for free

Many diseases can be prevented if you know how. You may have a feeling that you could do more to safeguard your health but resist checking with your doctor to determine what your personal risks are because you can’t afford the copay. The Patient Protection and Affordable Care Act requires health plans to cover a broad selection of preventive services. As of September 23, 2010, if you enroll in a new health plan, your plan must provide coverage for recommended preventive medical services at no cost to you.

So, depending on your health plan and some health factors, you may have better access to a host of recommended preventive tests and services including

✓ Blood pressure tests and tests for cholesterol and diabetes
✓ A range of cancer screenings
✓ Routine vaccines for diseases such as measles, polio, and meningitis
✓ Flu and pneumonia shots
✓ Pregnancy screenings and vaccines, and well-baby and well-child visits from the time she’s a charming bundle of
joy, through the terrible twos, beyond the “you’re embar-

rassing me” years, and until she’s 21 and can admit that 

you may not be wrong about absolutely everything.

Those things you know you should do and really want to do 

to improve your health aren’t always so easy to do. But you 

can get no-copay counseling services to help you quit smok-

ing, lose weight, make better food choices, and cut down 

your alcohol use. If you’ve got the time, you don’t need to pay 

money, and you can pick up a healthy new habit.

**Appreciating no limits and no “gotcha” rescission**

Before the Patient Protection and Affordable Care Act passed, 

many insurers set a limit on how much money they would pay 

for covered services over the lifetime of a policy holder. Most 

individual health insurance plans that take effect September 

23, 2010, and after prohibit insurers from setting a lifetime 

limit on coverage. Although insurers may still set annual 

limits for specific medical services in some circumstances, 

you no longer need to fear that you’ll “use up” all your insur-

ance before the end of your life due to treating a single seri-

ous disease in your 40s.

You no longer have to fear that your coverage will be cancelled 

because you made an unintentional mistake on your applica-

tion. Insurers can no longer cancel your insurance simply 

because you made an inadvertent error on your application.

**Jumping into the high-risk pool**

If you have a pre-existing health condition, you probably 

already know that it can pose problems when it comes to 

buying health insurance on your own.

The government is hoping that $5 billion of federal support 

will bridge the gap from 2010 to 2014, when provisions kick 

in that forbid discrimination against those with pre-existing 

conditions.

The money funds a new program for people in the high-risk 

category. Each state can strengthen or broaden access to
its high-risk pool with funds from the $5 billion program. If a state chooses not to participate, folks who live there can join a program established by the Department of Health and Human Services in their state. The insurance isn’t free, of course, but at least you can qualify for it and get it through a subsidized program.

You won’t necessarily be able to enroll in the high-risk pool right away. Depending on the volume of applications, it may be a while before you can get qualified and signed up. And you may actually have to be uninsured for up to six months first.

**Laying Out Changes from 2011 to 2013**

Further tweaks to the health care system come online between 2010 (when the Patient Protection and Affordable Care Act became law) and 2014 (when the final major provisions take effect).

** Tweaking prescriptions, prevention, and payment options in 2011 **

The donut hole in prescription coverage for people on Medicare shrinks even more in 2011. (“Changing things up for young and old alike” earlier in this chapter talks about 2010 compensation for those in the Medicare prescription gap.) If you reach the place where Medicare doesn’t pay any more prescription costs until your costs are so large they qualify as catastrophic, you’re entitled to a 50 percent discount on the cost of brand-name prescriptions instead of getting no coverage. Of course, the prescriptions must be for drugs approved by Medicare.

The plan is to phase out most of the donut hole by reducing co-insurance rates and establishing a discount program for both brand-name and generic prescription drugs for Medicare Part D enrollees in the gap. By 2020, the coverage gap will disappear almost entirely.
Also taking effect on January 1, 2011, is the benefit of free preventive health screening for seniors on Medicare. You get a free wellness visit every year where you can discuss your health and work up a personal health plan with your doctor.

As of January 1, 2011, you can use Health Savings Account (HSA) and Flexible Spending Account (FSA) funds to buy prescribed medications, but you'll have to pay for nonprescription medications — the aspirin, compression bandages, and salve you need after straining muscles at the games you played at your family reunion — with money in your pocket or your bank account.

### Decreasing deductions and establishing CO-OP in 2013

If you have a lot of medical expenses that you don’t get reimbursed for — either you don’t have insurance or your insurance doesn’t cover all your costs — you may have carefully added up all those expenses at tax time so that you could itemize tax deductions. Then, after all that careful adding, you discovered that your expenses didn’t reach more than 7.5 percent of your income and you didn’t qualify for a deduction after all. If you thought that was tough, just wait until 2013, when your unreimbursed expenses have to reach more than 10 percent of your income before you can get a tax break on them.

July 1, 2013, marks the release of $6 billion tied to the Consumer Operated and Oriented Plan (CO-OP) program. This money provides loans and grants and generally finances the establishment of new nonprofit, co-operative style health insurance plans (CO-OP) in each state and the District of Columbia.

These new CO-OPs will be devoted pretty much exclusively to providing health insurance to their members. They cannot be run by insurance companies or government agencies, although they need to be licensed by the state.

As the “CO-OP” name implies, these organizations are to be run by members, a majority of whom must vote to approve the governing board. Any profits a CO-OP earns must be returned to members in the form of lower premiums and improved benefits.
The theory is that these member-run CO-OPs would be able to control costs and give members an alternative to buying insurance from for-profit companies.

**Rolling Out the 2014 Provisions**

The last of the major consumer changes to the health-insurance landscape take effect in 2014. Along with the requirement that everyone buy insurance — a provision we explain in the next section — other changes affect how insurers spend money they get in premiums, make health insurance subsidies available, give the very poor (anyone making up to 133 percent of poverty, or approximately $14,400 in 2009) access to health care under Medicaid, and bar insurers from discriminating against people with pre-existing conditions.

