

EVERY
ARTIST
INSURED

**Understanding
Health Care Reform**

about

The Artists Health Insurance Resource Center

AHIRC, a program of **The Actors Fund**, was created in 1998 with the support of the National Endowment for the Arts to help people in entertainment and the arts find affordable health care and health care coverage and reduce the number of uninsured artists. AHIRC offers in-person counseling in New York and Los Angeles, national telephone support, an internet resource database (www.ahirc.org) with over a half-million visitors each year and over 100 *Getting and Keeping Health Insurance* workshops held at arts, cultural and human services organizations throughout the country. This guide was written by **Renata Marinaro**, LMSW. For more information and copies of this booklet or any of our 18 city and regional health care guides call **917.281.5975** or visit www.ahirc.org.

The Actors Fund is a national human services organization that helps everyone – performers and those behind the scenes – in performing arts and entertainment. Serving professionals in film, theatre, television, music, opera, radio and dance, The Fund's essential programs include social services and emergency assistance, health care and insurance information, housing, and employment and training services. With offices in New York, Los Angeles and Chicago, The Actors Fund has – for over 130 years – been a safety net for those in need, crisis or transition. Learn more at www.actorsfund.org.

The laws, regulations, rules and policies on which the information in this guide is based may be subject to change. Before commencing, terminating or changing coverage you should confirm the information herein with the appropriate company, organization, or government agency. In no event will AHIRC or The Actors Fund be liable for any decision made or action taken by anyone in reliance upon the information contained in this guide.

Since its inception, the Artists Health Insurance Resource Center (AHIRC) has had a single mission: to help all artists in this country get quality affordable insurance for themselves and their families. The passage of the Patient Protection and Affordable Care Act on March 23, 2010 has brought us within reach of that goal. Because so many of its provisions are directed at the individual and small group market, where the majority of visual and performing artists and entertainment professionals who are ineligible for union insurance find themselves, it is critical that we understand how we can benefit from them. This booklet is a clear explanation in a simple question and answer format of the most significant programs and reforms within the law, with special emphasis on those that directly impact the lives of artists. Our hope is that it will be widely distributed, both as a booklet and as an online document, by arts and cultural organizations and in artist communities throughout the country. Our intention is to have every artist in America insured by 2014.

{ TIMELINE OF MAJOR PROVISIONS }

<p>07.01 2010</p>	<ul style="list-style-type: none"> • Those with a pre-existing condition who've been uninsured for 6 months or more can get subsidized coverage through the Pre-Existing Condition Insurance Program
<p>09.23 2010</p>	<ul style="list-style-type: none"> • Children under the age of 19 with pre-existing conditions can't be denied coverage • Young adults up to age 26 can stay on or enroll in their parents' coverage • Insurers can't retroactively cancel the policies of people who get sick • Lifetime dollar limits on medical benefits will be banned • All new plans must cover certain preventive services, such as mammograms and colonoscopies, without charging a deductible, co-pay or co-insurance • All new plans will provide consumers with a way to appeal coverage or claims determinations <p style="text-align: right;"><i>continued »</i></p>

2011	<ul style="list-style-type: none"> • Medicare recipients in the Part D “doughnut hole” will receive 50% off brand-name drugs; by 2019, the discount will be 75% • Annual wellness visits and certain preventive services will be free for Medicare recipients • Insurers must spend at least 80-85% of premium dollars on medical benefits and quality improvement. If they fall short, they must offer customers a rebate. • There will be additional funding for the continuation and expansion of Medicaid, Child Health Insurance Programs and community health centers
2014	<ul style="list-style-type: none"> • Insurers cannot refuse coverage to anyone • Most people will be mandated to have coverage, and penalties will apply if you don't • New insurance marketplaces, called Exchanges, will offer insurance to those who don't get coverage through their employer or a government program like Medicare or Medicaid • Subsidies and sliding-scale limits on out-of-pocket costs will be available to people who buy insurance through an Exchange and have incomes up to 400% of the Federal Poverty Level • Employers with 50 or more employees who don't offer coverage will pay a penalty • All new plans must offer an essential benefits package with limits on out-of-pocket costs • Medicaid eligibility will be expanded to include people with incomes up to 133% of the Federal Poverty Level • Annual dollar limits on medical benefits will be banned

{ CONSUMERS }

Do I have to have insurance?

