



# TOOLKIT ON THE AFFORDABLE CARE ACT

This toolkit was developed with the help of Kristin Pulatie as part of her practicum at the University of Illinois at Chicago, School of Public Health; Oscar JeanPierre Coaquira, a rising junior at Cornell University as part of his Northwestern Engage internship; and Amara Ugwu a junior at the University of Chicago as part of her internship. IMCHC is extremely grateful for the time and effort they put into surveying Lake County health care providers, researching the Affordable Care Act, and the final product that we hope will help providers and their patients better understand health care reform.

For policy updates or to request a comprehensive in-person presentation on the Affordable Care Act, please contact associate director and director of policy and advocacy Kathy Chan at [kchan@ilmaternal.org](mailto:kchan@ilmaternal.org).

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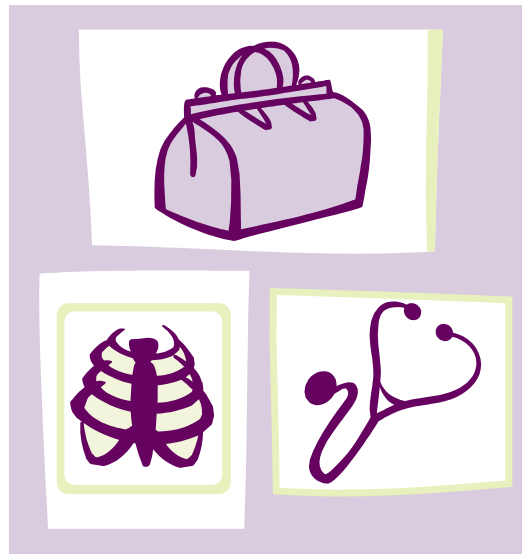
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# How to Use this Toolkit

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This toolkit is meant to provide an overview of some of the most frequently asked questions about the Affordable Care Act (ACA). While this toolkit covers a number of changes to public and private insurance coverage, it is by no means an exhaustive resource.

Given that a number of rules and regulations have yet to be issued and the fact that ACA provisions will be phased in over the next several years, this toolkit will also require periodic revisions. Updated copies of this toolkit will be posted on the Illinois Maternal and Child Health Coalition's website at [www.ilmaternal.org](http://www.ilmaternal.org).



You can subscribe to our mailing list to ensure that you receive the latest updates as they are issued and published. Send an email to [ACAtoolkit@ilmaternal.org](mailto:ACAtoolkit@ilmaternal.org) with your contact information.

Additionally, if there is information that you think would be helpful to other toolkit users, please let us know so we can try to include this information in future updates.

# Background on the Affordable Care Act

Compared to every other industrialized country in the world, the United States spends the most on health care, but still manages to have some of the worst health outcomes.

According to a 2010 report by the Census Bureau, over 50 million people were uninsured in 2009. In 2007 around 25 million people were also underinsured; this means that these individuals were spending more than 10% of their income on out-of-pocket medical expenses, based on a report conducted by the Commonwealth Fund.

The average family health insurance premium has increased by 27% since 2005, according to the Kaiser Family Foundation's annual employer health benefit survey. Two-thirds of personal bankruptcies resulted from medical expenses; of these individuals, the overwhelming majority were actually insured.

In order to make important and needed changes to the health care and health insurance systems, Congress passed the Patient Protection and Affordable Care Act, which was signed into law by President Barack Obama on March 23, 2010. A subsequent "reconciliation bill" that made small changes to the first bill was passed and signed into law several days later. Together, these two pieces of legislation are better known as federal health care reform or the Affordable Care Act (ACA).



# Background on the Affordable Care Act (continued)

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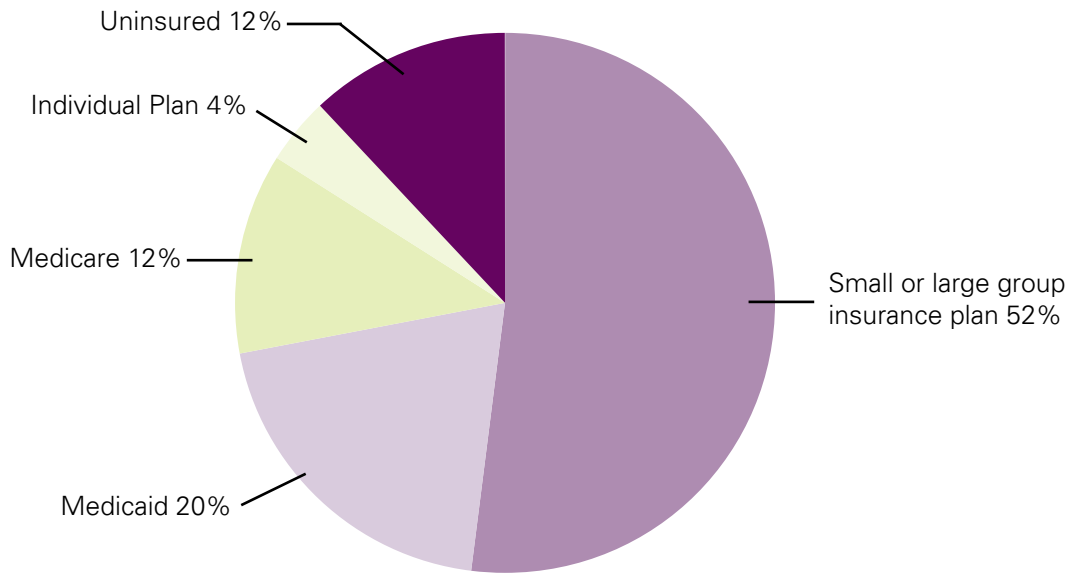
The ACA makes sweeping changes to the US health care system; some of these changes have already taken place, but most will be implemented in the next several years, with major changes occurring on January 1, 2014.

The ACA is intended to increase access to public and private health care coverage, lower medical costs, and improve health outcomes. The law also contains provisions to improve and expand the public health preparedness of the country and to provide incentives for health care providers to practice in underserved communities.

The US Department of Health and Human Services is the primary federal agency that will provide oversight to the implementation of the ACA. At the state level, the Illinois Department of Insurance and the Illinois Department of Healthcare and Family Services are the primary agencies implementing and carrying out provisions of the ACA.



# Overview of Insurance Coverage in Illinois



Deloitte Consulting LLP recently analyzed coverage rates in Illinois. The analysis indicates that:

- 52% of Illinois residents are covered by small or large group insurance plan
- 20% are covered by Medicaid
- 12% are covered by Medicare or another form of public insurance
- 4% are covered through an individual coverage plan
- 12% are uninsured

The analysis also included market projections of coverage rates, estimating that in 2020, (assuming full ACA implementation):

- Percentage of uninsured Illinois residents will decrease from 12% to 7%
- Improved economic conditions will temper Medicaid enrollment, but will still increase 1% to cover 21% of Illinois residents
- Individual plans will increase from 4% to 8% of market share
- Participation in plans purchased through the Exchange will be highest in the first three years of operation starting in 2014, with an estimated 1.4 million covered lives in 2020

# Present Health Care Coverage Options

While many new opportunities for affordable health coverage and health care options will be available in 2014 as a result of the Affordable Care Act (ACA), there are numerous programs that are available to Illinois residents right now. A summary of these programs, eligibility requirements, and instructions on applying online or resources for more information are listed below.

