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SPECIAL SECTION

GOING TO MARKET

Obamacare '17 enrollment period begins tomorrow

BY JORDAN GALLOWAY
NEW YORK DAILY NEWS

Health care has been a hot-button issue throughout this presidential election, and recent reports from the Department of Health and Human Services that premium rates are set to rise by an average of 22% in 2017 in the federal marketplace is only fanning the flames.

Here in New York, which operates its own exchange, New York State of Health, those premium increases are more modest by comparison at 16.6% for individuals and 8.3% for small businesses who enroll in health plans during its annual open enrollment period, which starts Nov. 1 and runs through Jan. 31. (You must sign up for coverage by Dec. 15 if you want your insurance to start on Jan. 1.)

Despite the hikes, premium rates in New York State are still 55% lower than they were before the state marketplace was established, and there are ways for consumers to reduce their monthly health care costs even further in the form of financial aid.

Last year, over half of the 350,000 New York residents who enrolled in private health plans through New York State of Health received financial assistance to subsidize their insurance.

If your income is between 200% and 400% of the federal poverty level (ranging from $11,880 for individuals to $40,890 for a family of 8), you qualify for a premium tax credit which can be put toward offsetting your monthly insurance payment.

New Yorkers with an annual income of 400% of the federal poverty level or lower for their household size are eligible to enroll in the state's Essential Plan, which has a monthly premium of $0 or $20, depending on your income.

This year, more than 600,000 New Yorkers are expected to enroll in the Essential Plan, which come with no deductible and free preventive care services, as well as lower premiums.

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Make a healthy choice for Obamacare coverage

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"The No. 1 thing that people can be doing is to make sure that they understand the subsidies that exist," advises Eric Gascho, government affairs vice president of the National Health Council. "Make sure you understand what you're eligible for and what you need to do to go about receiving them."

Gascho recommends utilizing a financial aid calculator via your marketplace's online portal – nystateofhealth.ny.gov for New Yorkers and healthcare.gov for anyone accessing insurance through the federal exchange.

"If people are struggling with these decisions they have to make, navigators are available, in-person assisters are available; certified application counselors are available," he says.

"There are so many opportunities for people to have personal contact and help walking through the process, and we've found that people who utilize these services often do a much better job of picking a plan that makes the most sense for them."

No matter what you pick, by law all Affordable Care Act health plans must cover the same 10 basic health services, known as the Essential Health Benefits.

These include types of medical care like hospitalization, prescription drugs and maternity care. Some plans might cover additional benefits like vision or dental.

There will be 14 different insurance providers offering plans through the state marketplace this year in New York, which are more options than most beneficiaries will have buying health plans through the federal marketplace.

The Department of Health and Human Services recently announced that one in five consumers buying insurance through the federal exchange will have only one insurance provider to pick a plan from in 2017.

Even with a decreased number of companies offering plans next year, consumers will still have options to weigh when choosing a policy.

More than half of New Yorkers enrolled in Obamacare get insurance subsidies.

"Recognize that when you're shopping in the marketplace, you'll see plans organized by these metal tiers – bronze, silver, gold and platinum," advises Karen Pollitz, a senior fellow at the Kaiser Family Foundation.

Each category of coverage comes with its own cost-sharing ratio – the amount a consumer pays for their health care versus the amount their insurance company pays.

And while the majority of people pick a health plan based on its premium, Pollitz cautions consumers to consider the bigger picture before buying insurance.

"When you're comparing the cost of plans, you need to compare both sides. It's easy to compare the premiums, because that's not going to change, but you also need to make your best estimate of how much health care you typically use, how much health care you might use during the year, and try to balance out how much you would pay for that expected use under a bronze plan versus, say, a silver."

With a number of national providers dropping out of the insurance exchange this year, a new policy has been put into place to help consumers transition coverage: People who don't do anything and are enrolled in a plan that's leaving the marketplace will automatically be enrolled in a new, similar plan.

