ElderLaw Advisor

This publication is provided by:
Nale Law Offices • Waterville, Maine 04901 • 660-9191
Visit our website at: www.nalelaw.com

Vol. XIII No. 2 Member, National Academy of Elder Law Attorneys Summer 2015

Report on the Patient Protection and Affordable Care Act a/k/a Obamacare

After a 4-year rollout, the Patient Protection and Affordable Care Act (ACA) reached full implementation on January 1, 2014. The ACA fundamentally changes the American health care system by creating new standards for health insurance policies, reducing the number of uninsured Americans, increasing accountability for health care costs, and rewarding medical professionals who produce positive patient outcomes.

The ACA goes right to the heart of the role of government in people's lives. Not since the New Deal of the 1930s or the establishment of Medicare and Medicaid in 1965 has the government's role in the intended welfare in its citizenry been more legislatively pronounced.

The ACA comprises consumer provisions, industry provisions, and regulatory provisions. The consumer provisions are designed to bring the American people greater access to and more choices in affordable health care and to ensure accountability of those providing their health care. The ACA also comprises industry provisions, such as hospital reporting requirements, recordkeeping, required safety measures, and cost controls. The regulatory provisions cover government action as it relates to oversight, revenue allocation, and collection and the relationship between the states and the federal government. This article focuses on the consumer provisions of the ACA.

FUNDAMENTAL CONSUMER PROVISIONS OF THE ACA

The ACA, along with all of its rules, is already an enormous body of law. The following sections detail ACA consumer provisions.

A. Resources for ACA Advocacy and Utilization

The ACA is a big new law that includes a mass of new statutes, regulations, court decisions, and variances that differ from state to state and county to county. The ACA creates education and training programs, uniform insurance plan explanations, and affordable health insurance

continued on page 2

"A failure to plan is a plan to fail."
~ Benjamin Franklin

JOHN NALE

MARK NALE

Report on the Patient Protection and Affordable Care Act, *continued from page 1*

exchanges, also known as health insurance external appeals.

1. Affordable Health Insurance Exchanges or Marketplaces

Affordable health insurance exchanges (also known as health insurance marketplaces) are designed to make buying health insurance affordable and easier for consumers, despite an array of confusing choices. The exchanges allow individuals and small businesses to compare health insurance plans, get answers to questions, find out if they are eligible for tax credits for private insurance or health programs such as the Children's Health Insurance Program or Medicaid, and enroll in a health plan that meets their needs. Some states have created their own federally funded exchanges, while other states, purposely or by default for not having created one, rely on the federal exchange.

2. Due Process Right of Appeal

The ACA includes a uniform process for the appeal of health care decisions made by private insurers. The patient can petition the insurer to reconsider a decision to deny payment for a service or treatment through an internal appeals process. If the insurer still denies payment after considering the patient's appeal, the ACA gives the patient the right to an external appeals process. The external appeal is conducted by an independent review organization, which decides whether to uphold or overturn the insurer's decision. If the external review overturns the insurer's denial, the insurer must make the payment for the service or treatment.

3. Consumer Assistance Programs

Most states have long offered help to consumers with health insurance problems. The ACA seeks to improve these services with grants that help states create a new type of resource, Consumer Assistance Programs. The states and territories that apply for these grants receive funds to provide residents direct help with problems or questions about health coverage.

4. Summary of Benefits and Coverage and Uniform Glossary.

The ACA makes it easier for consumers to compare insurance plans. For the first time, all health insurance companies must prepare and distribute a uniform Summary of Benefits and Coverage (SBC) and a uniform glossary defining terms and presenting examples of covered events and the costs to the consumer. All insurance companies must use the same standard SBC form to help consumers make an "apples-to-apples" comparison of health insurance plans among different companies. The SBC does for health insurance what the Nutrition Facts label has done for packaged foods. The SBC enables consumers to make simple comparisons in a familiar way. All health plans must provide a uniform glossary and an SBC to consumers and enrollees at important points in the enrollment process, such as upon application and at renewal.

B. Electronic Health Records

Adoption of electronic health records and uniformity of systems across health care provider platforms is expected to reduce medical mistakes, speed up treatment and diagnosis, and allow for greater portability of information. The health care system is mired in paper with surprisingly little ability to communicate data among providers, but this is changing.

C. Guaranteed-Issue Health Insurance and the Forgiving of Pre-Existing Conditions

As of January 1, 2014, health insurance plans can no longer limit or deny coverage to any person based on a pre-existing condition. This is

ElderLaw Advisor is written by John E. Nale, Esq. & Mark J. Nale, Esq. This newsletter is published as a service of Nale Law Offices, 58 Elm Street, Waterville, ME 04901. This information is for general informational purposes only and does not constitute legal advice. For more information please consult Nale Law Offices at 660-9191 or visit our website at www.nalelaw.com.

a sea change that redefines insurance in the United States – and not only for people with disabilities. Prior to the ACA, most insurance plans openly and proudly refused or limited insurance on the basis that a disability was a pre-existing condition.