During the debate over health reform legislation, the “public option” got a lot of attention. The final bill did not include a method for people to buy insurance from the government. However, in 2014 you can buy an individual or family policy from a not-for-profit insurance carrier or CO-OP plan.

**Having health insurance becomes the law**

The Patient Protection and Affordable Care Act of 2010 will require that most Americans buy health insurance starting in 2014 or else pay a penalty come tax season. The Promoting Individual Responsibility provision requires that you either buy an insurance policy or pay a penalty when you do your federal taxes. The penalty starts at $95 (or 1 percent of your income, whichever is greater) for a single person in 2014, goes up to $325 (or 2 percent of your income) in 2015, and levels out in 2016, when you’ll pay either $695 (or 2.5 percent of your annual income). The amount of the penalty is capped at the amount someone who bought a “bronze plan” of insurance coverage would pay in annual premiums (see the upcoming section, “Mandating basic benefits”).

The government will reveal the details of how they plan to enforce this provision as the time gets closer. But even now you can’t be turned away from an emergency room because you
don’t have insurance and don’t have the money to pay your medical costs — and the reforms don’t change that. You don’t have to fear being arrested for not having health insurance — you’re more likely to see a reduction in your refund at tax time.

With the requirement that you buy health insurance also comes a guarantee that you’ll get value for your money. A provision in the health care legislation called “Ensuring Value for Premium Payments” went into effect in 2011. Insurers who offer small group and individual health plans need to spend 80 percent of the money they collect in premiums on clinical services and wellness activities. If they don’t, they have to give policyholders rebates on the premiums they paid.

**Affording it on your own**

Even if you’re buying insurance on your own, you may be surprised at how affordable it can be. According to a study of individual and family plans sold through eHealthInsurance, the national average monthly health insurance premium paid (in February 2010) for individual coverage was around $167. Not a bad investment when you consider how much a few nights in the hospital can cost you.

**Getting a subsidy to help pay your premiums**

Starting in 2014, if you buy individual or family insurance on your own and can’t afford the whole tab, the government can help you pay your monthly insurance premiums.

If you earn more than $14,400 but less than 400 percent of the poverty level (which meant $43,320 for a single person and $88,200 for a family of four in 2010) you can qualify for a subsidy. The amount is determined on a sliding scale according to your income level. While the details surrounding subsidies have not yet been ironed out, the subsidy may be applied at the time of purchase or afterwards as a tax credit.

If your income is low enough to meet certain criteria, you may qualify for subsidized medical coverage through Medicaid.

**Eyeing online exchanges**

By 2014, every state and the District of Columbia should have in place a health insurance exchange where you can find insurance plans, compare costs and features, and choose the
plan that suits you best. If you can’t get insurance through your employer, you can buy it directly through your state’s online exchange or through a licensed agent.

The plans offered in these online exchanges need to meet certain standards — their benefits and costs must be competitive. And, Congress is putting its health care money where its mouth is: In 2014, members of Congress will start getting their insurance through these exchanges.

**Mandating basic benefits**

Health insurance plans certified to be sold through government exchanges beginning in 2014 will be required to offer essential health benefits that include office visits, hospitalizations, and prescription drug coverage.

These plans can be offered in one of five tiers (actually four tiers and a catastrophic option, but who’s counting):

- **Bronze plans** provide the minimum coverage that offers the essential health benefits, cover 60 percent of the benefit costs, and limit the amount you have to pay out-of-pocket to the current limits for Health Savings Accounts (HSAs), which were $5,950 for individuals and $11,900 for families in 2010.

- **Silver plans** offer the same essential health benefits and limit out-of-pocket expenses to the bronze plan levels, but cover 70 percent of insured medical costs.

- **Gold plans** increase coverage to 80 percent of costs along with bronze plan benefits.

- **Platinum plans** pay for all but ten percent of approved medical charges and include the other benefits included in the base-metal plans.

- **Catastrophic plans** will be available to adults up to 30 years old and to people who — due to lack of access to affordable coverage or to personal hardship — aren’t required to purchase insurance on their own. They offer just what the name says — catastrophic coverage — with the amount tied to the current HSA levels. This plan is available only to individuals; it isn’t available under small-group programs.
Buying insurance through even a smallish employer

An employer with 50 or more employees is obligated to offer health insurance or be liable for financial penalties. However, the penalties may cost less than providing insurance, so if you work for a small company, you may not be offered insurance after all.

For some employers, the financial strain of providing an insurance plan may be lessened by tax credits ranging from 35 to 50 percent of the cost of the premiums the company pays.

Insuring pre-existing conditions

If you have a pre-existing condition, in 2014 no insurer will be able to deny you insurance because of it. If you’re age 64 or under, you can’t be turned down for any health-related reason. Once you turn 65, you can sign up for coverage under Medicare.

Of course, you may have to pay a bit more than a completely healthy person, but even the rates you pay will be regulated so that you don’t end up paying ginormous premiums — or at least you won’t pay more than three times what a healthy person pays. (Of course, if the premiums for a healthy person get to be astronomical, you may pay ginormous premiums. But if that’s the case, no one will be able to afford health insurance, and we’ll all be uninsured.)

Shortening the pre-existing condition waiting period

Right now, if you buy health insurance on your own and have a pre-existing condition, you face one of three responses from the insurer, who typically:

✓ Refuses to offer you a policy at all.
✓ Lets you buy a policy, but refuses to pay any expenses related to your pre-existing condition.
Issues you a policy and promises to pay costs related to your pre-existing condition after a certain length of time — often six months to a year.

