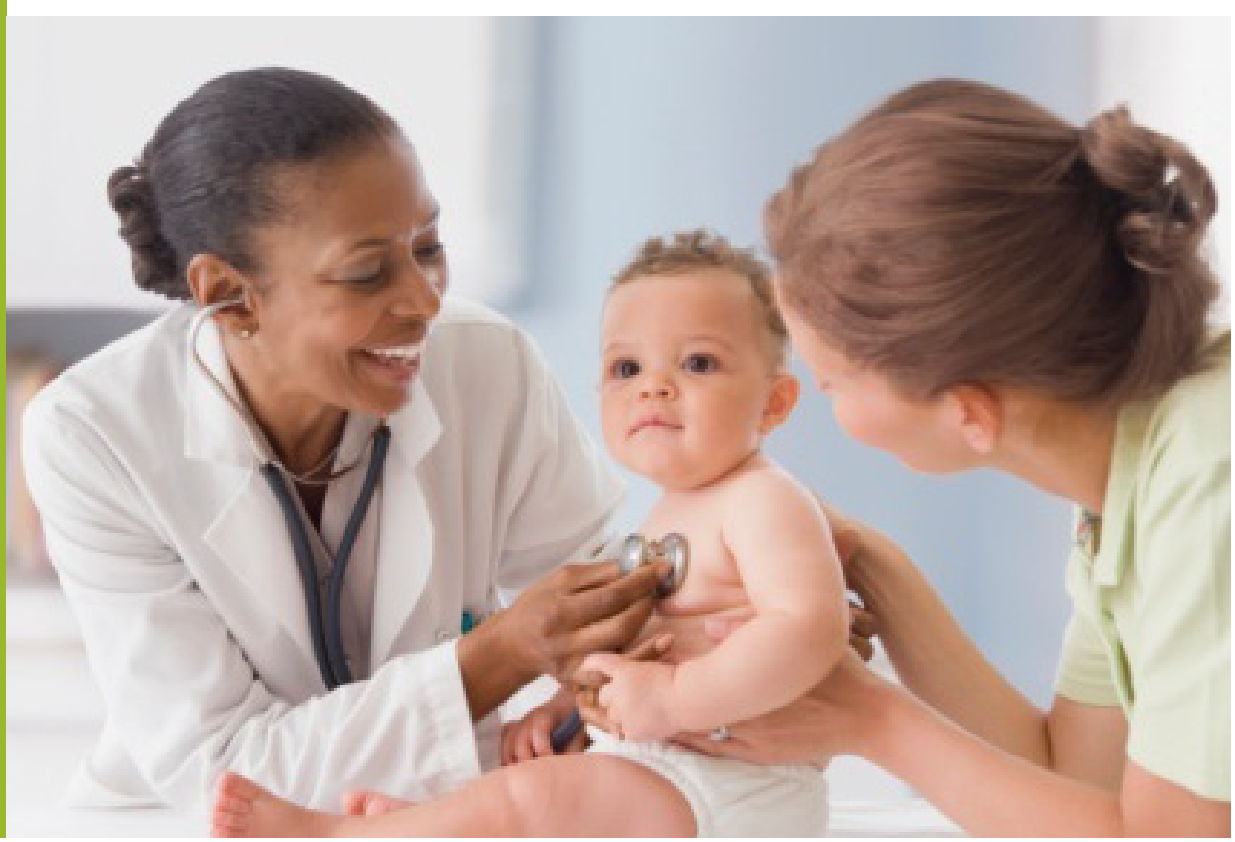
ConsumerReports®

Health Reform:
Seven Things You Need To Know Now



ConsumerReports®

UNDERSTANDING THE HEALTH REFORM LAW

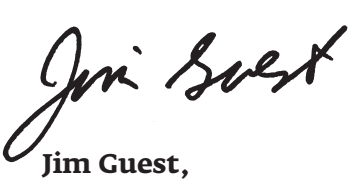
Consumer Reports has developed this brief guide to help you understand how the changes brought about by health reform, the Affordable Care Act (ACA) of 2010, will affect you and your family now, and in the future. Providing easy-to-understand comparative information to help consumers make the best decisions in the marketplace has been the mission of Consumer Reports, since our founding 76 years ago.