D. Doctor Choice and Emergency Room Access

The ACA allows the patient to choose the primary care doctor from the health plan's provider network. Even in cases in which other referrals may be necessary in HMO plans, the ACA guarantees that women can see an obstetrician/gynecologist without needing a referral from another doctor. The law also mandates that the patient can seek emergency care at a hospital outside the health plan's network without prior approval from the plan.

E. Abrogation of Lifetime and Annual Limits

The ACA prohibits health plans from putting an annual or lifetime dollar limit on the cost of any essential health care. Before the ACA, in addition to a lifetime limit, many health plans set an annual coverage limit. Prior to the ACA, the patient was required to pay the cost of all care exceeding those limits. If the patient could not pay, care was commonly denied, even after treatment began. Plans can still put an annual dollar limit and a lifetime dollar limit on spending for health care services that are not considered essential.

F. Young Adult Coverage

Under the ACA, if a plan covers children, parents can add a child to or keep their child on their health insurance policy until the child turns 26. Before the ACA, insurance companies could remove a child from policies usually at age 19 or at a slightly older age if the child was a full-time student. The ACA makes the status of the child irrelevant. A child can enroll in or remain on a parent's plan whether or not the child is a dependent, married, living with the parent, attending school, employed where a group plan is offered, or eligible to enroll in his or her own plan.

G. Preventive Care Explanation

Under the ACA, people are eligible for a greatly expanded list of preventive health services designed to help avoid illness and improve health. This is part of the ACA effort to cost shift from treatment to prevention where it makes sense to do so. To encourage use of preventive services, no copayment, coinsurance, or deductible is necessary to receive recommended preventive health services, such as screenings, vaccinations, and counseling. Some preventive services are offered as age specific and others are available to all patients.

H. Mandatory Health Insurance

The ACA gives Americans the right to expect health care coverage just as they have the right to expect to be beneficiaries of public services such as roads, schools, police, the military, and libraries. Following from the establishment of Social Security, Medicare, and Medicaid, the ACA manifests the right of all Americans to health care.

continued on page 4

What is Elder Law?

Nale Law Office is an elder law firm. We represent older persons, disabled persons, their families, and their advocates. The practice of elder law includes estate planning, estate and trust administration, powers of attorney, advance medical directives, titling of assets and designations of beneficiaries, guardianships, conservatorships, and public entitlements such as Medicaid/MaineCare, Medicare, Social Security, SSI, VA disability planning, care management, and fiduciary services.

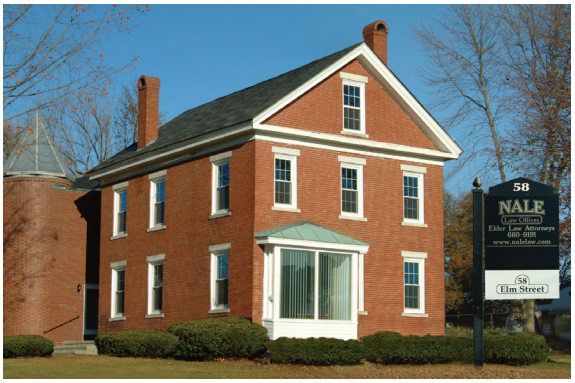
What Can We Do For You?

We frequently provide lectures for various groups in central and mid-coast Maine. A few suggested topics include estate planning, long-term care planning, MaineCare benefits, long-term care insurance and reverse mortgages. If your group is interested in any of these topics, please contact us at 207-660-9191 or sign-up at our website at www.nalelaw.com.

NALE LAW OFFICES
58 Elm Street
Waterville, Maine 04901

ELDERLAW ADVISOR

• Report on the Patient Protection and Affordable Care Act



Report on the Patient Protection and Affordable Care Act, *continued from page 3*

Under the ACA, most Americans were required to have health coverage by January 1, 2014. Non-compliant individuals are subject to paying a penalty that is being phased in through 2016.

I. Cost of Insurance

One of the most common questions asked by advocates and consumers is "How much will I have to pay for insurance?" The ACA implements new cost controls by limiting insurers' profits and overhead. Other factors in the plans' cost-effectiveness for consumers include subsidies, credits, and cost regulation.

1. Rebates and the Medical Loss Ratio

The ACA curbs health insurance costs in part by limiting the medical loss ratio. The medical loss ratio is the amount insurers spend on administrative overhead, marketing costs, and profit. The ACA limits how much of each premium dollar the insurer can spend on things other than providing health care and improving its quality. If the insurance company exceeds that limit, it must provide a rebate of the excess premium dollars.

2. Plan Levels

There are four levels of plans available on every exchange. Bronze plans pay 60 percent of health care costs, silver plans pay 70 percent, gold plans pay 80 percent, and platinum plans pay 90 percent. Employer-sponsored plans cover, on average, about 85 percent of health care costs, bringing employer-sponsored plans somewhere between the gold and platinum levels. Health care costs not covered by the plans are paid by the insured as deductibles and copays. Premium costs are lower for bronze plans and highest for platinum plans.