THE AFFORDABLE CARE ACT:
Making Insurance Work

NATIONAL WOMEN'S LAW CENTER
EXPANDING THE POSSIBILITIES

Beginning in 2014, the Affordable Care Act (ACA) will be fully implemented, providing Americans with more choice and more control over their health care. Many individuals and families will have new access to insurance that works for their budget and that covers the services they need. Even people who hold health coverage today will enjoy new benefits, such as preventive services without cost-sharing, and those who currently purchase coverage in the individual market will have important new protections. Americans will no longer have to worry that they will be denied coverage because of a pre-existing condition or dropped from coverage when they get sick. They will know that their coverage won't run out when they need it the most and they won't have to worry that burdensome out-of-pocket expenses will prevent them from receiving the care they need.

This report looks at the ways in which the Affordable Care Act improves insurance coverage, ensuring that premium dollars go towards high quality, affordable, and reliable plans. We will also introduce a few of the millions of Americans who will benefit, and in some cases are already benefitting from, these health insurance reforms.

CARE YOU NEED WHEN YOU NEED IT

Guaranteed Coverage

Before the Affordable Care Act, insurers would deny coverage to people with so-called "pre-existing conditions." Pre-existing conditions can range from cancer, heart disease, and diabetes, to a childhood history of asthma or a high school knee injury. Insurers might exclude coverage for that particular condition, impose a waiting period before that condition can be covered, or refuse to provide coverage altogether. This means that people who need coverage most, those with chronic conditions or untreated health problems, aren't able to access coverage at all. But it also means that some perfectly healthy individuals who have a past illness or injury aren't able to buy the coverage they need to stay healthy.

According to the Department of Health and Human Services, up to 129 million non-elderly Americans have some type of pre-existing health condition.[1] Up to 1 in 5 of these individuals is uninsured. Many of these Americans have attempted to purchase coverage on the individual market and were turned down. In fact, 36 percent of individuals who tried to purchase coverage directly from an insurer were either turned down, charged more, or had specific conditions excluded from their coverage.[2]

Beginning in January 2014, health insurance plans can no longer deny coverage because of an applicant's medical history, exclude coverage of certain conditions, or impose a waiting period on coverage for those conditions.

More Options for Women with Pre-existing Conditions

Women are particularly at risk for being denied coverage because of a pre-existing condition. In addition to having higher rates of chronic disease, such as diabetes or arthritis, women are often denied coverage for conditions more common among, or exclusive to, women—such as pregnancy, having a C-section in the past, or planning on becoming pregnant. Some women have even been denied coverage because they have experienced intimate partner violence or sexual assault.

The Affordable Care Act ensures that being a woman is no longer a pre-existing condition. Starting in 2014, insurers will no longer be able to deny women coverage because of pregnancy, intimate partner violence, sexual assault, or any other "pre-existing condition."

***Erin M. of New Mexico** was uninsured after losing her job in 2009. In 2010, she got pregnant but couldn't find insurance that would cover her pregnancy in the individual market. Her husband was even denied coverage as an "expectant father." Erin is now self-employed and holds health insurance that she buys on her own, but she still does not have coverage for maternity care since she cannot afford to add a maternity rider on her insurance plan. Beginning in January, individual health plans will not be able to deny coverage to pregnant women, and they will be required to offer maternity benefits.*

More Options for Children with Pre-existing Conditions

Before the Affordable Care Act, even children were routinely denied coverage because of pre-existing conditions. Up to 17 million children have some type of pre-existing condition[3] and many of them have experienced coverage denials because of this, but that is not the case any longer. One of the first provisions of the Affordable Care Act to go into effect was an end to coverage denials for children based on pre-existing conditions. This provision is already helping families access the important and, in some cases, lifesaving care their children need.