Visit [www.health.illinois.gov](http://www.health.illinois.gov) to view these programs, in addition to several more resources provided through the State of Illinois.

## All Kids

All Kids is Illinois' program for children who need comprehensive, affordable health insurance, regardless of immigration status or health condition. Families with income below 300% of the Federal Poverty Level (FPL), or ~\$67,000/year for a family of four, may qualify.

Some families may pay monthly premiums and co-pays for services. All Kids covers doctor visits, hospital stays, prescription drugs, vision care, dental care, and eyeglasses as well as regular check-ups and immunizations. Visit [www.allkids.com](http://www.allkids.com) or call 1-866-ALL-KIDS (1-866-255-5437) for more information.

## FamilyCare

FamilyCare is health coverage for parents living with their children 18 years old or younger. FamilyCare also covers relatives who are caring for children in place of their parents.

FamilyCare enrollees must have a family income below 185% FPL (~\$41,000/year for a family of four), be a US citizen, OR a legal permanent resident with at least five years of residency in the US. Some families may pay monthly premiums and co-pays for services. Visit [www.familycareillinois.com](http://www.familycareillinois.com) or call 1-866-ALL-KIDS for more information.

## Moms & Babies

Moms & Babies is health coverage for women while they are pregnant and up to 60 days after their baby is born, as well as for infants up to one year of age.

Families with incomes less than 200% FPL (~\$44,700/year for a family of four) may qualify. There are no immigration or citizenship requirements for Moms & Babies and enrollees do not have premiums or co-pays.

Pregnant women can get immediate, temporary coverage to help them get prenatal care for a healthy pregnancy. Visit [www.allkids.com/pregnant.html](http://www.allkids.com/pregnant.html) or call 1-866-ALL-KIDS to find out more information.

## Illinois Healthy Women

Illinois Healthy Women is a limited health care coverage program for women ages 19-44 to help them pay for family planning services and birth control. A woman needs to have an income less than 200% FPL (~\$44,700/year for a family of four) and be a US citizen or legal permanent resident with at least five years of residency in the US. Most services are free, but small co-pays may apply to some services, like brand-name prescription drugs. Enrollees receive a “pink card”, which indicates eligibility and is pink in color.

Because Illinois Healthy Women is a limited coverage program, specifically for family planning services, only women who are ineligible for All Kids, FamilyCare, or Moms & Babies can get Illinois Healthy Women. This includes women who turn 19 and are no longer eligible for All Kids, or women who do not qualify for FamilyCare because they make too much money.

Find out more by visiting [www.illinoishealthywomen.com](http://www.illinoishealthywomen.com) or by calling 1-800-226-0768.

## Illinois Breast and Cervical Cancer Program

The Illinois Breast and Cervical Cancer Program offers free mammograms, breast and pelvic exams, and Pap tests to uninsured women aged 35-64. Younger women may be eligible in some cases. There is no income limit.

Women who are diagnosed with breast or cervical cancer, through this program or another avenue, may receive free cancer treatments. For more information, visit [www.cancerscreening.illinois.gov](http://www.cancerscreening.illinois.gov) or call the Women’s Health hotline at 1-888-522-1282.

## Illinois Pre-Existing Condition Insurance Plan

The Illinois Pre-Existing Condition Insurance Plan (IPXP) is a special, temporary, private insurance program for adults with pre-existing conditions.

Individuals must be US citizens, national, or legal residents; be uninsured for at least the past six months; and have a pre-existing condition. There is no income requirement, but enrollees must be able to pay the monthly premium, which varies based on county of residence, age, and tobacco use.

Visit [www.insurance.illinois.gov/ipxp/](http://www.insurance.illinois.gov/ipxp/) or call 1-877-210-9167 for more information.

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Persons without insurance and who don’t qualify for these programs can get care at their local federally-funded health center. Federally funded-health centers provide services for all community members, regardless of income, immigration, or insurance status. Clinics offer a wide variety of services including primary care, sick visits, oral health, mental health, and substance abuse services. Find the nearest federally-funded health center by visiting [http://findahealth-center.hrsa.gov/Search\\_HCC.aspx](http://findahealth-center.hrsa.gov/Search_HCC.aspx)

# Overview of Key Provisions in the Affordable Care Act

Signed into law on March 23, 2010, the Affordable Care Act (ACA) is historic legislation that phases-in changes to private insurance coverage, expands public coverage programs, strengthens consumer rights, and establishes numerous funding opportunities to improve care.

It's important to note that the ACA sets forth a “floor” not a “ceiling” when it comes to improving access to affordable health insurance and health care. States play a large part in implementation and are free to go above and beyond the standards established in federal legislation.

The ACA also includes important protections to preserve existing coverage programs, including Medicaid and the Children's Health Insurance Program (CHIP). In Illinois, Medicaid and CHIP help fund our All Kids, FamilyCare, and Moms & Babies health insurance programs.

As of March 23, 2010, states cannot reduce eligibility or require additional documentation from new or renewing participants. If states violate this provision, they are at risk of losing ALL of their federal Medicaid and CHIP funding.

Millions of uninsured individuals will gain access to affordable health insurance coverage in 2014 as a result of an expansion of the Medicaid program or through premium tax credits and/or cost-sharing reductions that will help them purchase private insurance coverage. The competitive health insurance marketplace, aka, the Exchange, will be the “portal” through which persons will access these programs, as well as compare and select their health plans.

Reforms to the private insurance market are phased-in over the course of several years. Changes already in place include:



- Coverage expansion of adult children/young adults to age 26 on private insurance plans
- Free preventive care in new private health insurance plans
- Direct access for women to OB/GYN care
- Elimination of lifetime limits and phasing out of annual limits
- Ban on pre-existing condition exclusions for children under 19 years of age
- Increased transparency and accountability of insurance companies

In August 2012, seven key women’s preventive health provisions will be offered without cost-sharing, co-pays, or co-insurance for those with new health insurance plans. These provisions include: well-women visits; gestational diabetes screening; HPV DNA testing; STI counseling and HIV screening and counseling; contraception and contraception counseling; breastfeeding support, supplies, and counseling; and domestic violence screening.

Small businesses and nonprofits with up to 25 full-time employees, or the equivalent, and pay annual wages below \$50,000 can be eligible for tax credits to help them pay for private insurance for their employees. These tax credits are up to 35% for small businesses and up to 25% for nonprofits. These credits go up to 50% for small businesses and up to 35% for nonprofits starting in 2014.