Those who are automatically enrolled in a new plan will get a notice from that carrier alerting them that they've been enrolled in the new plan, and that they'll need to submit their first month's premium for their insurance to be activated.

"If you don't want that, at that point you can go online and pick a new one," Pollitz says.

"And if you don't pay the premium, you won't be enrolled, which is kind of always the case. But if you don't enroll, then you're uninsured and you owe a penalty," she adds.

"The penalty for 2017 is the greater of 2.5% of your income above the filing threshold, which is a little over $10,000 for a single person, or it'll be about $700."

While the Affordable Care Act has never been short on controversy regarding the cost and quality of its coverage, it's become a particularly volatile issue this election cycle.

"Much of the news that people end up picking up is in the context of these politically based criticisms, which just adds to misinformation and confusion," Pollitz says.

"It's not a perfect system by any means but there has been a substantial increase in coverage – we've covered 20 million more people. And the people we survey who've gone from uninsured to insured, they feel good about that."

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There are plenty of places to go to learn more about the exchanges and get help in enrolling in a plan. Here are some key resources.

NEW YORK STATE OF HEALTH'S CUSTOMER SERVICE CENTER
Trained reps are ready to take questions by phone from individuals and business owners. *Call toll-free:* (855) 355-5777.

NAVIGATORS
Face-to-face guidance from trained experts is available at offices set up throughout New York City. To find an office near you, go to **nystateofhealth.ny.gov.**

INFORMATION
Do your homework by going to the following websites for information on the insurance marketplace:

- **Nystateofhealth.ny.gov** The official website for New York State of Health.
- **Healthcare.gov** The federal government's official health insurance website.
- **Kff.org** The Kaiser Family Foundation, a nonprofit focusing on major health care issues, offers a treasure-trove of information and helpful online tools, including a health insurance subsidy calculator.

TEST YOUR METAL

Find your best tier plan

BY JORDAN GALLOWAY

More than 20 million people now have health coverage through the Affordable Care Act – bringing the number of uninsured to its lowest rate in four decades.

But as the fourth open enrollment cycle gets underway, a recent survey by the Kaiser Family Foundation found that there are still 27 million uninsured across the country.

The main reason? Cost.

"That continues to be the No. 1 reason people name for why they don't have insurance," says Karen Pollitz, a senior fellow at the foundation.

Of those who don't have health plans, the majority of which are low-income working families, nearly half – 11.7 million people – would qualify for financial assistance if they signed up for a plan through either Medicaid or a tax credit in an Affordable Care Act marketplace, Pollitz says.

"It's a two-part process," she explains. "One is applying for financial help to see if you might be eligible. Then, once you have that determination, the second part is looking for your health plan options and enrolling."

If your estimated income for 2017 is between 100% to 400% of the federal poverty level for your household size, you qualify for a premium tax credit, which can be put toward offsetting your monthly insurance payment.

And if your income is 250% of the federal poverty level or lower, you could qualify for extra savings in the form of cost sharing reductions.

New York State operates its own marketplace, New York State of Health (nystateofhealth.ny.gov), and residents might qualify for financial aid through one of its Insurance Affordability Programs – Medicaid, Child Health Plus, Advance Premium Tax Credits and Cost-Sharing Reductions.

Beneficiaries can determine their eligibility for extra savings during the enrollment process or by using the online Estimated Financial Help calculator.

Within the marketplace, plans are offered in four different categories of coverage – bronze, silver, gold and platinum – which are commonly known as the metal tiers.

All plans cover the same essential health benefits like hospital stays, prescription drugs, maternity care, mental health and doctor visits.

The main difference between them is their cost-sharing split – the amount a beneficiary pays versus how much their insurance company pays for their medical services.

In general, a beneficiary in a bronze-tiered plan would pay 40% for their coverage while their insurance company pays 60%; the split is 30/70 for a silver plan, 20/80 for a gold plan, and 10/90 for a platinum plan.

"The bronze plans generally have the lowest premiums, the amount that you pay each month, but the highest deductibles and other cost sharings," Pollitz says.

