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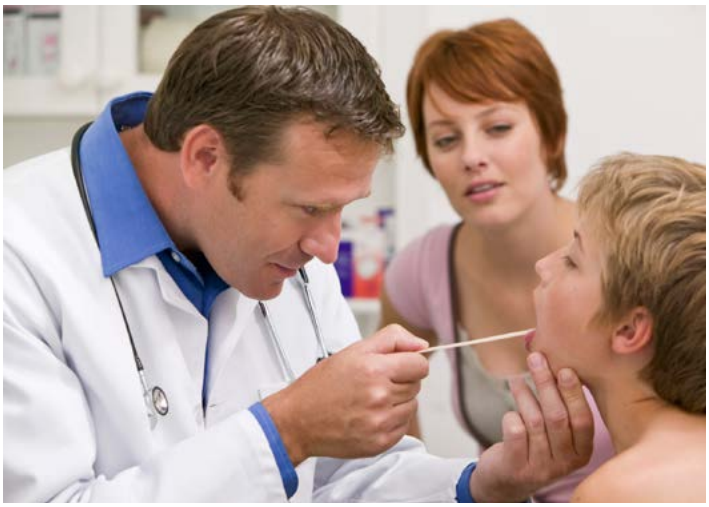
How the ACA Will Affect Your Health Insurance

In June, the U.S. Supreme Court upheld the constitutionality of two contentious provisions of the Affordable Care Act (ACA), paving the way for the law's continued implementation. Here's a brief overview of what the ACA entails for those with individual health insurance.



"Individual mandate": The ACA requires nearly all Americans to maintain "minimum essential" health coverage for themselves and their dependents or pay a "shared responsibility payment" beginning in 2014.

If you obtain your insurance coverage through an individual plan, you will be able to buy coverage through an insurance exchange. This does not mean you MUST buy coverage through an exchange. If you bought your plan on or before March 23, 2010, you will be able to keep it if you choose. These "grandfathered" plans do not have to meet certain requirements the ACA imposes on other health plans, which could make them less expensive than exchange plans.

Penalties: The ACA allows the government to penalize individuals who lack qualified health insurance for three months or more. They will pay this "shared responsibility payment" to the IRS along with their annual taxes. (This formed the basis for the Supreme Court's ruling that the "individual mandate" was a tax—which falls within Congress's authority—rather than an unconstitutional expansion of Congress's power to regulate commerce.)

Penalties start in 2014 at $95 per adult and $47.50 per child, to a maximum of $285 for a family or 1.0 percent of family income, whichever is greater. Penalties increase in subsequent years until they reach a maximum of $2,085 for a family or 2.5 percent of family income, whichever is higher, in 2016. Penalties will be pro-rated by the number of months without coverage. You won't have to pay an assessment if you have very low income and cannot afford coverage, or for specified other reasons, including religious beliefs.

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This Just In…

People of all ages experience critical illnesses. In fact, people under the age of 55 filed nearly half (47 percent) of critical illness claims in 2011, according to a study of critical insurance buyers and paid claims. The study, conducted by the American Association for Critical Illness Insurance (AACII) and General Re Life Corporation, found that some 13 percent of male policyholders and 12 percent of female policyholders who filed new claims were younger than 45. Roughly a third of claimants (33 percent male and 35 percent female) were between ages 45 and 54, and more than half (53 percent) of both groups were age 55 or older when they opened a claim on their critical illness insurance policy.

Cancer accounted for 61 percent of new claims opened by those with individual policies in 2011. Stroke came in second, accounting for 18 percent of new claims, while heart attacks accounted for 11 percent.

For more information on critical illness insurance, please see the article on Page 4.

Envision Better Health with Vision Coverage

Most major medical plans exclude coverage for vision care, including exams, glasses and contact lenses. Do you need vision coverage?

The Vision Council of America (VCA) estimates 11 million Americans have uncorrected vision problems, ranging from refractive errors (near- or far-sightedness) to sight-threatening diseases such as glaucoma or age-related macular degeneration. Nearly 90 percent of those who use a computer at least three hours a day suffer vision problems associated with computer-related eye strain.