Form **8941** Credit for Small Employer Health Insurance Premiums

Department of the Treasury Internal Revenue Service

OMB No. 1545-2198

2010 Attachment Sequence No. 63

▶ See separate instructions. ▶ Attach to your tax return.

Name(s) shown on return

	Identifying number
1 Enter the number of individuals you employed during the tax year who are considered employees for purposes of this credit (see instructions) . . . . .	1
2 Enter the number of full-time equivalent employees you had for the tax year (see instructions). If you entered 25 or more, skip lines 3 through 11 and enter -0- on line 12 . . . . .	2
3 Average annual wages you paid for the tax year (see instructions). If you entered \$50,000 or more, skip lines 4 through 11 and enter -0- on line 12 . . . . .	3
4 Premiums you paid during the tax year for employees included on line 1 for health insurance coverage under a qualifying arrangement (see instructions) . . . . .	4
5 Premiums you would have entered on line 4 if the total premium for each employee equaled the average premium for the small group market in which you offered health insurance coverage (see instructions) . . . . .	5
6 Enter the <b>smaller</b> of line 4 or line 5 . . . . .	6
7 Multiply line 6 by the applicable percentage: • Tax-exempt small employers, multiply line 6 by 25% (.25) • All other small employers, multiply line 6 by 35% (.35) . . . . .	7
8 If line 2 is 10 or less, enter the amount from line 7. Otherwise, see instructions . . . . .	8
9 If line 3 is \$25,000 or less, enter the amount from line 8. Otherwise, see instructions . . . . .	9
10 Enter the total amount of any state premium subsidies paid and any state tax credits available to you for premiums included on line 4 (see instructions) . . . . .	10
11 Subtract line 10 from line 4. If zero or less, enter -0- . . . . .	11

Visit the IRS’s website ([www.irs.gov](http://www.irs.gov)) for more information about the tax credit and to apply. The Small Business Majority’s website ([www.smallbusiness.org](http://www.smallbusiness.org)) includes a tax credit calculator to help estimate your annual tax credit.

Numerous grant programs authorized and funded by the ACA will help test out new models of health care delivery systems, develop innovative ways to reduce obesity and other chronic health conditions, and promote evidence-based practices to improve community health. Visit [www.grants.gov](http://www.grants.gov) for more information about federal grant opportunities.

# Medicaid: Now and in 2014

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Nearly three million people in Illinois are covered by Medicaid and Medicaid-funded programs which includes All Kids, FamilyCare, Moms & Babies, and Aid to the Aged, Blind and Disabled (AABD). However, being low-income does not automatically qualify a person for Medicaid coverage in Illinois.

Presently, Illinois Medicaid is only available to persons who meet income and immigration requirements, in addition to also fitting into a “category” of coverage. This means that in order to qualify for Medicaid, someone must be pregnant; a child 18 years or younger; a parent with a child 18 years or younger living in the household; or aged, blind, or disabled.


Low-income adults without children in the household and who don't meet the state definition of being disabled, are typically ineligible for Medicaid. This has left hundreds of thousands of adults without an affordable option for coverage.



The Affordable Care Act requires states to expand their Medicaid programs to all persons under 133% FPL.

The Affordable Care Act (ACA) requires states to expand their Medicaid programs to **all persons** under 133% FPL (just under \$15,000/year for one person and just under \$20,000/year for two-person household) to all US citizens and qualified residents. It is estimated that 500,000 - 700,000 uninsured adults in Illinois will be newly eligible for Medicaid in 2014.

Illinois currently receives a 1:1 match rate for Medicaid, meaning that Illinois receives one dollar from the federal government for each dollar Illinois invests in our state Medicaid program. The Medicaid expansion in 2014 will be fully financed by the federal government, meaning that the federal government will pay Illinois for the entire cost of the coverage for the newly eligible population. That match will slowly decrease over the course of several years, but will never dip below a 90% match rate.



The Medicaid expansion in 2014 will be 100% federally financed. Federal match will slowly decrease over the next several years, but will never go lower than 90%, making the Medicaid expansion a great fiscal investment for Illinois.

Medicaid reimbursement rates for primary care providers, including pediatricians, family practice doctors, and general internal medicine providers, will increase to 100% of the Medicare payment rates in 2013 and 2014. Medicare reimbursement rates are traditionally much higher than Medicaid. States will also receive 100% federal match to cover this increase in reimbursement rates.

Those expected to be newly eligible for Medicaid in 2014 include: single adults and couples without children in the household; young adults, ages 19-25; “pre-Medicare” seniors, ages 55-64; and homeless individuals.

Medicaid eligibility will take place via the Exchange. The ACA encourages states to use “paperless” verifications by cross-matching information available through other state and federal databases which can allow for a more efficient use of administrative resources.

# Competitive Health Insurance Marketplace aka the Exchange

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The competitive health insurance marketplace, or the Exchange, is the vehicle by which most individuals and small businesses (up to 100 employees) will use to determine whether they are eligible for help paying for insurance, access public programs and/or subsidies, and to also compare health plans. In 2017, states can make the decision to allow businesses with 100 or more employees to participate in the Exchange.

States are required to have their Exchanges operational by January 1, 2014. The Exchange is expected to deliver these services primarily online; however, the services of the Exchange must also be accessible by phone, mail, and in-person. Below are ways in which an Illinois Exchange will help individuals and small businesses in Illinois:

- **Competition** - An Illinois Exchange will make our insurance market more competitive. The Exchange will force insurers to compete for customers based on value, instead of luring them with the trickiest fine print. The Exchange will have an easy-to-use website that allows consumers to make apples-to-apples comparisons when they shop for health plans. On this level playing field, quality insurers of all sizes—not just the largest and most powerful—will be able to compete.
- **Transparency** - Insurers in the Exchange will have to use easy-to-understand language to describe their products—a vast improvement over the confusing jargon that consumers face now. And insurers will be required to share information about plan costs and quality in a standardized way so that consumers can truly understand what they're being offered.



- **Affordability** - In the Exchange, middle-class consumers (those who earn up to nearly \$90,000 for a family of four in 2011) will be eligible for tax credits to help them pay their insurance premiums. Many people will also receive help with copayments, deductibles, and other cost-sharing. And the Exchange will monitor insurers to make sure that they aren't unreasonably increasing their premium rates from year to year.
- **Accountability** - In the Exchange, consumers will gain important protections against insurer abuses. Marketing standards will prohibit unethical advertising. Provider network standards will ensure that every health plan has enough doctors. And premium reviews will make sure that plans aren't unjustly increasing costs for consumers.
- **Quality** - Quality and customer satisfaction ratings for all health plans in the exchange will be posted online, helping consumers make an informed decisions when choosing a plan. And Exchange plans will be required to meet quality standards and implement quality improvement strategies so that consumers know that they are getting a good product.
- **Assistance** - Health insurance can be confusing; but in the Exchange, direct assistance will be available. A toll-free hotline will take consumer questions and "navigators" will help people understand and enroll in coverage. In addition, consumer assistance programs will provide a place to turn to if Exchange enrollees have grievances with their health plans.