According to the provisions of the Patient Protection and Affordable Care Act, beginning in 2014 insurers will no longer have recourse to the first two responses — they must issue you a policy that covers your pre-existing conditions — and can delay coverage of those conditions for no longer than 90 days.

So, although waiting three months for coverage isn’t ideal, it’s much better than waiting forever!

**Lowering deductibles, raising credits for small business plans**

If you get health insurance as an employee of a small business, starting in 2014, your deductible can be no greater than $2,000 for an individual and $4,000 for a family.

If you’re the owner of a small business, whether for-profit or non-profit, and offer health insurance to your workers, you can qualify for a tax credit if you meet certain requirements:

- You employ fewer than 25 full-time employees or their equivalent (so having fewer than 50 half-time people qualifies).
- You cover at least 50 percent of the cost of health care coverage for at least some of your employees.
- The average annual wage you pay is below $50,000.

You can get a tax credit up to 35 percent of the business’ premium costs in 2010 (25 percent for tax-exempt employers). The rate goes up to 50 percent (35 percent for tax-exempt employers) for the 2014 tax year.

The IRS Website at [www.irs.gov](http://www.irs.gov) has more information on small business health care tax credits for small employers.
Chapter 3

Finding Insurance on Your Own

In This Chapter
▶ Shopping for the insurance you need
▶ Preventing a pre-existing condition from slowing you down, insurance-wise
▶ Being a woman in need of insurance
▶ Considering your insurance situation before retiring

Navigating the world of health insurance on your own isn’t as scary as it may sound. You can find all kinds of help from online resources and licensed independent agents — visit www.eHealthInsurance.com for the best of both. Plus, the information in this chapter offers an overview of what to consider as you look for insurance on your own, with a pre-existing condition, as a woman, and as a hopeful early retiree.

Buying Health Insurance by Yourself

Often, enrolling in health insurance through a group policy offered by an employer is the easiest way to get coverage. However, if you don’t have access to a group policy or you have the option but can’t afford the premiums, you can buy insurance on your own and become part of the non-group individual or family market.
## Some insurance-speak

Some insurance terms have become everyday language, but you may find the following explanations helpful as you consider health insurance:

- **benefit**: Any service or supply (an office visit, a prescription drug, and so on) your health insurance plan covers.

- **COBRA (the Consolidated Budget Reconciliation Act of 1985)**: A law that allows you or your dependents to continue group health insurance coverage through an employer’s health insurance plan for up to 18 months, so long as you pay both the employer and employee portions of the full monthly premium plus a 2 percent administration fee.

- **coinsurance**: The amount you pay for covered medical services after you’ve paid any copayment or deductible required by your health insurance plan.

- **copayment (copay)**: A specific amount you pay for a specific medical service or supply according to your insurance plan.

- **deductible**: A specific dollar amount you pay on your own each year before your health insurance plan begins to make payments for claims. Not all health insurance plans require a deductible.

- **grandfathered plan**: An individual health insurance policy in existence when the Patient Protection and Affordable Care Act was signed on March 23, 2010. Unless the company makes significant changes to the cost-sharing structure or benefit level, a grandfathered plan is not subject to many of the requirements of health care reform.

- **Health Savings Account (HSA)**: A tax-advantaged savings account offered with some high-deductible health insurance plans to pay for qualifying medical expenses.

- **Individual and family health insurance**: A type of health insurance purchased by an individual or family, independent of any employer group or organization.

- **out-of-pocket costs**: Health care costs you pay on your own. These include copayments, coinsurance, deductibles, and so on.

- **PPO (Preferred Provider Organization)**: A common type of health insurance plan. With a PPO plan, you won’t need to coordinate your care through a single doctor (like with an HMO), but you’ll still need to see doctors and hospitals within a provider network for your medical claims to be paid at the highest level.

- **pre-existing condition**: A health problem or diagnosis that you had before applying for health
Laying out the benefits

Among other things, the new health reform law aims to promote individual responsibility for health care by mandating that most people without employer-sponsored health insurance purchase their own by 2014. But forget the fact that you’ll have to buy health insurance then. You have plenty of excellent reasons to find and buy health insurance right now:

✓ **Being insured saves you money on health care costs.** Because insurers can negotiate discounted rates with medical service providers — everyone from doctors to hospitals to labs — you pay less for those services if you’re insured than you would if you paid on your own.

✓ **Health care costs are a leading cause of personal bankruptcy.** Without health insurance, the medical bills from even a brief hospital stay can soon become astronomical. A large percentage of personal bankruptcies filed in the United States are due at least partially to medical bills. Having a good health plan behind you is a form of financial security.

✓ **Insured people are generally healthier than the uninsured.** People with health insurance are more likely to receive regular medical care and thus prevent problems — and prevent them from worsening as well. People without insurance tend not to seek treatment until an ailment is in an advanced stage, by which time it’s often harder — and more expensive — to treat.
The emergency room isn’t an option for chronic conditions until the disease is so far along you’re in a critical state, and that’s not a state you want to be in.

✓ Being insured makes you insurable. If you’re uninsured and diagnosed with a serious medical condition, you’ll have a hard time finding a company willing to insure you — or you may find coverage that excludes the very illness you have. (In 2014, you won’t have this problem because insurers will be forbidden to deny coverage on the basis of a pre-existing condition.) But maintaining coverage when you’re healthy makes it likely you’ll be able to continue to get insurance when you need it.

The group of people most likely to be uninsured — people between ages 19 and 29 — is the same group more likely to make a trip to the emergency room. Starting your working life with thousands of dollars in medical bills to pay is no fun. When you’re young and healthy, you’re at the peak of your insurability — and at the cheapest rates you’ll ever pay — so check out your options, which we talk more about in Chapter 4.