Individuals who work as engineers, construction workers, stockbrokers, software developers, accountants and administrative assistants are among those most at risk for developing vision problems.

Types of Coverage

You can find two types of vision coverage: vision insurance plans and discount vision plans.

Vision insurance: Your health insurer might offer vision insurance as an add-on to your medical insurance policy; you can also buy standalone policies. Some insurers even offer combined vision and dental plans for individuals and families.

As the name implies, an insurance company underwrites vision insurance plans. When you buy vision insurance, you will receive a policy that outlines your benefits. In exchange for payment of annual or monthly premiums, your policy will probably cover the following basic services:

- Annual eye examinations, including dilation
- Eyeglass frames
- Eyeglass lenses
- Contact lenses
- LASIK and PRK vision correction at discounted rates

As with other health insurance policies, you will have a family and individual annual deductible and a co-payment each time you access a service. Vision insurance policies are only available through a licensed insurance agent. As with other types of insurance, your state insurance department regulates these policies and provides consumer protection services.

Discount vision plan: A discount vision plan provides eye care services at discounted rates after you pay an annual membership fee. Plans advertise discounts of 15 to 40 percent. Typical plans provide discounts on vision exams, eyeglass frames, eyeglass lenses, contact lenses and LASIK and PRK vision correction. To obtain discounts, you must use a participating eye care professional. You will pay the cost of services at the time of your visit, less any applicable discounts.

To determine whether a discount vision plan is worth the money, make sure your eye care professional participates. Unlike an insurance plan, benefits are not guaranteed under a discount program and plans are not regulated, as insurance is. However, if you and your family members wear glasses and change frames or prescriptions frequently, you might find the discounts worthwhile. For more information on vision care coverage, please contact us. ■

Critical Illness and Other Policies

Critical illness policies are intended to supplement, rather than replace, a major medical plan. They do not qualify as "minimum essential coverage" under the Affordable Care Act.

If you want to open a health savings account (HSA), you must have coverage under an HSA-qualified high-deductible health plan and no other health insurance. This does not prevent you from having a critical illness policy. Because they pay a lump-sum benefit directly to the insured if a specified event occurs, these policies are considered indemnity policies rather than health policies. In fact, the growing popularity of high-deductible plans is prompting interest in critical illness coverage. ■

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benefit of less than $100,000 often don't require a medical exam. Some plans require waiting periods of 30 days or even several months before coverage begins. Others stop paying benefits after a fixed period of two or three years

Limitations. Many insurers will not issue new policies to individuals older than age 59 or 65—cutoffs vary by insurer. After the cut-off age, many policies reduce the lump-sum payout by half, but don't reduce the premiums. In other words, if a policyholder has a stroke at age 75, she might get only half the benefit.

Critical illness policies limit your total benefits to a fixed amount. Limits usually range from a minimum of $10,000 to a maximum of $500,000, although some insurers will write policies with up to $1 million in coverage.

Some financial advisors and consumer advocates say critical illness coverage is unnecessary. They believe consumers should spend the premium dollars on savings, investments or even fitness programs to help reduce the risk of illness. However, if you lack the discipline to keep thousands of dollars in reserve, critical illness insurance can play an important role in filling coverage gaps.

Critical illness insurance offers features

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Insurance exchanges: The ACA requires every state to create an "affordable insurance exchange" by January 1, 2014 or default to a federal program. These online marketplaces will allow consumers, small businesses and brokers to compare and buy health insurance plans from private insurers, as well as the health plans available to members of Congress, administered by the Office of Personnel Management. (Members of Congress must buy their coverage through exchanges starting in 2014.) The ACA also creates a new type of non-profit health insurer, Consumer Operated and Oriented Plans (CO-OPs), which must meet the same state and federal quality and financial standards as other health insurance plans.

Individuals will be able to enroll in an exchange plan only if they are not enrolled in Medicare, Medicaid or acceptable employer coverage. They can also use exchanges to see whether they qualify for federal or state health programs (such as Medicaid), subsidies and tax credits

Essential health benefits: The law requires all individual and small group plans to cover "essential health benefits." These include services in the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

All health plans, including grandfathered plans, must meet ACA provisions that:

- prohibit lifetime dollar limits to key health benefits
- prohibit a plan from cancelling coverage due to a mistake on your application and
- require plans that offer dependent coverage to offer coverage to children until they turn age 26.