Illinois is currently in the process of making major decisions regarding the structure and financing of the Exchange. These decisions will be made by the Illinois General Assembly during the Fall 2011 Veto Session and will ultimately determine how well the Exchange responds to the needs of individuals and small businesses.

Visit Illinois Health Matters ([www.illinoishealthmatters.org](http://www.illinoishealthmatters.org)) or the website for the Illinois Health Benefits Exchange Legislative Study Committee (<http://www.ilga.gov/commission/cgfa2006/Resource.aspx?id=1227>) for the latest updates.

# Competitive Health Insurance Marketplace (continued)

Plans offered on the Exchange must be “qualified health plans” which offer a minimum benefits package that includes specific services. While specifics have yet to be announced by the US Department of Health and Human Services, the categories of coverage must include:

- Ambulatory patient services
- Emergency services, hospitalization
- Maternity and newborn care
- Prescription drug coverage
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services
- Chronic disease management
- Pediatric services, including oral and vision care.
- Mental health and substance abuse services (including behavioral health treatment)




Individuals and families who earn too much to qualify for Medicaid, but do not receive insurance from their employers and need help paying for health insurance, will have access to premium tax credits.

These premium tax credits will only be accessible through the Exchange. An individual or family can have annual income up to 400% of the federal poverty level (FPL) to qualify for the premium tax credits to help offset the cost of private insurance coverage. In 2011, 400% FPL is equivalent to the amounts listed below. Some will also be eligible for cost-sharing subsidies if they meet eligibility requirements.

Family Size	400% FPL Annual Income
1	\$43,320
2	\$58,280
3	\$73,240
4	\$88,200

The Illinois Department of Insurance leads Illinois’ planning efforts for the Exchange and works closely with the Illinois Department of Healthcare and Family Services, since Medicaid eligibility (for those with incomes below 133% FPL) will also be determined through the Exchange.

# Individual and Business Responsibility



The Affordable Care Act (ACA) defines “those who can afford health care insurance” as people for whom the minimum policy will not cost more than 8% of their monthly income and who earn more than 100% of the poverty line.

Starting in 2014, **nearly all** US citizens and legal residents will be required to have health insurance, through public or private coverage, or risk a penalty. The penalty will be paid as a federal tax liability on income tax returns and is enforced by the US Department of Treasury.

The individual responsibility provision is critical for minimizing the “hidden tax” that insured persons pay for care for the uninsured in the form of higher insurance

premiums and hospital reimbursements. Currently, the average American family with health insurance pays over \$1,000 a year in higher premiums just to cover the cost of care for the uninsured.

Since the individual responsibility provision requires **EVERYONE** to have health insurance, not just the sick and old, but also the young and healthy, a broad pool of people will have insurance and costs can be shared and kept under control.

The annual penalty for not having health insurance will be either a flat dollar amount **OR** a percentage of the individual’s taxable income, whichever is greater. For dependents under 18 years of age, the penalty is 50% of the individual amount.

The flat dollar amount starts at \$95 in 2014 and increases to \$695 in 2016, with prices indexed to inflation after 2016. The percentage of taxable income is equal to the percentage of a household’s income that is in excess of the tax filing threshold, which starts at 1% in 2014, increasing to 2.5% in 2016.



# Individual and Business Responsibility (continued)

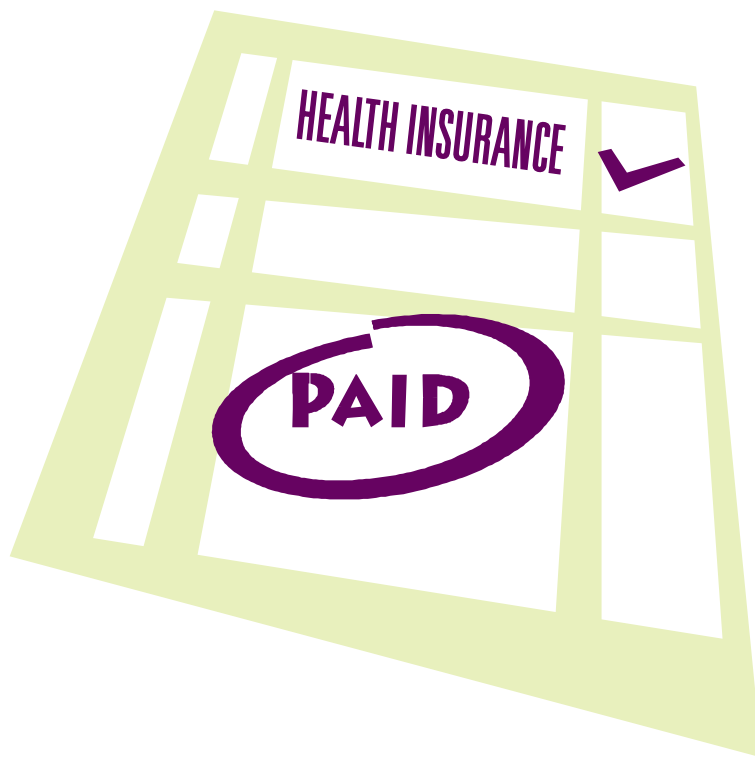
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On the business side, large employers that do not provide affordable health insurance to their employees will have to pay \$2,000 a year for each full-time employee, after the first 30 employees, if the business has at least one employee who receives subsidized coverage through the Exchange.

For employers with 50 or more full-time employees, the employer will pay \$3,000/year for each full-time employee who is offered coverage, but gets a premium tax credit instead through the Exchange.

The maximum amount that will be owed by employers whose employees access premium tax credits through the Exchange is \$2,000 multiplied by the total number of full-time employees in excess of 30 that a business employs.

Native Americans, undocumented immigrants, prisoners, and those below the tax filing threshold will be exempt from the individual responsibility provision. Exemptions will also be granted for religious conscientious and in situations where no affordable insurance coverage is available.



# Changes in Private Insurance to Date

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## Expansion of young adult coverage to age 26

As of September 23, 2010, insurance companies are required to extend coverage to young adults up to the age of 26, for plans that include dependent coverage. Prior to this change, young adults were often required to be financially dependent per their parents' tax return form or had to be a full-time student. As a result of this change, even married young adults can remain on their parent's private insurance plans.

In Illinois, veterans are allowed to stay on their parent's plan until the age of 30.

For more information about this provision, visit [http://cciio.cms.gov/resources/files/adult\\_child\\_faq.html](http://cciio.cms.gov/resources/files/adult_child_faq.html)

## Direct access for women to OB/GYN care

Women are now able to directly access an in-network OB/GYN without a referral from their primary care provider or requiring authorization from their health carrier.