***Doug T. of Texas** knew something wasn't right as soon as his son, Houston, was born. It turned out that Houston wasn't getting enough oxygen in his blood due to a rare congenital heart problem. Houston had his first surgery less than a week after his birth, and a few days later, the insurance company informed his family that they had denied him coverage because of his heart defect. The family had tried to apply for coverage prior to Houston's birth but were told they had to wait until he was born. Because of the Affordable Care Act, children like Houston will no longer be denied the coverage they so desperately need.[4]*

An End to Limits on How Much Your Plan will Pay

Prior to the Affordable Care Act, many plans imposed limits on the dollar amount they would cover during the year and during an individual's lifetime.[5] This practice was particularly widespread, with an estimated 100 million Americans enrolled in plans with lifetime limits. For patients with chronic conditions, illnesses that require lengthy treatments, or who have experienced costly accidents, this often meant that their coverage would run out during the time they needed it the most. For example, a recent survey found that 1 in 10 cancer patients reached the limit on what their plan would cover for cancer treatment.[6]

The Affordable Care Act ends the practice of lifetime and annual limits, meaning that plans will have to continue covering the full extent of care patients need. Lifetime limits are already prohibited and annual limits will be totally prohibited beginning in January of 2014.

*Doctors for **Aidyn B. of Wisconsin** discovered her congenital heart defect before she was even born. When she was 6 days old, Aidyn had her first surgery, followed by a cardiac catheterization at 10 days old. When she was not quite 1 year old, Aidyn had a 13-hour, open-heart surgery to do significant repairs to her heart—a long ordeal for Aidyn and her family, but a completely successful procedure that has enabled Aidyn to thrive.*

At age 5, Aidyn had already received approximately $750,000 worth of health care and was nearly halfway through her insurance policy's lifetime limit on benefits—and she faced valve-replacement surgery within the next few years, plus repeat surgery at 15 to 20 year intervals. But now, under the health insurance reforms within the Affordable Care Act, Aidyn and her family need not worry that she will run out of insurance coverage.

Insurers Can No Longer Drop You When You Get Sick

Prior to the Affordable Care Act, there was no guarantee that individual health insurance would be there when you needed it. In most states, insurance companies were allowed to drop enrollees from coverage or refuse to renew their coverage when they got sick. Six percent of cancer patients report being dropped from coverage as a result of their diagnosis,[7] and a recent federal investigation of three large insurance companies found 20,000 cases of dropped coverage over five years.[8]

Thanks to the Affordable Care Act, insurers are no longer allowed to drop or refuse to renew coverage because of a health condition. Now, you can be sure that your coverage will still be there when you need it the most.

***Jerome M. of South Carolina** was a college freshman when he was diagnosed with HIV. Although the diagnosis was scary for Jerome, he took comfort in the fact that he had health coverage that would cover his medical care. Before going to college, Jerome had purchased an insurance plan on the individual market, but his plan dropped his coverage shortly after diagnosis. Thinking his coverage had been dropped by mistake, Jerome contacted a lawyer to help him get his coverage reinstated. When that failed, a subsequent lawsuit revealed that his insurance company had been targeting people diagnosed with HIV to find reasons to revoke*

their coverage. As a result of the Affordable Care Act, patients like Jerome will no longer have to worry that insurers will drop their coverage when they get sick.[9]

***Jennifer L. of Colorado** was on the way home from the grocery story with her husband when a meth dealer fleeing police ran a stop sign and T-boned their car. Jennifer suffered a number of injuries including head trauma and broken limbs. She had purchased an insurance policy five months before the accident, but once the hospital bills began to come in, her insurer conducted a "review" of her original application and dropped her coverage. The reason they gave was that she failed to mention an emergency room visit and uterine prolapse episode in her original application. Jennifer was left with $200,000 in medical bills and no insurance for her and her two youngest children. Because of the Affordable Care Act, Jennifer's insurance company would no longer be allowed to drop her coverage.*[10]

Increased Accountability and Transparency Among Health Insurance Companies

Prior to the Affordable Care Act, insurance companies could use as much of your premium as they wanted on company profits and overhead. Now, 80 percent of your premium dollars must go toward your medical care and cannot be spent on administrative overhead or company profits. Insurance companies that don't meet that standard must refund consumers the difference. In fact, because of the law, insurance companies returned $1 billion to consumers in 2012. Further, if an insurance company wants to raise their rates more than 10 percent, the insurer must submit the increase to outside experts for review.