Everyone will be required to have insurance, with some exemptions, beginning in 2014. Exemptions include: Native Americans, people who have been uninsured for less than 3 months, those with religious objections, undocumented immigrants, those for whom the least expensive option

would cost more than 8% of their income, and those who don't meet the tax filing threshold (currently \$9,500 for a single person). Those who do not meet these criteria and remain uninsured will pay a tax penalty. The penalty will be phased in: in 2014 it will be the greater of \$95 or 1% of household income. It will rise to \$695 per person (with a maximum of \$2,085 per family) or 2.5% of the household income in 2016.

How will the government know whether I have insurance or not?

The law doesn't specifically address this. Most likely, you'll be required to submit documentation that proves you have insurance when you file your taxes. If you don't have insurance, the IRS will notify you and explain your options. If you still refuse to enroll, the IRS will levy a penalty that will show up on your tax forms.

Can an insurance company refuse to sell me insurance?

Beginning in 2014, insurance companies will no longer be able to deny you coverage for any reason.

Is my employer required to offer me insurance and, if so, do I have to take it?

Employers do not have to offer coverage, but those with 50 or more employees will have to pay a penalty of \$2000 per full-time employee (in excess of 30 employees) if they don't. In addition, employers that offer coverage will be required to provide a voucher to employees with lower incomes if the cost of the premium for the employer-sponsored plan would amount to 8%-9.8% of their income. The voucher is meant to enable employees to enroll in a potentially less-expensive plan through an Exchange.

If you choose to opt out of your employer's coverage, you will still have to be insured or pay a penalty. Employees who are offered coverage and choose not to take it will not be eligible for subsidies to pay for coverage through an Exchange, unless the employer's plan fails to meet certain benefit guidelines, or the employee qualifies for the voucher program.

Can I keep my current coverage?

Yes. There is nothing in the new law that forces you to change your plan. Plans that were in effect on March 23, 2010, are grandfathered under the

law. Grandfathered plans do not have to offer free preventive services or guaranteed access to OB-GYNs or pediatricians (which new plans must do). However, beginning September 23, 2010, all plans – grandfathered or new – will:

- be required to offer adults up to age 26 coverage under their parents' policy
- be prohibited from retroactively canceling your coverage
- not be able to impose lifetime limits on your coverage

NOTE

Renewing a policy that was in effect on March 23, 2010, or adding someone to that policy, does not change its grandfathered status

I have a pre-existing condition and have been denied coverage. What does this law do for me?

Those who have been uninsured for 6 months or more and have been denied coverage can receive insurance through the Pre-Existing Condition Insurance Program. Pre-existing conditions will be covered upon enrollment, and premiums will be capped at the average cost of private policies in your area. The federal government will operate the Pre-Existing Condition Insurance Program in those states who choose not to create their own program. In 2014 insurers will no longer be able to deny anyone coverage and this program will end.

NOTE

Beginning September 23, 2010, children under age 19 who have pre-existing conditions cannot be denied coverage

Where will I buy insurance?

People who don't get coverage through their employer or programs such as Medicaid and Medicare can buy their own insurance directly from an insurer, a broker, or through what's called an Exchange. Exchanges are competitive, private insurance marketplaces which will be established in every state beginning in 2014. The idea is that you'll be able to compare plans and buy coverage on the Exchange website. Only plans that meet certain quality and affordability guidelines will be allowed to sell on the

Exchange. Exchanges will also administer new subsidies and help people enroll in Medicaid and the Children’s Health Insurance Program (CHIP).

Is there minimum coverage I’m required to buy?

All insurers must offer an essential health benefits plan. (Grandfathered plans are exempt from this mandate). The plan must:

- provide a comprehensive set of benefits, including hospitalization, outpatient services, mental health services, and pharmacy benefits
- cover at least 60% of the cost of those benefits
- limit annual out-of-pocket costs to \$5,950 per person and \$11,900 per family

NOTE

Out-of-pocket costs include deductibles, co-insurance and co-pays, but not premiums

In addition, plans offered through an Exchange and on the individual and small group markets will be standardized. There will be 4 benefit categories for all insurance plans. They will be categorized by the percentage of benefit costs they cover.