Looking for what you need

Balancing copays with deductibles, weighing maternity and prescription coverage, deciding whether to put everyone on the same policy or pay for Junior’s separately now that he’s in college — the choices can be completely confusing. Which is why you need to sit down and consider what’s best for you before you buy. As you ponder health insurance options, keep the following points in mind:

✓ One plan may not fit all. Even if you have access to an employer-sponsored group plan, adding your spouse and/or including your kids may not be your most cost-effective option. An employer’s contribution to extra beneficiaries may be negligible or nonexistent, and you may be able to find better coverage independently.

Weigh the cost benefits of all the plans you have access to before ponying up for the premiums.

✓ The networks your doctor belongs to matter. If you like your current group of health professionals, make sure that they belong to the network under the health insurance plan you’re considering. You don’t want to pay
expensive out-of-network costs every time you see the doctor — or at all.

With some insurers, you need a referral from your primary care physician to see other specialists. If you see a specialist often, you may want a plan without the referral requirement.

**Options add up.** If you depend on daily medications, paying for prescription coverage probably makes sense. If you're planning to add to your family, maternity coverage is the way to go. If the kids need annual physicals to play sports, you want your insurance to cover these screenings. However, you can save money by shopping for plans without the options you don't need.

Some drug companies and pharmacies offer their own prescription-drug discount plans, which can be a low-cost option. But, be aware that your prescription options may be limited, and you probably won't have access to the newest, most advanced drugs through these plans.

The point is: Find the right plan so that you can pay for coverage you need and not for benefits you'll never use.

**Insurance is often a choice between paying more now or paying more later.** If you're pretty healthy, don't anticipate major medical expenses in the near future, and are strapped for cash on a monthly basis, think about buying an insurance plan with a high deductible and a correspondingly lower monthly premium. If the opposite is true — you have ongoing medical needs that require frequent cash (check or charge card) outlays and can afford higher premiums — shop for a plan with a low deductible so that you start getting benefits paid sooner.

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**Paying for coverage**

Health insurance may be cheaper than you think. In a 2010 survey of eHealthInsurance customers, individual policy holders paid an average of $167 a month in premiums with an average deductible of $2,632; family plans averaged $392 with a $3,531 deductible. When you consider that without insurance you may become liable for thousands of dollars in medical costs as the result of one small accident, those premium costs look like a bargain.
If you’re part of the individual or family health insurance market, you can shop for policies online — try www.eHealthInsurance.com for advice or call toll-free at 800-977-8660.

With the passage of the Patient Protection and Affordable Care Act of 2010 come some programs that offer financial assistance if you can’t afford your premiums:

**Medicaid:** If you have an especially low income, you may qualify for government assistance through Medicaid. Medicaid was available prior to the health care reform law, of course, but the new law makes it more accessible for some.

In 2014, Medicaid expands to include anyone making up to 133 percent of the federal poverty level.

**Subsidies:** Starting in 2014, if you make less than 400 percent of the federal poverty level, you can get help paying your insurance premiums through subsidies from the government. (In 2011 the poverty level for a single person was $10,890 and $22,350 for a family of four. So 400 percent of each translates to $43,560 and $89,400, respectively.) These subsidies are available at the same time the new online insurance exchanges are to start operating in each state. (See Chapter 2 for more on these exchanges.)

You heard a lot of talk about a “public health insurance option” during the discussion of health reform legislation, but that option didn’t make it into the final law. However, starting in 2014, you’ll be able to shop for policies offered by not-for-profit companies under the CO-OP program, which we talk more about in Chapter 2.

To help insure that your premium dollars are going toward providing you with good health care, the health reform legislation includes a provision that takes effect in 2011: “Ensuring Value for Premium Payments.” Insurers who provide individual and family health insurance and small-group coverage are required to spend 80 percent of the individual and family premium dollars they receive in each state for clinical services and wellness activities in that state. If a yearly accounting shows that the insurer hasn’t reached that threshold, it has to provide customer rebates on the difference.

The nonprofit Foundation for Health Coverage Education (www.coverageforall.org) has information on government-sponsored payment options.
Navigating Insurance with a Pre-existing Condition

The definition of a pre-existing medical condition has sometimes seemed a little arbitrary. Soon, however, it won’t matter what condition you have, because in 2014 no insurer will be able to deny you insurance because of a pre-existing condition.

In the meantime, however, in most states, you may still be turned down for individual or family health insurance coverage based on a pre-existing medical condition.

Treating yourself well

How well you treat yourself when it comes to managing your pre-existing condition plays a part in determining your attractiveness as a potential policy owner. If you take medications to keep your depression at bay, if you help control your high blood pressure with diet and exercise, you make a better candidate for insurance than someone who isn’t actively engaged in being healthy.

Be prepared to answer questions about your medical history and practices during the health insurance application process as well as questions specific to your condition:

- **When you were diagnosed.** If you just found out you have an ulcer, you still may be working out the best treatment plan. Insurers generally consider a new diagnosis riskier than a condition you’ve been managing successfully for a while.

- **How much your treatment costs.** If an over-the-counter or generic medication is all you need, or if you can handle your health issue with lifestyle changes, you’re more likely to be accepted than if you need expensive, brand-name drugs.

- **Whether your condition is under control.** If you’ve had to add a medication or change the dosage recently, an insurer may take that as a sign that your condition isn’t under control. And, in the eyes of insurers, a condition not under control is a risky condition.
Exploring your options

Even if you have a pre-existing condition, you may still be able to find health insurance you can afford. Insurers don’t consider every health condition so serious that they would automatically decline coverage.

Certainly, if you have one of the more expensive and chronic diseases — cancer, heart disease, insulin-dependent diabetes, for example — you can expect to be turned down by insurers. (You may still qualify for the high-risk pools covered in the next section, though.) But, if you have any of a larger list of conditions, you won’t necessarily be denied coverage automatically. Many conditions fall into a sort of gray area where some insurers may write you a plan despite a medical history that includes issues such as those listed in Table 3-1.