*As a young person just beginning her career, **Kate D. of Pennsylvania** works hard to cover her monthly expenses. She had no problem paying her share of the premium for her employer-sponsored plan, because she knows just how important having coverage is, but she certainly didn't have money to spare to pay for her insurance company's profits and overhead costs. Kate is one of the many Americans who received a rebate from her insurance company because of the Affordable Care Act. Kate put this money towards paying off her student loans and is now confident that her premium dollars are being used to pay for health care services, not profits and overhead.*

MAKING IT EASIER TO STAY HEALTHY

Coverage for Basic Services

Many health insurance plans on the individual market simply do not cover all the services people need, or do not cover all of their health care expenses. Plans frequently exclude critical services such as maternity care, mental health services, and prescription drugs. In addition, other plans, such as "mini-med" plans, major medical plans, and accident-only plans, offer limited coverage or coverage that applies to specific circumstances.

Maternity Care

Maternity coverage is largely unavailable in the individual market. In states where it is not mandated, only six percent of the health plans available to a 30 year old woman provide maternity coverage. Even when states that mandate maternity coverage are included in the calculation, the number only reaches 12 percent. Only nine states require all insurers on the individual market to cover maternity care.[11] Starting in 2014, the Affordable Care Act requires all new small group and individual plans to cover a certain set of essential health benefits that will include maternity care.

Behavioral Health Care

Nearly 20 percent of individuals who purchase their coverage on the individual market do not have coverage for mental health services and nearly one-third have no coverage for substance use disorder services.[12] Starting in 2014, the Affordable Care Act requires all new small group and individual plans to provide coverage for mental health and substance use disorder services that is comparable to coverage for medical and surgical care.

Prescription Drug Coverage

Forty-eight percent of Americans, including 1 in 5 children and 9 in 10 older Americans, report using at least one prescription drug in the past month, but many of these individuals have difficulty affording their prescriptions.[13] Over half of prescription drug users report that they have had to cut other household expenses or change how they manage their finances in order to afford their prescription drugs.[14] Starting in 2014, the Affordable Care Act requires all new small group and individual plans to cover a certain set of essential health benefits that will include prescription drugs.

Preventive Care Covered at No Cost to You

Cost-sharing is often a barrier to obtaining care. Studies show that even small changes in cost-sharing can significantly impact an individual's ability to access care. When cost-sharing is eliminated, individuals are much more likely to access preventive services.[15] The Affordable Care Act ensures that cost-sharing is no longer a barrier for individuals who want to stay up to date on important preventive screenings, services, and immunizations. Health plans are now required to cover a certain set of preventive services such as mammograms, pap smears, colon cancer screenings, and contraception without cost-sharing.

***Janis C. of New Hampshire** had good coverage while she and her husband were employed as real estate agents. But in the wake of the housing crisis, they both lost their jobs and with it the health insurance policy that covered their entire family—Janis, her husband, and their teenage son—for $700 a month. After searching diligently, she found a catastrophic policy that would cover herself and her husband for $600 a month. Unfortunately, this policy does not cover mental health services or prescription drugs, and has a $12,000 deductible. Janis's husband is on medication for a mental health condition, so the family must pay as much as $400 per month for his uncovered prescriptions. Thanks to the Affordable Care Act, which requires individual market plans to cover both prescription drugs and mental health care, Janis and her husband will be able to purchase coverage that meets their health care needs.*