BENEFIT CATEGORY	% OF COSTS COVERED BY INSURER	CONSUMER’S MAXIMUM ANNUAL OUT OF POCKET COSTS (INDIV/ FAMILY)
Bronze (Essential Plan)	60%	\$5,950/\$11,900
Silver	70%	\$5,950/\$11,900
Gold	80%	\$5,950/\$11,900
Platinum	90%	\$5,950/\$11,900

There will also be a high-deductible, “catastrophic plan” for those up to age 30.

What will it cost to buy coverage through an Exchange? Will there be financial assistance if I can't afford it?

People who have low to moderate incomes will receive subsidies which will lower the cost of premiums and out-of-pocket medical costs. The amount of the subsidy will depend on your household size and income. For example, a single individual who makes \$21,000 per year will have their premium capped at 6.3% of their income (or approximately \$110 per month). Their annual out-of-pocket medical costs (excluding premiums) will be limited to a maximum of \$1,983 per year.

Federal Poverty Levels* 2010

HOUSEHOLD SIZE	ANNUAL INCOME LIMIT
1	\$11,170
2	\$15,130
3	\$19,090
4	\$23,050

* INCOMES ARE 100% OF THE FEDERAL POVERTY LEVEL

Premium subsidies

INCOME AS % OF FEDERAL POVERTY LEVEL	MAXIMUM % OF CONSUMER INCOME SPENT ON PREMIUMS
Up to 133% FPL	2%
133-150% FPL	3 – 4%
150-200% FPL	4 – 6.3%
200-250% FPL	6.3 – 8.05%
250-300% FPL	8.05 – 9.5%
300-400% FPL	9.5%

Out-of-pocket cost limits

INCOME AS % OF FEDERAL POVERTY LEVEL	MAXIMUM ANNUAL OUT-OF-POCKET COSTS
100-200%	\$1,983/person, \$3,967/family
200-300%	\$2,975/person, \$5,950/family
300-400%	\$3,987/person, \$7,973/family

Is there a limit to what I will have to spend for health care per year?

Your annual out-of-pocket costs will be limited to \$5,950 per person or \$11,900 per family. Out-of-pocket costs will be even lower for those with incomes under 400% of the Federal Poverty Level (currently \$44,680 for one person).

Are there special programs for people under age 30?

Adults under the age of 30 may enroll in a lower-cost, high-deductible “catastrophic” plan. Prevention benefits and 3 annual primary care visits will be exempt from the deductible.

Adult children under the age of 26 can enroll in their parents’ coverage. Those already on their parents’ coverage can stay on it up to age 26 (or longer, depending on state laws). Young adults don’t have to live at home, be students, or be claimed as dependents on their parents’ tax returns. The new law applies to married and unmarried children. However, if your employer offers you coverage, you cannot enroll in your parents’ plan.

NOTE

You can enroll any child who is under the age of 26 in your group coverage at the first open enrollment period following September 23, 2010. Ask your Human Resources department when the next enrollment period begins.

How will I be able to afford insurance if my income is low? I am single, have no kids, and earn less than \$14,000 per year.

Beginning in 2014, an individual who earns less than \$11,170 per year (\$23,050 for a family of 4) will be eligible for Medicaid. Medicaid is a joint federal-state program that provides comprehensive medical coverage at no or very low cost to members. Those who make more than \$11,170 per year but less than \$14,856 per year (\$30,656 for a family of 4) will be able to choose between enrolling in Medicaid or buying government-subsidized coverage through an Exchange.

What should I do if my insurance company cancels my coverage after I get sick?

Insurance companies are no longer allowed to retroactively cancel your coverage unless you committed fraud or intentionally misrepresented yourself on the application. If your insurer tries to do this, immediately file a complaint with your state insurance department.

Are there other consumer protections in the law?

Beginning September 23, 2010, insurers will no longer be able to put a lifetime dollar limit on the amount they will pay for your medical care, and annual limits will be phased out over the course of the next 3 years.

Will I still be able to use my local community clinic?

Yes. In fact, the new law includes additional funding for community clinics.

Will there be more coverage for preventive services?

If you or your family enrolls in a new health plan on or after September 23, 2010, your plan will be required to cover certain preventive screening services without charging you a co-pay, co-insurance or deductible. These services include blood pressure, diabetes, and cholesterol tests, cancer screenings (including colorectal, breast and cervical cancers), vaccines and immunizations, flu and pneumonia shots, HIV and STD testing, screenings for healthy pregnancies, regular well-child visits, and counseling on healthy lifestyle changes.