The ACA keeps in place many parts of the existing private insurance system, but it makes other major changes as well. The Supreme Court has ruled on the constitutionality of the law, upholding all but one important part of the legislation.

It is not surprising that many consumers are confused and are now trying to understand what health reform does, and how it may affect their families. It's crucial for all of us to understand how the law affects our current family sitaution, and also how it changes the options for ourselves and our loved ones as circumstances change, due to an illness, job changes, or aging.

We hope that you find this guide helpful, and that you will share it with others. Copies are available for download on our Website, at ConsumerReportsHealth.org,and in Spanish at espanol.ConsumerReports.org/salud.

As always, we welcome your feedback, your partnership, and your collaboration as we work together to address the concerns of America's health-care consumers.



Jim Guest,
President
Consumer Reports

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Seven Things You Need To Know Now

Now that the U.S. Supreme Court has ruled to uphold the constitutionality of the Patient Protection and Affordable Care Act (ACA for short) many Americans are wondering how health reform will affect them once it is fully implemented in January 2014.

Typical questions include: If I get my health insurance through my employer or through Medicare, what, if anything, will change? If I don't have health insurance – or lose mine – how will I be able to find a policy I can afford? And, who is affected by the requirement (known as the 'mandate') that everyone sign up for health insurance?

Health reform will affect every American because the ACA establishes new consumer protections and responsibilities. The law is designed to keep in place today's job-based private insurance system and the Medicare system for those over 65 years of age or permanently disabled. Importantly, it provides new ways to obtain insurance for people who today are locked out of the market because of pre-existing conditions or inability to afford insurance. Even if you have good insurance today it is quite possible that this will make a difference for you or your loved ones at some point in your lives.

This Consumer Reports publication is your guide to understanding how the law affects you and your family. We can't cover every possible situation, detail, or exception, but we highlight the major changes that consumers need to know about to take advantage of the full benefits of health reform come January 1, 2014.

"If we had to pay for our daughter's health-care costs, we would be on the street."

– Jamie THOMPSON, of Harleysville, Penn., who no longer has to worry about approaching a lifetime limit for treating his daughter's cystic fibrosis.

1. New consumer protections & benefits available today

Whether your health insurance is purchased by you or your employer, the ACA has already outlawed practices that have left people without health insurance when they need it most. These protections include:

Curbs on canceling policies. Insurers can no longer cancel your policy if you get sick, a practice known as "rescission." They cannot cancel your coverage if you make an honest mistake on your application.

Rapid appeals. Consumers can appeal insurance company decisions to an independent reviewer and receive a response in 72 hours for urgent medical situations.

Ban on lifetime limits. Major or long-term illness can rack up serious medical bills. Health insurance policies used to set 'lifetime limits' on how much they would pay for an individual's medical bills. These are now illegal, meaning people with insurance won't have to get into debt because their coverage ran out.

Annual dollar limits on their way out. While insurance companies can still set limits on how much they pay for an individual's medical expenses each year, the laws says that as of September 23, 2012 this limit must be no less than $2 million. In January 2014 limits will be completely eliminated. **Exceptions:** Insurers can still impose other types of benefit limits like doctor visit limits, prescription limits or limits on days in the hospital.

Better Benefits

The law focuses on prevention and primary care to help people stay healthy and to manage chronic medical conditions before they become more complex and costly to treat. It also requires that insurance companies spend most of their premium income on providing care, not on salaries, profits, or administrative costs.

Free preventive care and annual check ups. New pri-

"I was excited about seeing a benefit from the Affordable Care Act. I like that the law limits administrative costs. It holds insurance companies accountable to running a successful business that is geared toward the policy holders."

— Gilbert Garza, 59, a custom clothier from Houston, Texas, received an $827 rebate check from his insurer because it hadn't spent enough money on health care, as required by law.

vate health plans must cover and eliminate cost-sharing (co-payment, co-insurance or deductible) for proven preventive measures such as immunizations and cancer screenings. Additional preventive measures for women kicked in August 2012, including free well woman visits, screening for gestational diabetes, domestic violence screening, breast feeding supplies and contraception, all with no cost-sharing.