## Elimination of lifetime limits and phasing out of annual limits

Many health insurance plans set lifetime and annual limits that caps the amount of services that will be covered by a plan in the course of time that someone is enrolled in a plan or over one year, respectively. Most people never meet these limits, but for persons who have chronic conditions or find themselves in a catastrophic health situation, they can easily reach these caps and be forced to pay for the cost of care that exceeds these limits. We have heard this occur frequently in the situation of premature infants who require extensive NICU stays and who easily meet these limits in the first few months of their lives.

As a result of the Affordable Care Act(ACA), lifetime limits on most benefits are prohibited in any health insurance policy issued or renewed after September 23, 2010.

New restrictions on annual limits for employer-sponsored and individual insurance affect plans issued after March 23, 2010. No annual dollar limits are allowed on most covered benefits starting January 1, 2014.

# Changes in Private Insurance to Date (continued)

## Ban on pre-existing condition exclusions for children under 19 years of age

As of September 23, 2010, children under the age of 19 can no longer be denied or excluded for private insurance coverage because of a pre-existing condition. Plans are also no longer allowed to limit coverage for a pre-existing condition. This applies to all employer-sponsored plans as well as to individual health insurance policies issued after March 23, 2010.

Starting in 2014, this provision will be applied to persons of all ages.

## Increased transparency and accountability by insurance companies

The Affordable Care Act requires insurance companies to spend a minimum amount of the money they collect from health insurance premiums on health care and improving the quality of care, as opposed to administrative, marketing, or overhead costs.

Insurers selling policies to individuals or small groups are required to spend at least 80% of their premiums on direct medical care and quality improvement efforts; those selling to large groups (usually 50 or more employees) must spend at least 85%.

Plans that don't meet these limits must provide a rebate of the difference to their policyholders.



## Limitation on rescissions

In the past, insurance companies were allowed to rescind coverage for treatment or care if an individual misrepresented his or her health status at the time of application, EVEN IF the misrepresentation was unintentional. Once an individual began to access his or her insurance policy for covered treatment, the insurance company would search for an error in the application. If an error was found, the company could retroactively cancel the policy and terminate coverage.

As of September 23, 2010, insurers must prove an “intent to deceive” in the misrepresentation on the application. This means that insurance companies must prove the individual knowingly misrepresented his or her health status during the application process to be able to rescind coverage.

The ban on most rescissions applies to both individual and group health plans that began on or after September 23, 2010. Insurance companies must give at least 30 days notice before a rescissions occurs to allow for an appeal to take place or for the individual to find alternate coverage.

### Access to out-of-network ER services

Some health plans limit payment for emergency room services provided outside of a plan’s preselected network of emergency health care providers. Or they would require prior approval for emergency care at hospitals outside its networks, which is counterintuitive since no one ever plans for an emergency.

Starting September 23, 2010, new or non-grandfathered health plans can’t require higher co-sharing for out-of-network ER services or require prior approval for ER services from a hospitals or provider outside the network.

### Free preventive care in new private health insurance plans

New health insurance plans created after March 23, 2010 are required to offer certain preventive health services without a co-pay, co-insurance, or deductible. Preventive services include certain screenings, vaccinations, and counseling.

Plans in effect prior to March 23, 2010 may still be required to offer these preventive services free-of-charge to plan participants if they make certain changes to the coverage package or cost. Individuals should check with their private health insurance plan to see whether they are eligible for free preventive services.



## Emergency

# Changes in Private Insurance to Date (continued)

Services offered free of cost include immunizations recommended by the Centers for Disease Control and Prevention and those decided by the US Preventive Services Task Force. Infants, children, and adolescents will receive evidence informed preventive care and screenings provided for in guidelines supported by Health Resources and Service Administration (e.g. Bright Futures).

See the chart below or visit <http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html> for a full list of preventive services that must be offered without cost-sharing by new health insurance plans.

Covered preventive services for children	Covered preventive services for women, including pregnant women	Basic preventive services
Alcohol and Drug Use assessments	Routine Anemia screening	Abdominal Aortic Aneurysm one-time screening
Autism screenings and behavioral assessments	Bacteriuria urinary tract or other infection screening for pregnant women	Alcohol Misuse screening and counseling
Blood Pressure and Dyslipidemia screening	BRCA counseling about genetic testing for women at higher risk	Aspirin use for men and women
Cervical Dysplasia, Congenital Hypothyroidism, and Phenylketonuria (PKU) screening	Breast Cancer Mammography screenings every 1 to 2 years for women over 40	Blood Pressure screening
Depression screening	Breast Cancer Chemoprevention counseling for women at higher risk	Cholesterol screening
Developmental screening and surveillance throughout childhood	Breast Feeding interventions to support and promote breast feeding	Colorectal Cancer screening
Fluoride Chemoprevention supplements	Cervical Cancer screening for sexually active women	Depression screening
Gonorrhea preventive medication	Chlamydia Infection screening for younger women and women at high risk	Type 2 Diabetes screening
Height, Weight, and Body Mass Index measurements for children	Folic Acid supplements for women who may become pregnant	Diet counseling
Hematocrit and Hemoglobinopathies screening	Gonorrhea screening for all women at higher risk	HIV screening
HIV screening, Sexually Transmitted Infection (STI) prevention, counseling, and screening	Hepatitis B screening for pregnant women at their first prenatal visit	Immunization vaccines for adults
Iron supplements and lead screening	Osteoporosis screening for women over age 60 depending on risk factors	Obesity screening and counseling
Medical History, Immunization vaccines, and hearing and vision screening	Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk	Sexually Transmitted Infection (STI) prevention counseling
Obesity screening and counseling	Tobacco Use screenings and interventions for all women, and expanded counseling for pregnant tobacco users	Tobacco Use screening and cessation interventions
Oral Health risk assessment	Syphilis screening for all pregnant women or other women at increased risk	Syphilis screening


(U.S. Preventative Services Task Force 2010)

# Changes in Private Insurance in 2014

Illinois has been called the “Wild, Wild West” when it comes to health insurance, since we have minimal regulation on our private insurance market. At present, insurance companies are allowed to deny coverage to individuals for any reason other than those related to “race, color, religion, or national origin.” The Affordable Care Act (ACA) will change this in 2014.