Table 3-1 Conditions That Don’t Necessarily Make You High-Risk

| Allergies, unless you need steroids to control them | Diabetes, non-insulin-dependent or gestational (diabetes during pregnancy) | Macular degeneration, “dry” type but not “wet” type |
| Arthritis, osteoarthritis only; rheumatoid arthritis is generally high-risk | Enlarged prostate | Migraine, depending on frequency and treatment history |
| Asthma | Epilepsy (when successfully managed) | Pleurisy |
| Body weight/Body mass index (BMI) | GERD (gastro-esophageal reflux disease) | Pneumonia, non-recurring |
| Bursitis | Hemorrhoids, when successfully treated | Rheumatic fever |
| Carpal tunnel syndrome, when treated without surgery | Hernia, in some cases | Scoliosis, depending on severity |
| Cataract, post-operative | High blood pressure, when successfully managed | Sleep apnea, when treated without surgery |
The impact of pre-existing conditions often varies by insurer and where you live. Your best bet is to talk to an insurance agent for advice given your particular circumstances. (Visit www.eHealthInsurance.com to find a licensed agent and more info.)

**Testing the high-risk pool**

If you do not qualify for individually purchased health coverage because of a pre-existing condition or have been offered coverage that excludes benefits for a medical ailment, and have been uninsured for six months or more, you can find insurance through a high-risk pool.

The Pre-Existing Condition Insurance Plan (PCIP) is a federal program that provides $5 billion to help get affordable health care to people with existing medical conditions. In some states, you join a pool set up by your state; other states choose not to run their own pools, so you can apply to the one run at the federal level by the U.S. Department of Health and Human Services (HHS). Go to the HHS Website, www.hhs.gov, and search for PCIP to find info on the program and how to apply.

Your state, whether or not it administers a PCIP, may have a pre-existing pool you can apply to. To find out about low-cost options in your state, visit the Foundation for Health Coverage Education Website, www.coverageforall.org.

The PCIP program will cease to exist in 2014 when insurers will not be able to turn you away because you have a pre-existing condition. And by then each state and the District of Columbia are supposed to have an online health exchange set up where you can shop for and buy health insurance that best suits your needs and your wallet. (We explain these online exchanges in Chapter 2.)
Buying Insurance as a Woman

Yeah, we know, women get all the attention — no one ever talks about men’s needs. But the reality is that women have different insurance needs and medical issues — it’s a biological thing.

Expanding to cover pregnancy

Pregnancy is the big medical issue that sets women apart from the get-go. If you’re a woman of child-bearing age, you need to shop around for an insurance policy to cover you before and during a possible pregnancy.

Not all insurance plans currently cover pregnancy. With some plans, you can pay more and add maternity coverage as a rider. But if you don’t have maternity benefits and get pregnant, all your pre-natal and post-natal health costs are yours to pay.

Of course, if you’re not planning to get pregnant, you can save money by not buying maternity coverage.

If you opt for maternity coverage, make sure that the policy or rider covers what you want it to — or change what you want. For example, some insurers don’t cover home births or mid-wifery services, so if you’re planning to deliver at home, find a policy that accommodates that option. You can also talk to your doctor about what you want.

Once you have that bundle of joy in your arms, most insurers who offer maternity benefits let you add your baby to your policy. Just be sure to make the conversion to a family plan within the insurer’s time limit — often 30 days — so that your newborn isn’t denied coverage.

Some states require insurers to offer maternity coverage, but others don’t. If you can’t find coverage, get in touch with the Foundation for Health Coverage Education at www.coverageforall.org for options.

Adding preventive care

Women score high on the need for preventive screenings. Although the timeframes keep changing, most medical
professionals recommend that women get PAP tests and mammograms with some regularity.

A provision of the health care reform law requires new individual or family health insurance policies purchased after September 23, 2010, to cover many preventive screenings at no out-of-pocket cost to you. Refer to Chapter 2 for more info.

### Checking Up on Your Health Insurance before Retiring Early

You work your whole life so that you can enjoy your retirement. If you’re thinking about moving up your stop-work date and retiring before you reach age 65 (when Medicare kicks in), take a few minutes to consider what your health insurance picture will look like before you take that plunge.

Unless you can get coverage on your spouse’s plan or can afford to pay for insurance on your own (and your health is good enough that you qualify for insurance), you may want to rethink early retirement just to hold on to your health care benefits.

The reality is that, in most cases, you don’t qualify for Medicare before you turn 65, so that option is out. And, being of mature age — but not mature enough just yet — puts you in a bit of a pickle when it comes to getting health insurance:

- You typically can’t stay on your (former) employer’s group health plan beyond the 18 months you can continue it under COBRA provisions. (*COBRA* is a federal program that enables you to maintain health coverage through a former employer for a limited time so long as you continue to pay the whole premium amount, which, without your employer’s contribution, can be very pricey indeed.)

If your company is offering early retirement packages in an effort to reduce its payroll, try to negotiate an extension of your insurance benefits to cover the gap between now and when you turn 65 and qualify for Medicare. The Early Retiree Reinsurance Program (ERRP) was created as part of the Patient Protection and Affordable Care Act of 2010. It gives large businesses, schools, state and local governments, and nonprofit organizations reinsurance.
protection to help cover the cost of insuring high-cost retirees, so your employer may be able to join that program to help pay for your coverage.

✓ Your age works against you. You know you’re in your prime, but insurers fear that you’re just around the corner from developing chronic — and expensive — medical conditions. And, if you’ve been around this long, chances are you do have a health issue or two, so you may well be in the unhappy place of being rejected for coverage due to a pre-existing condition. (“Navigating Insurance with a Pre-existing Condition” earlier in this chapter offers advice on getting insurance despite your medical issues.)