"So it's not unusual to see bronze plans that have a $5,000 or $6,000 deductible, per year per person, before the plan will reimburse anything. So all your doctor visits all year long, all of your ER visits, you might end up paying out of pocket," Pollitz says.

"The silver plans tend to have somewhat higher premiums but lower deductibles, although still pretty high. In most areas, it's $2,000 to $3,000. With gold plans, the trade-off continues – even higher premiums but lower deductibles."

Platinum plans, meanwhile, tend to be the most expensive month by month.

"But you will pay the least amount when you go to the doctor or if you need hospital care," Pollitz adds.

"It's the cost of that monthly insurance payment that motivates most people's choices when picking a health plan or metal tier," says Eric Gascho, vice president of government affairs for the National Health Council,

"What we've seen is that most people are purchasing their plans based on the premium and that's the No. 1 thing driving their decision," he says.

"However, for people with chronic conditions, it would make a lot of sense for them to look at some of the higher metal levels, the platinums and the golds, because while they will have a higher premium, they will also have lower cost-sharing.

"A lot of the platinum plans have a reduced out-of-pocket maximum. So for someone who is going to be utilizing a lot of services, that could save them a lot of money in the long term."

Those who are eligible for extra savings should pay special attention to the silver plans, Pollitz advises.

"If your income is 250% of the poverty level or less, there are modified silver plans available to you. They're still called silver; they cost the same as regular silver plans, but they've been modified so that the deductibles are more like what you would find under a gold or a platinum level plan. You won't find those cost sharing subsidies in any other tier."

ISTOCKPHOTO

Obamacare essentials

Here are some basic terms to know:

OUT-OF-POCKET COSTS

Any medical expense not reimbursed by an insurance provider is considered an out-of-pocket cost.

This includes the premium — the monthly amount you pay to your insurance provider regardless of whether you've utilized any medical services or not — as well as the deductible, the amount beneficiaries must pay for covered health services before an insurance company pays anything.

Other costs include co-payments and co-insurance — costs you pay for medical services after reaching your deductible — and the out-of-pocket maximum, the cap on costs for medical services a beneficiary is responsible for paying in a given year.

COST-SHARING REDUCTIONS

Depending on your income, you might be eligible for discounts that can lower your out-of-pocket expenses like deductibles, co-payments and co-insurance.

The maximum amount a marketplace beneficiary could be required to pay for medical care in a given year is also lowered if they qualify for cost-sharing reductions, which are sometimes referred to as extra savings.

Once they meet this out-of-pocket maximum, their insurance provider will then pick up the tab for 100% of all covered services.

COVERAGE CATEGORIES

Marketplace beneficiaries have the option to enroll in five categories of coverage: bronze, silver, gold, platinum and catastrophic.

The first four are known as the metal tiers. Each offers the same routine medical services as the others but at different levels of cost to the consumer. The ratio of how much you pay out-of-pocket versus how much your insurance pays varies from tier to tier.

The general consumer-versus-provider percentage split is: bronze (40/60), silver (30/70), gold (20/80) and platinum (10/90).

The fifth category, catastrophic health plans, offer low monthly premiums (the tradeoff being a high deductible of $6,850). As the name implies, this category is really more worst-case scenario coverage in the event of serious illness or injury, as enrollees will be responsible for paying most of their routine medical expenses out of pocket. Only those under 30 years old or with a hardship exemption can sign up for catastrophic coverage.

ESSENTIAL HEALTH BENEFITS

All marketplace plans, no matter the coverage category, must provide beneficiaries access to 10 basic types of medical services known as essential health benefits.

These include ambulatory patient services; emergency services; hospitalization; pregnancy, maternity and newborn care; mental health and substance use disorder services; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care.

DRUG FORMULARY

This is the complete list of drugs covered under your marketplace health plan.

What falls under a formulary can vary from plan to plan, so it's important to compile a full list of the current prescriptions you're taking to confirm they are covered prior to picking a plan.