Non-grandfathered plans must also cover certain preventive services at no cost to the policyholder. The law also prevents plans from putting certain restrictions on coverage, such as choice of primary care provider and requiring prior approval or higher copayments or co-insurance for out-of-network emergency room services. Although these provisions will reduce your out-of-pocket costs, they will likely increase premiums.

These provisions are designed to ensure that health policies cover a comprehensive set of services to avoid serious coverage gaps. They may make it easier for consumers to avoid the mistake of thinking that limited benefit (or "mini medical") health insurance plans provide comprehensive coverage. While these policies can supplement comprehensive health insurance plans, they do not offer an adequate substitute.

Coverage levels: Health exchanges will offer four tiers of health insurance coverage, ranging from "bronze" to "platinum." All plans will cover the "essential health benefits"; the different tiers indicate "actuarial value," or the percentage of covered expenses plans in each tier will pay. Bronze plans will pay 60 percent of covered expenses, silver plans 70 percent, gold plans 80 percent and platinum plans 90 percent. The remaining percentage becomes the insured's out-of-pocket financial responsibility. Your out-of-pocket expenses could take the form of annual deductibles, copayments and co-insurance or any combination thereof, depending on how your plan is structured. Please note that "actuarial value" indicates the percentage of covered medical costs, not your actual medical costs, which could be much higher.

Costs: The Congressional Research Service said premiums within exchanges will likely vary depending on "…enrollees' age, the health of the people actually enrolled in the plan, the varying prices paid by plans for medical goods and services, the breadth of the provider network, the provisions regarding how out-of-network care is paid for (or not), and the use of tools by the plan to reduce health care utilization (e.g., prior authorization for certain tests)."

A Kaiser Family Foundation study projected costs for plans that would meet bronze-level requirements. With a 20 percent coinsurance level, a bronze plan might have a per-individual deductible of $4,375. Thus, after meeting the $4,375 annual deductible, insureds would have to pay 20 percent of healthcare expenses out of pocket. Alternatively, a plan with a lower deductible meeting the bronze plan requirements might have a deductible of $3,475 and a coinsurance percentage of 40 percent. Both plans would cap total patient out-of-pocket costs at $6,350, as required by the ACA. Family deductibles for families would be double these amounts.

Credits and subsidies: Low-income individuals and families might qualify for subsidies and tax credits; these would only be available through an exchange. The law creates sliding-scale federal subsidies for individuals and families who make too much to qualify for Medicaid, but up to 400 percent of the federal poverty level. States will have the flexibility to establish basic health plans for low-income individuals not eligible for Medicaid.

Insurance agents: Although exchanges will allow individuals and small employers to shop online for health plans, insurance agents and brokers will still service and sell the policies provided by private insurers. This means you can still rely on your insurance agent to steer you through the buying process and recommend the products that best meet your family's needs.

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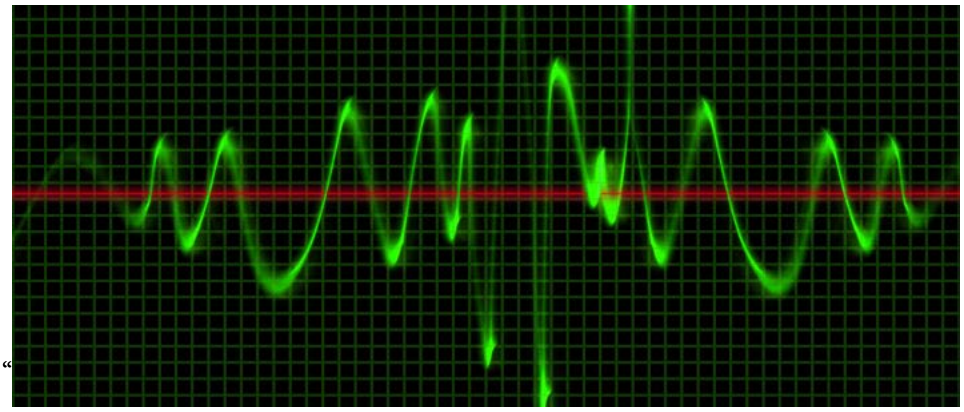
other types of medical insurance lack. Most importantly, benefits are flexible—instead of going directly to medical providers, you can use them however you choose. You can use a critical illness policy to supplement disability coverage as well as your medical coverage. Business owners who suffer a critical illness can use policy benefits to supplement any lost income or operating expenses—they can even help cover the lost income of a person who acts as your caretaker during your illness. Because you don't have to prove disability, only illness, to collect benefits, critical illness insurance may offer more flexible coverage than many disability policies. For more information, please contact us.