✓ Premiums for people in their 50s and 60s can be very expensive. So, even if you’re physically healthy enough to qualify for coverage, your bank account may not be healthy enough to pay for it — especially if you’re on a fixed income.

The benefits that come as part of the Patient Protection and Affordable Care Act of 2010 apply to you. So, if you have a heart condition or other ailment that puts you into the high-risk category, you can find insurance as part of your state’s high-risk pool right now, and you can’t be excluded for coverage starting in 2014. Turn to Chapter 2 for a rundown of the benefits and when they kick in, or flip to the last page for a stripped-down timeline.

One other reform of interest to elders that comes online in 2014 is the safeguards put in place to make sure that folks in the high-risk category — those sicker and older than the average insured person — don’t pay disproportionately more. In 2014, an older person can’t be required to pay more than three times what a younger person does for the same coverage.
Buying Insurance for Your Family or Employees

In This Chapter

▶ Protecting your family
▶ Safeguarding your business

Even if you’re buying health insurance as a non-group individual (insurance-speak for people who aren’t part of a group plan like those offered by some employers), you can purchase coverage for people beside yourself — your children, for example, or all the members of your immediate family. If you run a small business, you can get group health coverage for yourself and your employees. The good news is that health care reforms make all these options a little easier to navigate, which is what this chapter is about.

Providing Insurance for Your Family

The word family means different things to different people, but in the insurance world, it generally means spouses and relatives with very close ties — parent-and-child close. The next sections take you through the life-long journey of insurance options for you and your family.
Buying for you and your young kids

If you’re a parent, you need to provide a roof over your family’s head, put food on the table, and furnish all the must-haves of modern life. You also need to consider health insurance a basic necessity.

You may be able to enroll in coverage under a group policy your employer offers, but if your employer doesn’t offer group coverage or offers it at a price you can’t afford, you face finding insurance on your own in the non-group market.

If you’re looking for insurance coverage for your family and not everyone is in perfect health — someone has a pre-existing condition or a troublesome medical history (troublesome to insurers anyway) — you may be faced with:

- Finding coverage for everyone except the person(s) with the medical issue
- Getting insurance for everyone, but having specific medical conditions excluded

The Patient Protection and Affordable Care Act of 2010 makes finding health insurance for your family a bit easier:

- **Acceptance of pre-existing conditions:** As of September 23, 2010, insurers are no longer able to deny coverage to dependent children age 18 and under based solely on pre-existing medical conditions, and by 2014 won’t be able to deny anyone coverage on that basis.

- **Access to online state insurance exchanges:** By 2014, individual states and the District of Columbia have the opportunity to set up online insurance exchanges where residents can look for and purchase insurance coverage. (Chapter 2 discusses these online exchanges.)

- **Availability of subsidy money:** Starting in 2014, when most people without employer-based coverage will be required to purchase health insurance, if you can’t afford it, you may qualify for subsidy money to help pay your premiums. More details will emerge as the time grows closer.
Currently, if you can only afford insurance for your child, you may be able to purchase a child-only plan.

**Choosing plans for the college-age crowd**

One of the first health care reforms instituted was a mandate that for policies issued (or renewing) after September 23, 2010, children up to 26 years old can remain on or re-enroll on their parents’ policy. That holds true whether the 20-something is in college or not — although benefits may be less or non-existent if the child is out of the network, such as in school in a different state.

Going on (or back on) a parent’s plan is often a good deal — especially if it’s an employer-sponsored plan. But if you’re age 19 or older and your parents buy their own insurance, you could still be declined based on your medical history.

The next sections offer some additional insurance choices for a member of Gen Whatever.

**Insuring yourself**

If you’re of college age, whether you’re enrolled in a university or not, insuring yourself may be the way to go for a number of reasons:

- If you live outside your parents’ health-plan network, your medical benefits would be covered at a lower, non-network rate or not covered at all. Often, an insurer pays 80 to 100 percent of costs for services provided by an in-network professional. Out-of-network coverage may drop to 50 percent or nothing.

- Individual costs may be cheaper than the premiums your parents would pay to have you on their policy.

In many states, healthy young adults can find individual health plans for less than $70 a month. If an individual policy is a whole lot cheaper, you can impress your folks with your economic acumen and make a case for a parental subsidy.
If you’re actually enrolled in a college, you have a couple more options:

- **A student policy**: These policies, sometimes offered by the university itself, can be a bit restrictive, requiring you to use the student health center facilities and personnel, capping your annual coverage benefits, or otherwise limiting your benefits, but they’re often inexpensive.

  If you’re a soon-to-be graduate insured through a student plan, explore your health insurance options before graduation, not after. Your student plan may end with your enrollment, and you may find yourself uninsured the day after graduation.

- **A short-term health policy**: Available for anywhere between 1 and 12 months, a short-term policy can bridge the gap between graduation and the start of coverage under a new employer’s policy, or the end of school and the effective date for coverage when you re-enroll on your parents’ policy, or any number of other situations.

  You’re young, you’re freewheeling, you’re open to new opportunities — make sure you’re smart enough to have the safety net of health coverage.

**Saving with a health savings account**

Investing in a Health Savings Account (HSA) is one bright thing for a bright young thing to consider. Paying into an HSA-eligible insurance plan not only gets you health care coverage, but the opportunity to save money tax-free.

Benefits of HSA-eligible plans include

- You pay (relatively) lower premiums — you’re young, you’re healthy, so insurers consider you low-risk. (If you can’t afford your premiums, in 2014 you may qualify for a tax subsidy to help pay them.)

- You get no-cost preventive care screenings and immunizations, thanks to health reform.