In 2014, a number of reforms will take place in the private insurance market. They include:

- Elimination of gender rating – Gender rating is a practice by which women are charged more for insurance compared to men, just because of their gender, even in situations when maternity coverage is not included.
- Elimination of pre-existing conditions – Health conditions will no longer be a reason for health insurance companies to deny coverage to individuals or to be used in the determination of the cost of coverage.
- Limits on age rating – Age will continue to be a factor, but the ACA limits the oldest person to be charged a maximum of three times what the youngest person is charged within the same health plan.
- Exchange – The competitive health insurance marketplace will be in effect starting on January 1, 2014. The Exchange will help consumers by requiring insurers to compete for their business in a transparent, easy-to-understand, and accessible manner.
- Premium tax credits – Eligible individuals with an annual household income less than 400% of the Federal Poverty Level will be able to apply for premium tax credits through the Exchange to help them pay for the cost of private insurance.
- Cost-sharing subsidies – Eligible individuals will be able apply for cost-sharing subsidies through the Exchange that will help with out-of-pocket costs.
- Elimination of annual limits – Individuals and group health plans will be prohibited from placing annual limits on the dollar value of coverage starting in 2014. However, annual limits can still be placed on grandfathered plans and on health services considered “non-essential”.




**Pre-Existing Conditions** - a health problem that existed before a person applied for a health insurance policy or enrolled in a new health plan. These conditions might include things like heart disease, cancer, type 2 diabetes, and asthma. Some insurers also classify accidental injuries, pregnancy, and previous caesarean sections as pre-existing conditions.

# Changes in Private Insurance in 2014 (continued)

- **Individual Mandate** – Starting in 2014, all individuals who can afford health care insurance are required to purchase at least a minimally comprehensive insurance policy. Individuals who choose not to purchase insurance coverage will be assessed \$695 per year or 2.5% of their income, whichever is higher, beginning in 2016.

The individual mandate will broaden the insurance pool and provide an incentive for most people to purchase coverage.



The law defines “those who can afford health care insurance” as people for whom the minimum policy will not cost more than 8% of their monthly income and who make more than the poverty line. The individual mandate will broaden the insurance pool and provide an incentive for most people to purchase coverage.



Oral health has been one of the most overlooked medical fields in America; however, the Affordable Care Act (ACA) addresses disparities in care by implementing a number of programs and benefits that gradually improve the quality of and access to oral health care.

## Improving access to oral health services

The ACA requires that insurance plans in the Exchange include oral care coverage for children, but not for adults. However, adults will be able to purchase a stand-alone dental coverage plan through the Exchange.

Preventive pediatric oral health services in new and non-grandfathered health plans must be provided without cost-sharing or co-pays for children. And new federal grant opportunities are authorized for school-based health centers to provide oral health services.

## Increasing education and awareness about the importance of good oral health

The ACA establishes a five-year, evidence-based public education campaign to promote oral health with a focus on childhood caries (which cause cavities), prevention, oral health of pregnant women, and oral health of at-risk populations.



# Oral Health (continued)

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## Training and increasing the number of oral health providers

The ACA establishes a five-year, 15-site, demonstration program to “train or employ” alternative dental health care providers. The definition of “alternative dental providers” is expected to include newly suggested dental professionals and others to be determined by the Secretary of the US Department of Health and Human Services.

The ACA creates a National Health Care Workforce Commission with oral health care workforce issues as a designated priority. This commission will increase eligibility for new grant programs in the Title VII Health Professions Programs to train dental and allied dental health professionals.

The new reforms will support stipends and loan repayments to institutions (including dental schools) which obligates trainees to serve in the National Health Service Corps, a network of providers working in communities with limited access to care. The ACA also authorizes grants to establish new primary care residency programs, including dental programs.



## State and Local

### Illinois Maternal and Child Health Coalition (IMCHC)

Statewide nonprofit policy and advocacy organization that produced this toolkit. Visit our website to download additional fact sheets and resources on the Affordable Care Act (ACA) and other helpful information. IMCHC also provides leadership to several projects that work on adolescent health, immunizations, infant mortality, health disparities, and premature infants.

<http://www.ilmaternal.org>

### Illinois Health Matters

Collaboratively produced website that provides information on the ACA, with specific information on how Illinois residents, small businesses, providers, and others will be affected.

<http://www.illinoishealthmatters.org>

### Campaign for Better Health Care

The Illinois Campaign for Better Health Care is a grassroots coalition of more than 300 local and statewide organizations representing consumers, health care workers and providers, community organizations, seniors, religious, labor, disability rights organizations, and other citizens concerned about health care and wellness.

<http://www.cbhconline.org>

### Health and Disability Advocates

Health and Disability Advocates uses multiple strategies to improve health care access and services for children, people with disabilities, and low-income, older adults.

<http://www.hdadvocates.org>

### Sargent Shriver National Center on Poverty Law

As a law advocacy center, the Shriver Center provides information on the implications of health care reform, and also presents information on how policies will affect Illinois residents.

<http://www.povertylaw.org>

### Health care reform in Illinois

Information provided by the State of Illinois about how the ACA will impact Illinois residents.

<http://www2.illinois.gov/healthcarereform/>

# Resources

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## [Illinois Department of Healthcare and Family Services](#)

The Illinois Department of Healthcare and Family Services administers Illinois' Medicaid, All Kids, and other public health insurance programs. They will play a leadership role in the Medicaid expansion and in changes to the service delivery system.

<http://www2.illinois.gov/hfs>

## [Illinois Department of Insurance](#)

The Illinois Department of Insurance regulates private insurance products offered in Illinois. This website provides an overview of how the ACA will affect private insurance in Illinois, includes news and highlights as to how insurance will change, as well as who to contact for more information.

<http://insurance.illinois.gov/hirc>

## National

### [HealthCare.gov](#)

Healthcare.gov is the federal government's website that helps explain how the ACA will affect different populations. The website provides easy-to-understand information that can be emailed or downloaded, as well as several tools to compare providers and facilities.

<http://www.healthcare.gov/>

### [Children's Dental Health Project](#)

The Children's Dental Health Project designs and advances research-driven policies and innovative solutions by engaging a broad base of partners committed to children and oral health, including professionals, communities, policymakers and parents.

[http://cdhp.org/cdhp\\_healthcare\\_reform\\_center](http://cdhp.org/cdhp_healthcare_reform_center)

### [Community Catalyst](#)

Community Catalyst is a national advocacy organization that has been giving consumers a voice in health care reform for more than a decade. They provide leadership and support to state and local consumer organizations, policymakers and foundations that are working to guarantee access to high-quality, affordable health care for everyone.

<http://www.communitycatalyst.org/>

### Enroll America

Enroll America works to ensure that all Americans are enrolled in and retain health coverage. They are a collaborative organization, working with partners that span the gamut of health coverage stakeholders—health insurers, hospitals, doctors, pharmaceutical companies, employers, consumer groups, faith-based organizations, civic organizations, and philanthropies—to engage many different voices in support of an easy, accessible, and widely available enrollment process.

<http://www.enrollamerica.org/>

### Families USA

Families USA is a national nonprofit, non-partisan organization dedicated to the achievement of high-quality, affordable health care for all Americans. Working at the national, state, and community levels, they have earned a national reputation as an effective voice for health care consumers for 25 years.

<http://www.familiesusa.org/>

### Georgetown University Center for Children and Families

Georgetown’s Center for Children and Families (CCF) is an independent, nonpartisan policy and research center dedicated to expanding and improving health coverage for America’s children and families.

