

Understanding Health Insurance Coverage under the Affordable Care Act

This fact sheet is intended to summarize some of the protections in place under the Patient Protection and Affordable Care Act (ACA) so that you understand how the law affects your healthcare. Although the ACA (also commonly known as “Obamacare”) was signed into law by President Obama on March 23, 2010, it was implemented over the span of several years. Many lawmakers have attempted repeal the ACA unsuccessfully, but some parts of the ACA were changed through provisions in a tax law passed in late 2017. Those changes are highlighted below. Keep in mind that health care law is rapidly changing; for the most up to date information, contact the CLRC.

How do I find a new insurance plan?

Prior to the ACA, if you did not have insurance through your employer or a family member’s employer, or did not qualify for government-based health coverage, you had to buy insurance privately through a broker or directly from an insurance company. Not only was this process confusing, it was also expensive. The ACA established a “marketplace” (also called an “exchange”) where you can buy and compare health insurance for yourself and your family. The main health insurance marketplace is run by the federal government, and you can access it at www.healthcare.gov. However, some states have set up their own marketplaces. When you enter your information on [healthcare.gov](http://www.healthcare.gov), you will be directed to your state’s marketplace if your state has its own.

Plans in both the federal and state marketplaces are sold as different tiers of coverage, often referred to as the “metal tiers” because of their names (bronze, silver, gold, and platinum). The tiers of coverage are based on the percentage of your health care costs that the policy will cover. For example, bronze plans will cover 60% of your health care costs, silver covers 70%, and so on. As a result, bronze and silver plans usually have the least expensive monthly premiums, while gold and platinum plans generally have the most expensive monthly premiums. Be sure to compare costs of health plans and ask your health providers which insurance plans they accept if you want to keep your same doctors. You may want to compare out of pocket costs like copays and deductibles, as well as the monthly premiums and provider networks, in order to decide what plan is best for you.

Can I be denied insurance coverage or charged more because I have/had cancer?

Before the ACA, health insurance companies could charge you more or could deny you coverage altogether if you had a pre-existing condition such as cancer. As of January 1, 2014, health insurance companies are no longer allowed to take your medical status into consideration when determining whether to insure you and/or how much to charge. Health insurance companies are now only able to consider four things when setting premium rates: age, geographic location,

number of people insured, and in some states, tobacco use. Additionally, there are limits to how much more insurance companies can charge people based on age. It is important to keep in mind that the ACA's rule on pre-existing conditions applies only to health insurance, and not life, long-term care, or disability insurance.

Do health insurance plans have to cover preventive services?

The ACA requires all health plans created after March 23, 2010 (“non-grandfathered”) to cover certain preventive services such as screenings, vaccinations, and counseling, without needing to pay a copay, coinsurance, or meet a deductible. However, only *screening*, not diagnostic tests, are considered “preventive.” If you have been diagnosed with cancer and later need a scan or test on that same part of the body, the health provider would likely consider the test diagnostic rather than preventive, and would bill you accordingly. For example, a mammogram may be covered with no cost sharing for women over a certain age, but if the same woman was previously diagnosed with breast cancer, further mammograms might not be considered “preventive screenings.” You must also be sure the provider you want to visit is in your insurance network. If your plan is grandfathered, these preventive services may still be covered by your policy, but you may have to pay a copay or deductible.

Under the ACA, certain preventive services also must be covered by Medicare free of cost. However, the preventive services that apply to Medicare are different from the list of preventive services that apply to private plans.

What type of medical care does my health insurance have to cover?

Under the ACA, health insurance plans must cover certain “essential health benefits.” These essential benefits include: ambulatory patient services (outpatient care), emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drug coverage, rehabilitative and habilitative services and devices (devices and services for people with injuries or disabilities), laboratory services, preventive and wellness and chronic disease management, and pediatric services such as oral and vision care. The specific treatments included in each category may vary by state. Plans may offer additional benefits beyond these ten essential benefits, so if you are shopping for new insurance, be sure to compare each plan to see what additional benefits are included.

What resources are available to help me afford my insurance premiums?