How will this be paid for? How does it reduce the deficit?

By cuts in spending and increased fees and taxes. The total cost over 10 years is estimated to be \$940 billion. These costs are financed through savings from Medicare and Medicaid, excise taxes on expensive insurance plans, a surtax on investment income from high earners, annual fees on the pharmaceutical and private insurance sectors, and other savings and revenue sources. It's estimated that the law will cover an additional 32 million Americans and ultimately reduce the deficit by \$120 billion.

{ EMPLOYERS }

Will I have to offer my employees insurance?

No. However, beginning in 2014, businesses that employ 50 or more people will be fined if they don't provide minimum essential coverage. The penalty will be \$2,000 for each employee beyond the first 30. For example, a business with 60 employees would be fined \$60,000 per year. Businesses with fewer than 50 employees won't be fined and can enroll their employees in coverage through an Exchange.

What is the new small business tax credit and how do I know if I'm eligible?

Businesses with fewer than 25 full-time equivalent employees with average yearly wages of less than \$50,000 may qualify for the Small Business Tax Credit. The credit is available beginning with the 2010 tax year. To receive the credit, the employer must offer a group health plan and pay at least 50% of the premium. The credit is equal to a percentage of what the employer pays. For 2010-2013, the maximum credit is 35% of the employer's contribution (25% for non-profits). Beginning in 2014, the maximum credit is 50% (35% for non-profits).

I am self-employed. How will the new law change my options?

Beginning in 2014, self-employed people must be allowed to purchase insurance on the small group market and will have the option of buying insurance through an Exchange. This will increase their options and potentially reduce costs for those with low to moderate incomes.

{ SENIORS }

Will my Medicare benefits be cut?

No. In fact, certain costs have gone down: those in the Part D "doughnut hole" currently receive a 50% discount on brand name drugs, and income thresholds for Part B premiums were frozen at 2010 rates.

I have a Medicare Advantage Plan. Will I be able to keep it?

Yes. However, the new law does cut government subsidies of these plans. Since Medicare Advantage plans are not guaranteed renewable, some insurers may decide to no longer offer Advantage plans, forcing enrollees to change insurers or return to traditional Medicare.

Will preventive care be free?

As of January 1, 2011 the following services are free under Medicare: blood pressure, diabetes, and cholesterol tests, certain cancer screenings (including colorectal, breast and cervical cancers), osteoporosis screenings, vaccines and immunizations, flu and pneumonia shots, HIV and STD testing, and counseling on healthy lifestyle changes.

I have a Medigap plan. Do I have to change it?

No. Medigap plans aren't affected by the reform.

{ GLOSSARY }

Annual limit – the maximum dollar amount payable by the insurer for covered expenses for the insured in one year.

Coinsurance – the amount you must pay for your portion of medical claims, usually expressed as a percentage. For example, if you have an 80/20 plan, your insurer will pay 80% of the contracted charges and you are responsible for 20%.

Co-payment – the flat dollar amount you pay for services, such as office visits, prescriptions, and exams.

Deductible – the annual amount a patient pays out-of-pocket before the insurer begins paying its share of claims.

“Doughnut hole” – also called the Medicare Part D coverage gap, the doughnut hole is when Medicare temporarily stops paying for your prescriptions. For example, in 2012, your initial drug coverage limit is \$2,930. Once you meet that limit you enter the coverage gap. You are then responsible for 100% of your drug costs until the total cost reaches \$6,657, at which point you will be responsible for only 5% of the cost of your drugs.

Employer mandate – the requirement that employers with 50 or more workers offer a health plan with an essential package of benefits, or pay a fine per employee.

Essential benefits – beginning in 2014, all plans sold through an Exchange and on the individual and small group markets must include the following benefits: hospitalization, outpatient services, maternity care, mental health and substance abuse services, prescription drugs, emergency care and preventive services.

Federal poverty level (FPL) – income levels based on family size that are often used by public programs to determine poverty status and eligibility for services. The Federal Poverty Level in 2010 is \$11,170 for 1 person and \$23,050 for a family of four.

Grandfathered plan – a health plan that an individual was enrolled in before March 23, 2010. These plans are not required to follow some of the rules and regulations enacted by the Patient Protection and Affordable Care Act.