- The money you put into your HSA is yours to keep. You can make tax-free deposits up to a certain amount each year. In 2010, the limit was $3,050 for the year; the limit may fluctuate year-to-year, but the insurer will be able to keep you informed.
An HSA functions like a beefed-up IRA (individual retirement account):

- You put in pre-tax funds.
- Your pre-tax money stays untaxed as long as you use it to pay qualified medical costs.
- If you withdraw money to spend on non-medical things (not advised), you pay a 20 percent penalty and regular income tax on the amount you take out.
- The tax benefits keep going and growing: You put in pre-tax dollars, and the HSA money you don’t spend within a year earns tax-free interest — what could be sweeter?
- If you don’t have occasion to tap into the account for medical needs, the money can become a retirement fund when you turn 65, although withdrawals may be taxed as income.
- You retain control of the account no matter what. If you eventually join a group health plan, you can still keep your HSA. And if you luck out in the employer sweepstakes, your employer can contribute to your HSA (something they can’t do with an IRA).

Uniting lives: Insurance for the newly married

Along with planning the wedding, the honeymoon, and your whole new life together, it makes sound financial sense to work out your health insurance needs as part of your wedding preparations — and sooner rather than later.

Typically, health-insurance options for newlyweds include joining one of the following:

- An employer’s group plan: If one of you has access to a group plan, you don’t have to worry about pre-existing conditions or other qualifying restrictions. On the other hand, adding a spouse to a group plan isn’t always the most affordable option. Employers often contribute substantially less for a spouse’s coverage; and in a group plan, you may be forced to pay for benefits you never use.
✓ A family plan for the two (and maybe more) of you:
Finding a family health plan to suit you should be fairly easy. In most states, you can find a broad range of plans with differing premiums, deductibles, and co-pays.

And a joint health plan may be more affordable than you think: According to a survey of plans purchased through eHealthInsurance and still active in February 2010, the median premium paid for a family plan was $336.

If you’re planning to enlarge your family with children, make sure that the policy you choose offers the coverage you need. Not all states require insurers to offer maternity coverage, and even then, it may not kick in until months after the rest of the policy is in effect. However, thanks to health reform legislation, mothers-to-be who have coverage may qualify for necessary vaccines, and children are entitled to no-cost well-baby, well-child, and well-teens-until-they’re-19 visits (that last one isn’t the official name, you realize, but no teen wants to be part of a well-child program).

✓ An individual plan for each of you: Sometimes paying for individual plans is the most economically feasible decision. Especially if you have differing health care needs — you want chiropractic coverage, she wants a prescription plan — going your separate ways in this instance may make sense.

If neither of you has health insurance, start shopping now. The last thing you need as you embark on a brand-new life together is the emotional and financial strain of dealing with the repercussions of an illness or accident with no health insurance. Medical bills are one of the most common causes of personal bankruptcy, and good health insurance helps you avoid that unhappy outcome.

Covering Your Business

If you’re a small business owner, the bottom line is: You need health insurance. Whether your business consists of you, yourself, or you and a small number of employees, your business is more stable when you have health coverage.
Health insurance protects not only the physical but the financial health of your enterprise. If you’re uninsured and have an accident that runs up major medical expenses, your business could go under as a result of paying those costs. And the devastation spreads to the people you employed and their families as well.

**Being sure to insure yourself**

“It’s only me,” you think. “I don’t need to see a doctor all the time, I can work through the flu if I get it, and I really can’t afford it anyway, so I’m not going to bother with health insurance right now.” If you think your budget is too tight to allow you to insure yourself, think again: What happens if you develop a chronic medical condition, or break a leg while hiking, or get caught in a natural disaster and suffer an injury, or encounter any number of other unexpected scenarios? The answer is that you’re going to draw on your business and personal resources to pay medical costs until you have no more resources to draw on.

With health coverage, you can treat a chronic condition so that it doesn’t become a catastrophic condition; you can pay for the care you need to recover from an accident or an act of God. And, if your business suffers while you’re recuperating, at least you’ll have a business to get back to when you’re healthy again.

When you are your sole support, you can’t afford not to have health insurance. A health insurance policy protects the financial future of your business.

**Providing insurance options for employees**

Probably the best reason to provide health benefits to your employees is that doing so helps you attract and retain good workers. A person you’d really like to hire may turn you down because she needs the security of insurance coverage for her family.
Though large employers may face penalties for not providing coverage, small businesses aren’t required to provide coverage to employees unless you employ the equivalent of 50 or more full-time workers. However, the new legislation does provide tax incentives if you offer group health insurance options to your workers and meet certain other criteria:

✓ You employ fewer than 25 full-time workers. (Don’t worry, your brother’s kid, who only comes in on Saturdays and spends most of her time texting, doesn’t count as full-time.)

✓ You pay the equivalent of at least 50 percent of your employees’ premiums.

✓ You don’t pay your employees too much — an average below $50,000 in 2010.

If you can tick off each of these requirements, you can get a tax break for up to 35 percent (25 percent for non-profits) of the amount you pay in premiums in 2010. The tax break goes up to 50 percent (35 percent for non-profits) in 2014.

If you’re regarded as a legal business in your state and purchase a small business group health plan, one thing you don’t need to worry about is having one of your employees rejected for coverage. Certain medical conditions may affect the price of the policy you’re offered, but none of your employees — or you! — will be declined for medical reasons.
Chapter 5

Ten (Plus One) FAQs about Health Care Reform

In This Chapter
▶ Covering requirements and costs
▶ Excluding exceptions and limits
▶ Considering kids

You may have questions about what the health care reform legislation means for you. Convenient, then, that in this chapter we offer answers to some of the most frequently asked questions (those are just the FAQs, ma’am).

Now that health care reform has passed, am I automatically covered?