***Gail G. of Minnesota** has been self-employed for 17 years, purchasing coverage for herself and her husband on the individual market. "My husband and I were paying high premiums for coverage that always felt inadequate," she says. Their policy covered only part of her husband's treatment for cataracts and kidney stones, leaving them with $18,000 in medical expenses that they had to pay using a home equity line of credit. This was on top of the $3,000 a year they paid for his prescription medications, since their policy did not include drug coverage. Beginning next year, health plans sold in the Marketplace will need to include prescription drug coverage. Gail and her husband will get the help they need to cover their prescriptions starting next year, but they are already benefitting from the Affordable Care Act's preventive services provision. Gail was thrilled to learn that because of the ACA, her insurance company was covering preventive services without cost-sharing. This new policy prompted Gail to schedule a colonoscopy. The procedure revealed that Gail had a precancerous polyp that was difficult to remove. Gail had to undergo two more colonoscopies and eventually colon resection surgery, but the polyp was successfully removed. Thanks to the ACA, Gail was able to get the preventive care she needed to help her avoid more costly and serious health problems down the road.*

*Immediately after **Adrienne A. of North Carolina** gave birth to her daughter Cora, both mother and daughter were rushed to the hospital with complications. Cora ended up being in the neonatal intensive care unit (NICU) for nine days, and her total hospital bills amounted to more than $160,000. Luckily, Adrienne had good coverage that covered all of her and Cora's needs. After going through this experience with Cora, Adrienne says she will never go without maternity coverage.*

Adrienne has started her own business, a life-long dream, but it's only part-time because she wants to keep her employer-sponsored insurance and does not want to go without maternity coverage ever again. Fortunately, under the Affordable Care Act, all plans in the individual and small group market will cover maternity care, so Adrienne can pursue her dream of running her own business full-time because she will be able to find coverage that meets her needs.

INSURANCE THAT WORKS FOR YOUR BUDGET

Cost continues to be the primary barrier to obtaining health insurance for people who lack insurance. Although most Americans have coverage through their employer, millions of Americans who are self-employed, work for companies that don't offer coverage, or are jobless have to rely on the individual market to purchase coverage. Coverage purchased on the individual market is significantly more costly than coverage purchased elsewhere.

> *Some segments of the population are much more likely to rely on individual insurance policies. One example is farmers and ranchers. 98 percent of farms in the United States are family operated, meaning that unless the owners work a second job, have access to employer coverage through a spouse, or qualify for a public insurance program, their only option is to purchase coverage through the individual market. Over a third of farmers and ranchers report that they purchased coverage on the individual market, compared with just eight percent of the population as a whole. And of those who purchase coverage on the individual market, 68 percent had monthly premiums over $500, compared to just 24 percent of people who had coverage through off-farm employment. The ACA will ensure that farmers, ranchers, and other hardworking Americans who don't have access to employer-sponsored coverage will have more affordable options available to them.*[16]

In fact, 40 percent of uninsured people cite cost as the number one reason they don't have health insurance.[17] The high cost of care not only prevents people from obtaining coverage, it prevents them from accessing health care services altogether. In 2012, 43 percent of adults, nearly 80 million people, reported cost-related problems getting needed health care, including not filling a prescription or not visiting a doctor when sick.[18]

The Affordable Care Act provides new opportunities for affordable insurance options:

- Individuals and families with incomes below 400 percent of the federal poverty level (currently about $45,900 for an individual and $94,200 for a family of four) who do not have access to affordable job-based coverage may be eligible for subsidies to help them purchase health plans through the new health insurance marketplace.
- In states that have chosen to accept federal funding to expand their Medicaid programs, people making less than 133 percent of the federal poverty level (currently about $15,300 for an individual and $31,300 for a family of four) will be eligible for Medicaid coverage.

In addition to this help with private and public coverage, the Affordable Care Act makes some important insurance market reforms that will make coverage more affordable. Two of the most important include restrictions on gender rating and health status rating.