When you apply for health insurance on the marketplace, you will be asked to estimate your income for the following year, and will be notified if you qualify for Advance Premium Tax Credits (APTC) that would lower the cost of your monthly payment (“premium”). These tax credits are available to help make your monthly insurance premiums more affordable. APTC are generally available to people with incomes below 400% of the Federal Poverty Level who are not eligible for Medicaid or Medicare and do not have affordable employer-sponsored health insurance.

Medicaid is a state-run federal health insurance program, which provides free or low-cost health care to those who qualify. Before the ACA, to qualify for “traditional” Medicaid, you had to (1) meet income and asset requirements and (2) belong to a category of eligible individuals (i.e. disabled, pregnant, child). Under the ACA, Medicaid was “expanded” to cover a new population: low-income individuals age 19-64, regardless of additional categorical eligibility. Eligibility for expanded Medicaid is based on your Modified Adjusted Gross Income (“MAGI”). States can decide whether to offer expanded Medicaid, so if you live in a state that has not opted in to Medicaid expansion, you will have to continue to meet the requirements for traditional Medicaid. Additionally, if you are 65 or over or disabled, you will have to meet traditional Medicaid requirements. Contact your state Medicaid agency to determine your eligibility into Medicaid.

Can insurance companies set lifetime or annual limits on my health care?

Prior to the ACA, insurance companies would impose annual and lifetime limits on plans, meaning once the insurance company paid the maximum amount allowed in the policy, your insurance coverage would essentially end, leaving you responsible for all costs beyond those limits. Cancer care is very expensive, so these limits were a huge problem for people with serious (expensive) medical conditions. Under the ACA, insurance companies can no longer impose lifetime limits or annual limits on essential health benefits (see above). Individual grandfathered plans are not subject to the rule about annual limits, so those plans can impose annual limits on coverage. If you have a grandfathered individual health plan, you may want to buy a new health plan on the marketplace to avoid the annual limit. Insurance companies can still put lifetime or annual limits on health care that is not considered an essential health benefit.

What are my rights if my insurance company refuses to pay a claim?

If your insurance company denies coverage for a service you think is supposed to be covered, you can appeal that decision. The ACA strengthened appeal rights for consumers. The law sets specific deadlines for decisions made by insurance companies, and gives individuals the right to an external appeal (“independent medical review” or “IMR”). An external appeal or IMR is a review of your appeal by a third party who has no relation your health insurance company. That means if you appeal a decision by your insurance company, and the company still denies your appeal, you can ask an independent reviewer to look at the decision, and independent reviewer will have the final say in the decision. Your health plan is required to notify you of the reason for any denial and of your right to file both an internal and external appeal, as well as notify you of deadlines. This provision on external appeals does not apply to grandfathered plans. However, if you have a grandfathered health plan, you may still have external appeal rights under state law, depending on where you live. To determine how to file internal and external appeals, check with your state’s department of insurance.

Can my health insurance company cancel my policy?

Prior to the ACA, health insurance companies would sometimes rescind (cancel) health insurance policies retroactively based on mistakes made on the application – meaning, the policy would be cancelled back to the date of the mistake. Consumers were often surprised by retroactive cancellations and were surprised to learn that they were now responsible for medical bills that they thought would be covered under their now-cancelled policy. Now, insurance companies can only cancel your policy if you committed fraud or intentionally misrepresented facts on your application or if you fail to pay your monthly premiums.

When can I buy an individual health insurance plan?

The yearly enrollment period to buy a new health plan through the federal or state insurance marketplace is called “Open Enrollment,” and refers to November 1 – December 15 of each year. Some states that offer their own marketplace have open enrollment periods that extend beyond those dates, so it is a good idea to check open enrollment dates in your state each fall.

A “Special Enrollment Period” (SEP) may be available to you if you had a qualifying life event in the last 60 days such as: losing insurance coverage, getting married, having a baby, turning 26, moving to the United States, or moving to a new zip code or county.

If you qualify for Medicaid, you can apply at any time. Medicaid does not have a limited time to enroll so the special and open enrollment rules are only for buying health insurance on the marketplace. Medicare has different enrollment periods as well.

Does my employer have to provide health insurance?