Guaranteed issue – the requirement that insurers sell a policy to anyone who requests it, regardless of their health status, age or gender.

Exchanges – new, competitive marketplaces that will facilitate the purchase of a range of private insurance plans, all of which must provide certain benefits and meet cost standards. Exchanges will be open to qualified individuals and small employers.

continued »

High-deductible (“catastrophic”) plan

– a type of health plan that requires greater out-of-pocket spending by the consumer up front before the insurer pays its share of benefits. These plans generally have lower premiums.

High risk pool – a state-run insurance plan, also known as the Pre-Existing Condition Insurance Program, for people with pre-existing conditions who have been uninsured for 6 months or more. It is temporary and will end in 2014.

Individual mandate – the requirement that every person, with some exceptions, have health insurance.

Lifetime limit – the maximum dollar amount (for example, \$1 million) payable by the insurer for covered expenses for the insured over the course of his/her life.

Medicaid – a joint state and federal program that insures people with low incomes. Medicaid is comprehensive and includes hospitalization, outpatient visits, and drug benefits. There are no premiums and very low co-payments.

Medicare – a federal government health insurance program for all eligible individuals 65 and older, as well as for people under 65 with a disability. It provides hospital services (Part A), medical services (Part B), and a prescription drug benefit (Part D).

Medicare Advantage – a program that allows Medicare beneficiaries to receive their benefits through private insurers. Medicare Advantage plans must provide all standard Medicare benefits, but can do so with different rules, costs and restrictions that can affect how, with whom, and when you can get care. Some plans require that you use only the insurer’s network of providers, while others allow you to see an out-of-network provider at a higher cost.

Medicare supplemental (Medigap) plan – a private insurance plan that specifically fills in some of the gaps in Medicare Parts A and B coverage. These plans may pay for deductibles, co-insurance, and limited additional benefits.

Out-of-pocket costs – health care costs such as deductibles, coinsurance and co-payments.

Out-of-pocket maximum – the annual dollar limit a person will pay for their health care costs (not including premiums). Once you reach your out-of-pocket maximum, the insurer pays 100% of the cost of covered medical expenses for the remainder of the calendar year.

Patient Protection and Affordable Care Act – signed into law by President Obama on March 23, 2010, this law, also known as “health care reform”, expands coverage, mandates new consumer protections, and improves the health care delivery system.

Pre-existing condition – a medical condition for which a person has received a diagnosis or treatment within a specified time period before the start date of the plan. The practice of charging more or refusing coverage to an individual because of a pre-existing condition will be prohibited for children after September 23, 2010 and for adults beginning January 1, 2014.

Premium – Money paid on a regular basis to an insurer for insurance coverage.

Small Business Tax Credit – an incentive to encourage employers with fewer than 25 full-time employees to offer health insurance to employees. To receive the credit, the employer must offer a group health plan and pay at least 50% of the premium. The credit ranges between 25%-50% of the employer's cost.

Tax credit – the dollar amount a tax payer can subtract from their income tax payment. In some cases, it can be a refundable amount in the form of a payment from the government.

{ LINKS/RESOURCES }

The following websites are excellent resources for more detailed information on the Patient Protection and Affordable Care Act and how it will impact you as a consumer:

- Artists Health Insurance Resource Center: www.ahirc.org
- The federal health care reform website: www.healthcare.gov
- Center for Consumer Information and Insurance Oversight: <http://cciio.cms.gov>
- Kaiser Family Foundation: <http://healthreform.kff.org>
- Families USA: www.familiesusa.org
- National Association of Insurance Commissioners: www.naic.org/index_health_reform_section.htm

The Actors Fund, for everyone in entertainment.

EASTERN REGION

729 Seventh Avenue
10th Floor
New York, NY 10019
212.221.7300

CENTRAL REGION

203 North Wabash
Suite 2104
Chicago, IL 60601
312.372.0989

WESTERN REGION

5757 Wilshire Boulevard
Suite 400
Los Angeles, CA 90036
323.933.9244

www.actorsfund.org

LINC



LINC

237 W. 35th Street, Suite 1202
New York, NY 10001
646.731.3275 | www.lincnet.net



**NATIONAL
ENDOWMENT
FOR THE ARTS**

A great nation
deserves great art.

www.nea.gov