<http://ccf.georgetown.edu>

### Kaiser Foundation Health Reform Source

The Kaiser Family Foundation serves as a non-partisan source of facts, information, and analysis for policymakers, the media, the health care community, and the public. Their health care reform page provides news, research and analysis about the ACA. Information provided also includes history, timeline, and state specific information about health care reform.

<http://healthreform.kff.org>

### National Center for Health Reform Implementation - Association of Maternal & Child Health Programs

The Association of Maternal & Child Health Programs is a national resource, partner, and advocate for state public health leaders and others working to improve the health of women, children, youth and families, including those with special health care needs. Their National Center for Health Reform Implementation offers information about how health care reform will improve health of women, children and families, by increasing access to quality health care and promoting health and wellness.

<http://publish.amchp.org/Advocacy/health-reform/>

# Resources (continued)

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## National Immigration Law Center

The National Immigration Law Center is a leading expert on immigration, public benefits, and employment laws affecting immigrants and refugees. Policy documents and issue briefs about how these populations are affected by the ACA are available from their website.

<http://www.nilc.org/immspbs/health/index.htm>

## Small Business Majority

Small Business Majority is an advocacy group founded and run by small business owners to focus on solving the biggest problems facing small businesses today. They actively engage small business owners and policymakers in support of solutions that promote small business growth and drive a strong economy. Their website includes fact sheets and materials that can be used to help educate small businesses on opportunities in the ACA, along with a calculator to help estimate potential tax credits.

<http://www.smallbusinessmajority.org/>

## Young Invincibles

The Young Invincibles represents the interest of 18-34 year-olds to ensure that their voice is heard when decisions are made about their future. They have been active in mobilizing and sharing information related to how this population will be affected by the ACA.

<http://www.younginvincibles.org/>

# Glossary

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Below are some words and phrases used in this toolkit and commonly used in conversations about health reform. If you have other terms that you think should be included, please email [ACAtoolkit@ilmaternal.org](mailto:ACAtoolkit@ilmaternal.org).

[Affordable Care Act \(ACA\)](#) – This is the comprehensive health care reform law enacted in March 2010. The law was enacted in two parts: the Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name “Affordable Care Act”, or ACA, is used to refer to the final, amended version of the law.

[Affordability Credits](#) – Starting in 2014, individuals and families who do not qualify for Medicaid but who do not make enough money to purchase individual insurance and do not receive insurance through their employers will be eligible for affordability credits to help them purchase coverage on the new competitive health insurance marketplace (aka the Exchange). Families may earn up to 400% of the federal poverty level and still receive affordability credits. These are also referred to as premium tax credits.

[All Kids](#) – All Kids is Illinois’ program for children who need comprehensive, affordable health insurance, regardless of immigration status or health condition. Families with income below 300% FPL may qualify. All Kids covers doctor visits, hospital stays, prescription drugs, vision care, dental care, and eyeglasses as well as regular check-ups and immunizations. Visit [www.allkids.com](http://www.allkids.com) or call 1-866-ALL-KIDS for more information.

[Annual Limits](#) – Yearly limits on the financial amount an insurance company is responsible for covering.

[Basic Benefits Package](#) – The ACA will standardize the benefits to be offered on insurance plans on the new competitive health insurance marketplace, so that everyone has access to the same basic level of coverage. All plans offering coverage on the Exchange must offer a plan that includes a basic benefits package.

# Glossary (continued)

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Cost-Sharing- The share of covered insurance costs that you pay out of your own pocket. This term generally includes deductibles, coinsurance and copayments, or similar charges, but it doesn't include premiums, balance billing amounts for non-network providers, or the cost of non-covered services. Cost-sharing in Medicaid and CHIP also includes premiums.

Consolidated Omnibus Budget Reconciliation Act (COBRA) – Gives employees and their families the option to continue health coverage after termination of work-sponsored health benefits. Beneficiaries of an existing group health plan (not for individual plans) have the right to stay under their health plan for a limited amount of time if termination of benefits was due to a qualifying event. For more information on COBRA please visit <http://www.dol.gov/ebsa/faqs/faq-consumer-cobra.html>

FamilyCare - FamilyCare offers health care coverage to parents living with their children 18 years old or younger. FamilyCare also covers relatives who are caring for children in place of their parents. Parents can get FamilyCare if they live in Illinois and meet the FamilyCare income limits. They must be US citizens or meet immigration requirements (legal permanent resident for at least five years in the US). Visit [www.familycareillinois.com](http://www.familycareillinois.com) or call 1-866-ALL-KIDS for more information.

Federal Poverty Level (FPL) - The set minimum amount of income that a family needs for food, clothing, transportation, shelter, and other necessities. In the United States, this level is determined by the US Department of Health and Human Services. FPL varies according to family size. The number is adjusted for inflation and reported annually in the form of poverty guidelines. Public assistance programs, such as Medicaid, define eligibility income limits as a percentage of FPL.

Gender Rating – The practice of charging women more than men of the same age and health status for health insurance.

Grandfathered Health Plans – These plans are exempt from some of the private insurance reforms enacted by the ACA because they were in existence prior to March 23, 2010.

Health Insurance Exchange – A new competitive health insurance marketplace also referred to as “the Exchange”. This is where individuals and small businesses can compare and purchase different insurance packages available to them based on zip code. Information will be posted on web portals administered by the state or federal government, and consumers may consult a telephone hotline and in-person advisors. State websites must be up and running by Fall of 2013 and be ready for public use by January 1, 2014.

Illinois Comprehensive Health Insurance Plan (ICHIP) – A health insurance plan for state residents available through the Illinois Department of Insurance and administered by private insurance for individuals who have pre-existing conditions and who have no other options available for insurance coverage.

Illinois Healthy Women – Program that covers family planning (birth control) and certain services provided at the family planning visit, such as the physical exam, pap tests, lab tests for family planning, testing and treatment for sexually transmitted infections found during a family planning visit, and sterilization. Illinois Healthy Women also covers mammograms, multivitamins, and folic acid if they are ordered by the doctor during the family planning visit. Family planning services are free; however, women may be required to pay a small co-payment for brand name vitamins or other medicines ordered by a doctor.

Individual Mandate - The requirement that all individuals who can afford health care insurance purchase at least a minimally comprehensive insurance policy. The mandate is intended to broaden insurance pools and foster a competitive insurance marketplace. Certain groups including Native Americans, undocumented immigrants, prisoners, and those for which insurance would cost more than eight percent of their monthly income, do not have to comply with the individual mandate.

Illinois Pre-Existing Condition Insurance Plan (IPXP) – A federally-funded temporary high risk pool, established by the ACA for Illinois residents who are US citizens who have been denied coverage due to a pre-existing condition and who have been without insurance coverage for at least six months. IPXP is funded entirely by federal funds and will only exist until 2014, since this is the year when private health insurance reforms will go into effect AND when the health insurance Exchange will be running, therefore, allowing for those with pre-existing conditions to gain fairer access to affordable health insurance coverage.

