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How to Understand the Affordable Care Act

In March 2010, a new health care law was signed by President Obama. Some people call it Obamacare. But the official name is the Affordable Care Act.

The purpose of the law is to make quality, affordable health insurance more accessible to individuals, families, and small businesses and to provide consumer health care protection.

Some people might find the Affordable Care Act to be confusing, though. The actual law is thousands of pages long, and state and federal officials use an abundance of new terms to describe how the law provides access to health care.

There are also *different* Websites where you can register for government-approved health plans.

So, you might wonder how to navigate this ever-growing landscape of health insurance and how to actually **select health care plans**.

Thankfully, the U.S. Department of Health & Human Services (HHS) thought of a way to help. Through one of its divisions — the Centers for Medicare & Medicaid Services —HHS started training and certifying various professionals to help you pick and enroll in affordable health plans.

HHS lists those professionals as navigators, non-navigator assistance personnel, certified application counselors, and agents and brokers.[1]

You might be the most familiar with insurance agents and brokers. According to MaketWatch.com, brokers can give consumers something that navigators aren't allowed to offer: advice on which plans to choose.[2]

Of course, brokers earn commissions from health insurance companies for enrolling consumers in health plans from those companies. However, there isn't necessarily anything wrong with that practice.

In fact, the Center for Consumer Information & Insurance Oversight, a government agency, says: "They [agents and brokers] play a crucial role in educating consumers about the Health Insurance Marketplaces…" [3]

You might ask yourself, 'What are Health Insurance Marketplaces?' They're the places where you can shop for and enroll in health plans that adhere to the new standards set by the Affordable Care Act.

Where can you find these marketplaces? Well, they're typically run through Websites.

Some U.S. states have their own Websites where consumers can enroll in government-approved health plans. Other states allow the federal government to offer consumers these plans through HealthCare.gov. One of those states is Florida. Why? Well, in 2012, the Miami Herald reported that Florida missed the deadline for notifying the federal government about whether it would run its own health exchange. [4] So, the government must take on that responsibility.

Of course, you might wonder whether there's a difference between a health exchange and a health insurance marketplace. There's actually *no* difference. Both terms have the same meaning. That's why the Affordable Care Act might seem a bit confusing.

When it comes to the new health care law, there's additional terminology that might not seem clear right away. But, rest assured that there are trained professionals who can help you understand the new verbiage.

The Centers for Medicare & Medicaid Services (CMS), a division of the U.S. Department of Health & Human Services, has established a training and certification program where insurance agents and brokers study new health-care terminology such as qualified health plans, essential health benefits, and premium tax credits.

When you speak to an agent or broker, you'll learn that CMS defines **qualified health plans** as health insurance plans that have been approved by the U.S. Government to be sold through a state or federal health insurance marketplace. [5]

You're probably wondering what a plan must offer to be approved by the government. According to CMS, the plan must provide what are known as **essential health benefits**, which are standards for the quality of health care offered to consumers. [5]

Currently, there are ten categories of these benefits. The National Conference of State Legislatures lists them as ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness and chronic disease management; and pediatric services, including oral and vision care. [6]

As essential health benefits, some of the **preventive health services** are free to consumers through the new health plans. HealthCare.gov, the federal Website and marketplace for these plans, categorizes the free service under headings for adults, women, and children. [7]

The site states that adults qualify for free preventive services such as blood pressure screening, cholesterol screening, colorectal cancer screening for adults over fifty, depression screening, immunization vaccines, and many more.

There are also preventive services that apply only to women and children.

I'm sure you're wondering about the health services that you'll have to pay for through the new health plans. You might ask yourself, 'How exactly do these plans make health care more affordable?'

There's more than one answer to your question. You see, one of the factors that will determine how much you will pay for a government-approved health insurance plan is your income.

According to the third training course from the Centers for Medicare & Medicaid Services (CMS), if you earn a certain percentage of the federal poverty level, you may qualify for two types of discounts: premium tax credits and cost-sharing reductions. [8]

CMS adds that if you meet certain income requirements when you apply for health coverage through a health insurance marketplace, your premium, or monthly cost, may be immediately lowered through a type of premium tax credit known as an advance premium tax credit.

CMS also notes that, based on your income and family size, you may qualify for cost-sharing reductions. Cost-sharing expenses for health plans include deductibles, copayments, and coinsurance. These expenses are separate from the monthly premium that you would pay a health insurance company.

A quick visit to HealthCare.gov will give you an overview of what the different types of health plans cost and which services they cover. Start by clicking the sentence, See plans and prices, on the home page there.

After entering a small amount of information on the Website, you'll see four categories of plans: bronze, silver, gold, and platinum. Each type of plan covers a certain percentage of your health care expenses. Bronze plans cover 60 percent; silver plans, 70 percent; gold, 80 percent; and platinum, 90 percent.

However, please keep in mind that plans covering a higher percentage of your health care expenses will also have higher monthly premiums. So, these plans cost more because they offer more.

The different categories of health plans also have different rates for cost-sharing expenses such as deductibles, copayments, and coinsurance.

Usually, plans with lower monthly premiums will have a higher yearly deductible, which is the amount you must pay out of pocket each year for medical expenses before your plan will begin covering those expenses.

Though health insurance still costs money, you will now have greater access to health care. Under the provisions of the Affordable Care Act, it's now harder for insurance companies to deny you coverage.

WhiteHouse.gov, the official Website for the Executive Branch of the government, states that the Affordable Care Act prevents health insurance companies from denying you coverage for
pre-existing conditions, stops insurers from placing lifetime dollar limits on essential health benefits, and stops insurers from cancelling your coverage when you get sick or if you make a mistake on your insurance application. [9]

If the health plans made possible by the Affordable Care Act still seem overwhelming and confusing to you, remember that help is available from trained and certified professionals. Among those professionals are health insurance agents and brokers.

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