In a word: No. The government is not going to just sign you up for coverage. Some provisions make it easier to qualify for coverage and other provisions offer financial help in paying your premiums if you can’t afford them, but you still have to find your own health insurance.

Am I required to have health insurance?

In a different word: Yes, you will be. Starting in 2014, most Americans must be enrolled in a health insurance plan or pay a penalty. Chapter 2 talks about this aspect of the new law.)
If I don’t buy health insurance by 2014, will I go to jail?

No jail time is involved, but you will be assessed a penalty on your taxes if you don’t have minimum essential coverage. Turn to Chapter 2 for more information on the insurance requirement and penalties.

I’ve been denied insurance because I have a pre-existing condition. Can I get coverage now?

Yes, you can. Until 2014, you may be able to join what’s called a high-risk pool — a new program set up just for people like you who can’t get insurance from insurance companies. (We talk more about options for folks with pre-existing conditions in Chapter 3.)

By 2014, the high-risk pools will disappear because a provision of the reform law kicks in that prevents insurers from turning you down for insurance, no matter what your medical history is.

My neighbor’s insurance was cancelled because of a mistake on his application. Can that happen to me?

As of September 23, 2010, insurance companies may not rescind coverage because of administrative errors made on applications. If you don’t pay your premiums, or outright lie on your insurance application, your insurer can cancel your policy. But, if you remain a customer in good standing, your policy can’t be revoked for petty mistakes you or an employer made in filling out an application.
My child has been denied coverage. Can I get her insured now?

Yes, if you can find a child-only plan for your under-19-year-old. Some insurers stopped offering child-only plans but many states have established special open enrollment periods when children cannot be declined coverage. You may also have government-sponsored options to help get your kids covered.

Can I sign up for free health insurance?

Sorry, but no. If your income is low enough you may qualify for Medicaid, but there is no option for free health insurance.

Beginning in 2014, when the requirement to buy insurance goes into effect, you may be eligible to apply for premium tax credits or cost sharing subsidies to help pay your premiums if your income is 400 percent of the federal poverty level or less. The subsidy won’t pay the whole tab, though. (Chapter 2 talks more about these subsidies.)

I like the health insurance I have now. Can I just keep it?

Most likely. You can keep your coverage as long as the insurance you have meets federal guidelines and the insurer doesn’t make substantial changes. Of course, if your insurance company or employer stops offering the plan, then you’re out of luck.
Is health insurance cheaper now?

Not necessarily. However, depending on your health, your age, where you live, and other factors, insurance costs can be quite affordable. A survey of plans purchased through eHealthInsurance.com and in effect in February 2010 showed that the average premium paid for individual coverage was only $167 a month.

The Patient Protection and Affordable Care Act does require insurers to spend the majority of the money they take in from premium revenue (80 to 85 percent) on medical care and health care quality improvements. So, you know that at least you’ll be getting good value for your money.

My current policy has a lifetime limit on the amount it pays. Will insurers be able to keep imposing those limits?

Any policy written after September 23, 2010, cannot include a lifetime limit on insurance coverage for essential health services. If you have a group plan through your employer, you may still be subject to limits for certain medical procedures, but you no longer have to fear outliving your health insurance.

My kid just graduated college and doesn’t have insurance. Can I get him back on my policy?

After September 23, 2010, you can include or re-include your children on your policy until they’re 26 years old, in most cases. The coverage extends to all your children, whether they’re in school or not. (For more on this, go to Chapter 4.)
A Brief Timeline of Health Care Reform

The Patient Protection and Affordable Care Act was signed into law on March 23, 2010, but many of its provisions roll out over the next four years. Following is a year-by-year list showing when some major provisions become effective.

**2010**

New consumer protections for many plans in the non-group, individual market, including:

- Children can no longer be denied coverage based on their medical history although they may be limited to special enrollment periods in some states.
- Insurers must cover preventive screenings for new health plans.
- No more lifetime coverage limits for essential health services.
- Protection from arbitrary policy cancellation.
- Temporary high-risk pools make it possible for adults with pre-existing conditions to obtain health insurance coverage.
- Adult children up to age 26 are eligible to stay on their parents’ health plans.
- Small businesses can qualify for tax deductions if they provide group coverage for their employees.
- Medicare Part D members in the prescription donut hole get refunds to help pay their prescription costs.
- The Health and Human Services informational Website — www.healthcare.gov — is launched.

**2011**

- The federal government starts ensuring that you get value for your premium payments by requiring insurance companies that offer policies in the individual and small group market to spend at least 80 percent of the premium dollars they take in on clinical services and wellness activities. The percentage for insurers in the large group market is 85.
- The Medicare Part D donut hole shrinks even more with a discount of 50 percent for covered brand-name prescription medications in the gap.
- You lose the special tax treatment you used to get for buying over-the-counter remedies with money from your Health Savings Account or Flexible Spending Account.

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A Brief Timeline of Health Care Reform

2013

✓ The Consumer Oriented and Operated Plan (CO-OP) program creates nonprofit, member-run insurance companies in all 50 states and introduces new health insurance options into the market.
✓ It gets harder to deduct medical expenses on your federal taxes as the deduction level rises from 7.5 percent of gross income to 10 percent.

2014

✓ Most U.S. citizens and legal residents are required to have health insurance coverage.
✓ Qualifying people in the individual and family (non-group) market get subsidies to help pay for insurance premiums.
✓ If you employ 50 or more workers, you’re required to provide health coverage to workers or face financial penalties.
✓ States establish their own, state-based health insurance online exchanges.
✓ No insurer can refuse to sell you a policy simply because of a pre-existing medical condition.
✓ You wait no longer than 90 days for your coverage to kick in.
✓ Limits to deductibles are put in place even for policies offered by small businesses.
✓ All plans must offer basic benefits.