Lifetime Limits – Dollar limits on total lifetime spending for covered benefits set by insurers.

Medicaid – Medicaid is a state administered program and each state sets its own guidelines regarding eligibility and services. Medicaid is available only to certain low-income individuals and families who fit into an eligibility group that is recognized by federal and state law.

Medicare – A health insurance program for people age 65 or older, people under age 65 with certain disabilities, and people of all ages with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant). Medicare provides hospital insurance, medical insurance, and prescription drug coverage.

# Glossary (continued)

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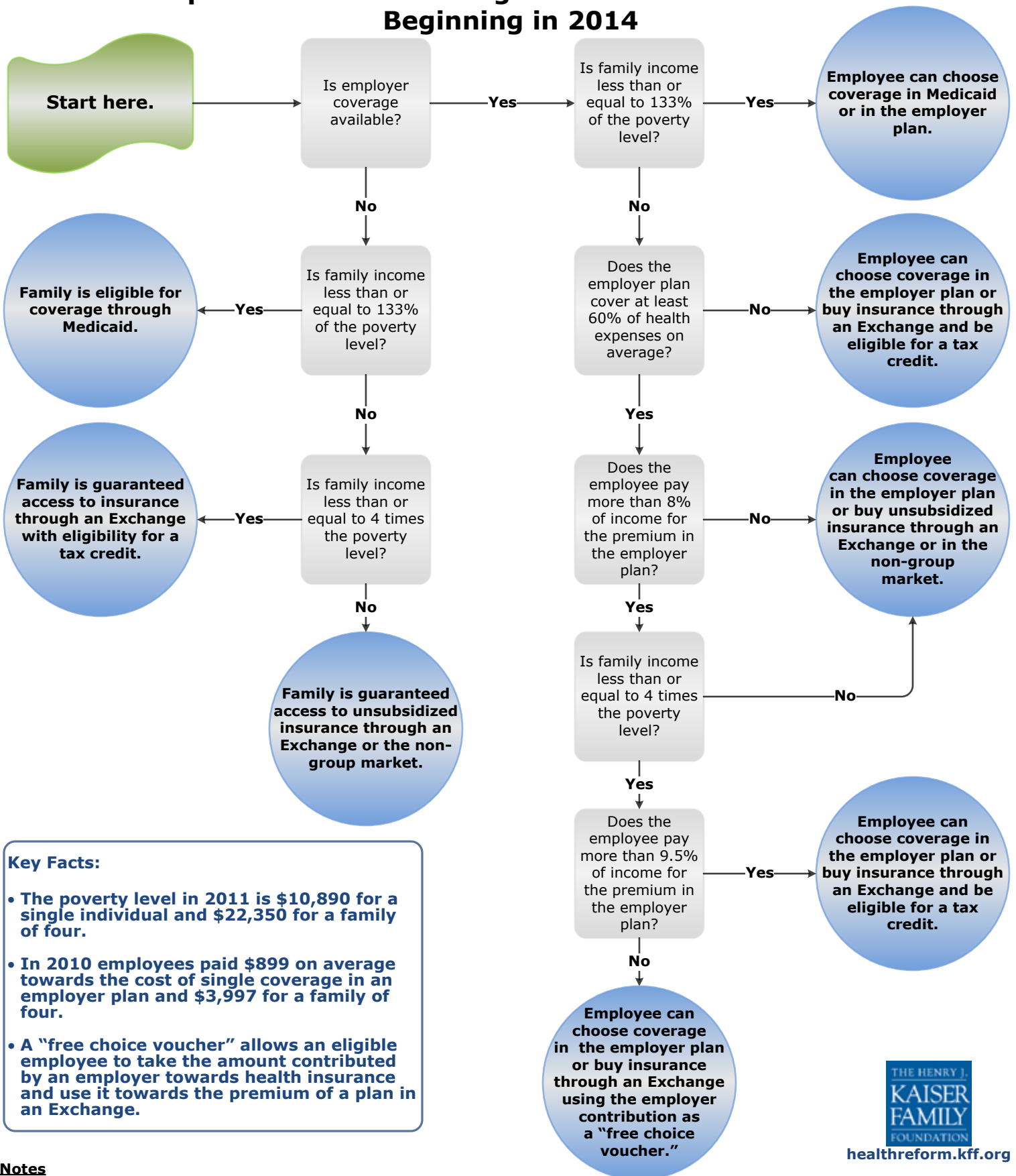
Navigators – Entities authorized by the ACA that will serve as guides to help individuals get health insurance through their state Exchange learn about their options and assist with enrollment.

Pre-Existing Condition – A health problem that existed before a person applied for a health insurance policy or enrolled in a new health plan.

Qualified Health Plans – Under the Affordable Care Act, starting in 2014, qualified health plans will be certified by an Exchange. These plans will provide essential health benefits, follow established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meet other requirements.

Rescissions – Insurance companies have been allowed to rescind or cancel coverage for treatment or care if an individual misrepresented his or her health status at the time of application, EVEN IF the misrepresentation was a mistake. Once an individual began to access his or her insurance policy for covered treatment, the insurance company would search for an error in the application. If an error was found, the company could retroactively cancel the policy and terminate coverage. An error could include a simple mistake or a forgotten illness, or could be due to an administrative coding error over which the patient had little control. Insurers will now have to prove that an individual intentionally lied on his or her application before they can rescind coverage.

# How People Get Health Coverage Under the Affordable Care Act Beginning in 2014



**Key Facts:**

- The poverty level in 2011 is \$10,890 for a single individual and \$22,350 for a family of four.
- In 2010 employees paid \$899 on average towards the cost of single coverage in an employer plan and \$3,997 for a family of four.
- A "free choice voucher" allows an eligible employee to take the amount contributed by an employer towards health insurance and use it towards the premium of a plan in an Exchange.

- Notes**
- Some states may have higher income eligibility levels for Medicaid.
  - In some cases, children may be eligible for public coverage through Medicaid or CHIP while their parents are covered through an employer or an Exchange.
  - Undocumented immigrants are ineligible for Medicaid and may not purchase coverage in an Exchange or receive a tax credit.
  - In general, people are required to obtain coverage or pay a penalty, but those whose health insurance premiums exceed 8% of family income (after tax credits or employer contributions are taken into account) will not be penalized if they choose not to purchase coverage.
  - Employees are eligible for "free choice vouchers" if they must pay 8-9.8% of income for employer coverage, so employees facing premiums of 9.5-9.8% of income under an employer plan are eligible to buy coverage in an Exchange using a free choice voucher or receive a tax credit.
  - Regulations specifying how dependents of workers with employer coverage available are treated have not yet been issued.
  - Small businesses may choose to buy insurance through newly created SHOP Exchanges or directly from insurers.



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