***Lori O. of Illinois** has not had health coverage in 19 years. Lori cares for her elderly mother and works as a school crossing guard, making only $5,000 a year. Her job doesn't provide health coverage and she can't afford the $3,000 to $4,000 annual premiums she has been quoted. It took Lori five years to pay off a hospital bill after she was rushed to the ER with a severe asthma attack. Lori, who is pre-diabetic, pays for her test strips out-of-pocket and uses the computers at her local public library to research tips for managing her blood sugar. She has not had a pap smear or mammogram in nearly 15 years. Lori desperately wants health coverage so that she can manage her chronic conditions and get the preventive services she needs, but she simply can't afford it. Thanks to the Affordable Care Act, starting in January Lori will have new affordable insurance options available to her.*

An End to Gender Rating

Women in particular have a difficult time paying for health insurance because insurance companies charge women more than men. In a practice known as gender rating, insurance companies charge individual women and companies with a predominately female workforce more than they charge men for the same coverage. According to data from the National Women's Law Center, 92 percent of individual market plans practice gender rating, costing women collectively approximately $1 billion every year. One individual market plan charged women 85 percent more than men for the exact same coverage.[19] The Affordable Care Act ends this practice. As of January 2014, insurance companies will no longer be able to charge women or companies with a predominately female workforce more for their coverage.

After graduating from college, ***Hanh N. of Virginia*** *got a full-time job that did not provide any benefits—including health insurance. For years, her mom nagged her to get health coverage but it didn't hit home that it was critical until her sister was diagnosed with cancer at only 35 years old. Every time Hanh looked into the cost, it seemed impossible to afford. However, with the help of her family (and a lot of encouragement from her mom), she finally decided to buy health insurance directly from the insurance company. She checked out e-health insurance and picked a best-selling plan with a good provider network. At 25 years old, without any pre-existing conditions, the plan costs Hanh $122 a month, which is a lot when you're living paycheck-to-paycheck. If Hanh had been a man, the exact same plan would have cost her one-third less. She knew because she checked what the price would have been if she had marked "male" instead of "female." It would have only been $80 a month. The extra $500 a year is a lot of money for a young person with college loans.*

An End to Health Status Rating

Insurance companies have routinely charged people with health problems, including chronic conditions, more for their insurance coverage, a practice known as health status rating. Health status rating can happen at the time of enrollment, but it also happens after individuals are already enrolled, with insurance companies hiking up a customer's rates after they have become sick or injured. This has meant that the people who need coverage the most are often unable to afford it. But starting in 2014, insurance companies will no longer be able to base rates on an individual's health status. Instead, they will have to charge everyone the same premium regardless of their health history, with adjustments for age and (in some cases) tobacco use.

Jill H. of North Carolina *dropped her $200 per month catastrophic insurance plan after her policy covered only $400 of a $5,000 emergency room bill. A couple of years later, she developed a heart arrhythmia. While changing her lifestyle—for example, giving up her regular jogging routine to protect her heart, she searched for health insurance coverage so that she would be able to afford the surgery she needed—a $20,000 to $30,000 procedure. Blue Cross Blue Shield of North Carolina offered her an inadequate policy with a $1,100 per month premium, which she could not afford. Next January, health plans will not be able to charge sick people more for health insurance.*

Coverage with Lower Out-of-Pocket Expenses

Even when individuals can obtain coverage and afford the premiums, the care they need may still be out of reach. High deductibles or high co-payments can make health care unaffordable for individuals who have insurance. According to a recent survey, nearly 30 million people are insured but have such high out-of-pocket medical costs that they have difficulty affording the care they need.[20] In 2012, one-quarter of insured adults had a deductible of $1,000 or more.[21] These cost barriers can result in people going without the medical care they need or being unable to adhere to their treatment plans. For example, a recent study found that a 100 percent increase in prescription drug co-payments reduced prescription adherence by 25 percent.[22]

A number of provisions in the ACA will help lower out-of-pocket spending on health care services. These include:

- Caps on how much money patients will have to spend out-of-pocket each year on covered health care services.
- Coverage of preventive care without cost-sharing, including co-payments and deductibles.
- A user friendly Health Insurance Marketplace that will make it easier for consumers to compare plans' cost-sharing requirements and choose the plan that is right for themselves and their families.
- Cost-sharing credits for individuals with incomes below 250 percent of the federal poverty level (about $28,700 for an individual and $58,900 for a family of four) to help cover co-payments, co-insurance, and deductibles.