PROVIDER NETWORK

While all marketplace health plans cover the same routine medical services, the doctors and hospitals providing these services in a given network will vary from plan to plan.

Getting to know your network is important because seeking medical care outside of it comes at additional costs above the out-of-pocket expenses you already pay for insurance.

If you have preferred medical providers you want to keep using, take time to ensure they're in your provider network prior to picking a health plan.

EQUITABLE CARE

New ruling makes services more accessible for minorities, LGBT

BY JORDAN GALLOWAY

While Obamacare has made medical coverage more affordable for millions of Americans, it has not necessarily made it equal.

Vulnerable populations, such as minority and LGBTQ communities, continue to experience higher rates of discrimination in the health care system.

That prompted the Department of Health and Human Services to release a new nondiscrimination ruling in May aimed at ensuring at-risk groups receive equal access to health care and health coverage through Affordable Care Act marketplaces and other health programs funded by HHS.

Discrimination on the basis of race, color, national origin, sex, age or disability has always been illegal under the Affordable Care Act, but this new ruling is drilling down on just what constitutes bias under these tenets.

For example, gender identity discrimination is prohibited as a form of sex discrimination; health care providers cannot deny sex-specific health care based on the fact that the person requesting them identifies as another gender.

It also stipulates that women receive equal access to health care and insurance.

Similarly, HHS is trying to eliminate discrimination against those for whom English is not a first language by requiring medical providers supply access to free and accurate language assistance services in a timely manner.

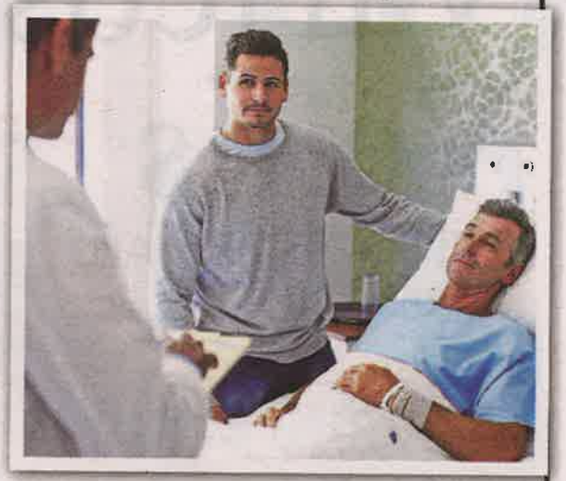
And it outlines similar requirements to prevent discrimination on the basis of disability.

"One of the key tenets of the Affordable Care Act is that plans cannot discriminate, and there's been a lot of work to really flesh out what that means," says Eric Gascho, vice president of government affairs for the National Health Council.

"What they are really focusing on is looking at minorities and the LGBTQ community, populations that were often discriminated against pre-ACA, (which) now have a lot more protections."

Uninsured rates tend to be higher among minority groups, which also tend to see higher rates of chronic medical conditions such as diabetes, heart disease and breast cancer – especially among African-Americans and Hispanics.

Major health concerns like HIV/AIDS, mental illness, substance abuse and sexual and physical violence tend to be higher among LGBT communities.



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The insurance rates for at-risk populations have steadily been on the rise since the Affordable Care Act went into effect in 2010, but over half of the country's uninsured population is still made up of people of color, according to the Kaiser Family Foundation, which reports the uninsured rates for blacks is 17.2% and 12.2% for Hispanics, compared to 8.1% in white, non-Hispanic communities.

In addition to making health care more equitable, federal and state governments, under the Affordable Care Act, are also working to make it more accessible, says Karen Pollitz, a senior fellow at the Kaiser Family Foundation.

"There's been an effort, particularly in New York State, to sign up in-person assisters who have close ties to these communities and who can target populations who may be vulnerable, who may have very high uninsured rates, who may have language barriers and so may need additional assistance," she says.

"One of the goals of the In Person Assistance Programs (is to) really ramp up outreach in the most impacted communities and get the word to them about coverage and financial assistance."