Critical Illness Insurance Fills a Benefits Gap

Almost a third of cancer patients have healthcare costs totaling 10 percent or more of their family income, and roughly one in nine have costs that exceed 20 percent of family income. As a result, 11 percent of individuals with cancer report being unable to pay for food or other necessities while paying for cancer treatment.



As medical technologies and treatments improve, more people are surviving once fatal forms of cancer, heart disease and other conditions. Battling serious illness costs money, though. Even if you have medical insurance, your plan won't cover the entire bill.

In a recent Kaiser Family Foundation poll, 51 percent of insurance agents reported the most common health plan deductible is $2,000 or more, compared to 20 percent who said the same two years ago. In the individual health insurance market, deductibles can be even higher—$4,000 or more.

In addition to deductibles, health plans have copayments, coinsurance and exclusions—all of which add to your out-of-pocket costs. Critical illness insurance can help you pay some of these costs, along with the indirect costs of a major illness. A critical illness policy pays a lump sum benefit if you are diagnosed with a serious health condition, such as cancer, covered by the policy. You can use policy benefits for any expense: co-payments for doctor/hospital bills, travel costs, experimental treatments, or even to replace the wages of a family member leaving work to provide care.

Illnesses covered under critical illness policies vary, but most cover cancer, heart attack and stroke. Many cover a far longer list of ailments, including Alzheimer's, paralysis, coma, multiple sclerosis and loss of hearing. Payouts for critical illness policies typically average around $25,000, with premiums costing about $300 to $500 annually, depending on your age, gender, health and location. Higher-end policies covering a dozen or more conditions generally pay benefits of more than $100,000 and cost about $1,500 to $2,000 a year.

Eligibility and enrollment. To buy critical illness coverage, you must complete a detailed medical questionnaire. An insurer will likely deny coverage if you already have a covered illness or if several blood relatives have had one. Policies paying a maximum

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Backup Financial Records Electronically

Any family financial plan needs accurate documentation. The IRS recommends that taxpayers make and keep duplicate copies of their financial records.

Keeping a backup set of records — including, for example, bank statements, tax returns, insurance policies, etc. — is easier now that many financial institutions provide statements and documents electronically, and much financial information is available on the Internet. Even if the original records are provided only on paper, they can be scanned into an electronic format. With documents in electronic form, taxpayers can download them to a backup storage device, like an external hard drive, or burn them to a CD or DVD.

Document Valuables

Taxpayers can also prepare for disaster by photographing or videotaping the contents of their homes, especially items of higher value. The IRS has a disaster loss workbook, Publication 584, that can help taxpayers compile a room-by-room list of belongings.

A photographic record can help an individual prove the market value of items for insurance and casualty loss claims. Photos should be stored with a friend or family member who lives outside the area.

You can generally deduct casualty or theft losses related to your home, household items and vehicles on your federal tax return. A casualty loss can result from the damage, destruction or loss of your property from any sudden, unexpected or unusual event such as a flood, hurricane, tornado, fire, earthquake or even volcanic eruption. It does not include normal wear and tear or progressive deterioration. You may not deduct casualty and theft losses covered by insurance unless you file a timely claim for reimbursement, and you must reduce the loss by the amount of any reimbursement.

Insurance is an important part of any family's financial plan. For a review of your family's coverage, please contact us. ■