It depends. Large employers (those with 50 or more full-time employees) are required to provide affordable minimum essential health coverage to full-time employees and their dependents. You are considered a full-time employee for purposes of this law if you work at least 30 hours per week on average. If your employer does offer group health insurance to its employees, you cannot be required to wait more than 90 days to enroll in the group plan.

Will I have to pay a penalty if I do not have health insurance?

Maybe. The individual mandate was an important part of the ACA, designed to encourage healthy people to enter the insurance market to bring costs down for insurance companies, who are now required to cover anyone without regard to health status or pre-existing conditions. Under the mandate, all individuals are required to have minimum essential health coverage, unless you qualify for an exemption. You may qualify for an exemption if you do not have to file a tax return because your income does not meet the tax filing threshold; if the cheapest coverage would be more than 8.16% of your income; if you have a financial hardship or other hardship that prevented you from getting health insurance. You may also qualify for an exemption if you are a U.S. citizen living abroad or a certain type of non-citizen or not lawfully present; or if you are in prison or jail; and some other exemptions exist. See www.healthcare.gov for a full list of current exemptions to the individual mandate penalty.

In December 2017, the tax penalty associated with the individual mandate was repealed. Effective in 2019, you will still be required (mandated) to have insurance, because the mandate itself was not repealed. However, you will not have to pay a tax penalty if you do not comply. Additionally, you must still report that you had creditable (minimum essential) coverage to the Internal Revenue Service (IRS) or request an exemption. You are still responsible for having insurance for the 2018 tax filing season, or risk a penalty of either \$695 for an adult, or 2.5% of the household income, whichever is higher.

Can my adult child stay on my health insurance plan?

Yes, until he or she turns 26. If your health insurance plan covers your children, they can stay on your health insurance plan until they turn 26 years old. It does not matter if your child is in school, lives with you, or even if the child is married. However, if your child is married, the child's spouse would not be covered under your insurance.

Do health insurance plans have to pay for clinical trial costs?

Most health insurance plans are required to cover routine patient costs for clinical trials. If you qualify for participation in an approved clinical trial for the treatment of cancer or any other life-threatening condition, you cannot be denied participation in the trial. Your referring provider must be a participating provider and determine that your participation in the trial would be appropriate, and you must provide enough scientific information to show your participation in the trial is appropriate. Health insurance companies do not have to pay for costs that would help determine your initial eligibility, but must pay for routine costs associated with the trial. States are not required to cover routine care costs of clinical trials for Medicaid recipients, and grandfathered plans are not required to cover routine clinical trial costs. However, many states already had clinical trial laws in place prior to the ACA, so check with your state's Department of Insurance to learn whether any state law provides you additional protection.

RESOURCES

For information about the different types of individual insurance plans:

<https://www.healthcare.gov/choose-a-plan/plans-categories/>

For information about preventive care services covered under the ACA:

<https://www.hhs.gov/healthcare/about-the-aca/preventive-care/index.html>

<https://www.healthcare.gov/preventive-care-adults/>

For information about covered preventive services under Medicare:

www.medicare.gov/coverage/preventive-and-screening-services.html

www.healthcare.gov/law/features/65-older/medicare-preventive-services/index.html

For information about health insurance coverage of clinical trials:

<https://www.cancer.gov/about-cancer/treatment/clinical-trials/paying/insurance>

For information about essential health benefits covered by insurance:

<https://www.healthcare.gov/coverage/what-marketplace-plans-cover/>

For information about lifetime and annual limits:

<https://www.healthcare.gov/health-care-law-protections/lifetime-and-yearly-limits/>

For information about Advance Premium Tax Credits that help lower premiums:

<https://www.healthcare.gov/glossary/advanced-premium-tax-credit/>

For information about the individual mandate penalty and exemptions:

<https://www.healthcare.gov/fees/fee-for-not-being-covered/>

<https://www.healthcare.gov/health-coverage-exemptions/forms-how-to-apply/>

<https://www.healthcare.gov/exemptions-tool/#/results/2017/details/short-gap>

For information about grandfathered insurance plans:

<https://www.healthcare.gov/health-care-law-protections/grandfathered-plans/>

<https://www.healthcare.gov/appeal-insurance-company-decision/>

For information about health insurance options and insurance appeals:

www.cancerlegalresources.org

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