Elizabeth S. of Florida *continues to struggle with the medical debt her family incurred when their employer-sponsored health plan featured a high deductible and limited coverage. While they were covered by this policy, Elizabeth and her family were left responsible for 60 percent of the cost of a C-section delivery and 80 percent of the cost of caring for her son after an accident. Elizabeth notes that three-fourths of her family's debt is related to these out-of-pocket costs. Under the Affordable Care Act, plans for sale within the Marketplace must meet certain coverage standards to ensure that families do not bear the majority of their health care costs through excessive cost-sharing. In addition, if employer-sponsored plans do not offer coverage that meets these standards, workers and their families may qualify for premium subsidies to purchase coverage within the Marketplace.*

***Lauren M. of New Jersey** is a single mom who struggles to cover her cost-sharing responsibilities for her younger daughter, who was born with a genetic deficiency that affects her kidneys and her heart function, among other issues. Although both of her daughters have coverage through their father's health insurance, Lauren must cover more than $200 per month in co-payments and other cost-sharing because of her daughter's chronic needs. This represents a significant burden for Lauren, who works freelance so she can care for her daughter, and earns approximately $20,000 a year. Lauren lost her own health insurance when she got divorced, and worries about how to manage her own health when she doesn't have health coverage. Under the Affordable Care Act, Lauren and her daughters will qualify for help with premiums and cost-sharing.*

***Maureen B. of California** survived stage 4 lymphoma but is still struggling with medical bills from her illness. Her major medical policy not only featured a high deductible, but also refused to pay for many of her medical services. After a series of appeals to her insurance plan, and negotiations with her health care providers, Maureen paid more than $200,000 out-of-pocket for her cancer care. She lost her house, liquidated her savings and investments, and continues to carry more than $80,000 in credit card debt related to her medical bills. The Affordable Care Act establishes annual out-of-pocket maximums that ensure consumers are protected from excessive cost-sharing.*

Affordable Coverage for Young Adults

Although many people believe that young adults don't purchase health coverage because they think they don't need it, polls actually show that young adults want health coverage but often can't afford it or have trouble accessing it. The Affordable Care Act provides more coverage opportunities for young adults by allowing children to stay on their parent's insurance until age 26. Additionally, young adults will benefit from the ACA's full range of consumer protections and coverage opportunities, including the ban on pre-existing condition exclusions, requirements that plans offer comprehensive coverage, and tax credits to help them purchase health insurance. Nearly 83 percent of uninsured 18 to 20 year olds and over 70 percent of uninsured 21 to 27 year olds will be eligible for Medicaid or tax credits to help them purchase private insurance.[24] This means young adults will meet fewer road blocks when trying to access coverage.

***Ellen C. of Oregon** has an adult son who suffers from allergy-related asthma. Three years ago, a simple cold landed him in the hospital. By the time he was discharged, he had partially-collapsed lungs, an H1N1 infection, a fungal infection, and a $20,000 hospital bill. His health insurance, an accident-only policy through one of his employers, did not cover his treatment. In time, the hospital forgave the debt, but in Ellen's words, "it still isn't right that the hospital had to swallow the cost of the care my son received." Ellen's son was attending community college and working two jobs but couldn't afford coverage that was more comprehensive. Under the Affordable Care Act, Ellen's son will have more affordable coverage options available to him, won't be denied coverage because of his allergies and asthma, and will be able to find a plan that covers the services he needs.*

CONCLUSION

As these stories demonstrate, individuals across the country are already benefitting from the changes in the law and millions more stand to benefit once all provisions of the law are fully in effect. The Affordable Care Act gives individuals more choice and more control over their health care. Insurance companies can no longer deny coverage because of a pre-existing condition or put an annual or lifetime cap on coverage. And, after decades of premium hikes, the Affordable Care Act requires insurance companies to spend at least 80 percent of premium dollars on care and submit any rate increase over 10 percent for review. Additionally, all plans on the Health Insurance Marketplace must cover the important things like doctor visits, hospital stays, maternity care, emergency room care, and prescription drugs. And preventive care is covered at no cost to you, so small issues don't turn into major medical problems. From now on, Americans won't have to worry that they won't have the coverage they need to get and stay healthy.

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