Exceptions: Workplaces run by religious organizations that object to birth control do not have to pay for contraception, but insurers must pick up the cost. Existing plans that haven't changed significantly since passage of the law can continue to charge for preventive care until January, 2014.

Premium rebates if insurers underspend on care. The ACA says that insurers must spend at least 80 percent (85 percent for insurers covering large employers) of the premiums you pay on medical care and quality improvements. The new standard is known as the "medical loss ratio." If insurers spend too much on salaries, bonuses, or administrative costs as opposed to health care, they must issue premium rebates to consumers each summer. In 2012, nearly 12.8 million individuals and employers received more than $1.1 billion in rebates as reduced premiums or direct refunds. Households receiving rebates got an average of $151.

Exceptions: Insurers in a few states may spend a higher portion of premiums on overhead for now to give them more time to meet the new standard. The rule does not apply to self-insured plans offered primarily by large employers who pay employee health expenses on their own. Check with your employer to see if it is self-insured.

Standard disclosure forms. Starting September 23, 2012, all health plans must use a standardized form to summarize benefits and coverage, including information on co-payments, deductibles and out-of-pocket

MEDICARE AND HEALTH REFORM

Most of the reforms impacting Medicare have already been put in place, including increased access to preventive care and discounts on the cost of prescription drugs.

Cheaper drugs. Older adults who have Part D drug coverage and reach the "donut hole" – the point when they must start paying the full prescription drug expenses themselves – in 2012 get a 50 percent discount when buying brand name drugs and a 14 percent discount on generic drugs covered by Medicare Part D. The prescription drug coverage gap continues shrinking until disappearing completely in 2020, when only the usual co-pays will apply.

Free preventive care. Seniors no longer need to put off preventive care or yearly check-ups because of cost. Since 2011, they are eligible for free cancer screenings, wellness visits, personalized prevention plans, vaccines, flu shots and more.

Changes to Medicare Advantage. The law reduces federal payments to Medicare Advantage plans run by private insurers as an alternative to traditional Medicare. In the past, Medicare paid these private insurance companies over $1,000 more per person on average than spent in traditional Medicare. These overpayments are slowly being reduced and instead insurers are awarded bonuses for quality. The law also slows the rate of growth in payments to some providers.

For more information about Medicare, visit Medicare.gov.

limits. Insurers must note any excluded services all in one place. Insurers must also calculate and disclose your typical out-of-pocket costs for two medical scenarios: having a baby and treating type 2 diabetes. Future years will include more coverage examples.

Expanding coverage

The law makes it easier for many uninsured Americans to find more affordable health insurance now.

Coverage for children with pre-existing conditions. Most insurers cannot deny coverage to children under 19 with pre-existing conditions, although they can charge more until 2014. Some individual plans can still refuse to cover a child until January, 2014. **Young adults can stay on their parents' plan until age 26.** Health plans must allow young adults to remain as dependents on their parent's policy until they turn 26, whether or not they live at home, attend school, or are married. Exception: Some health plans are not required to extend benefits to young adults if they can get coverage at work; this exception goes away in January 2014.

Temporary help for some adults with pre-existing conditions. If you have been without coverage for at least six months and have a pre-existing condition, you may be eligible for subsidized coverage through the temporary Pre-Existing Condition Insurance Plan in your state. (Visit PCIP.gov for information.)

2. Coming in 2014 - Overview

Some of the biggest changes from the health care law take effect January 1, 2014 with the goal of making affordable health care available for all Americans, regardless of their medical history or ability to pay.

No more pre-existing conditions denials. Insurers cannot deny coverage to anyone, regardless of pre-existing conditions or gender. And they cannot charge you more than a healthy person your same age. That means you can buy health insurance even if you are seriously ill.

Most Americans must have health insurance. Americans who can afford coverage will be required to purchase health insurance or pay a tax, as of January 1, 2014.

"I am excited about the health-care reform act. But I have to get through 2013 first."

– Tammy NORDSTROM, 56, of Crescent, Iowa, who uses almost half of her monthly unemployment benefits to pay for her COBRA health plan.

ASK NANCY

A woman in my book group says that because of the health reform law, if you sell you house you'll have to pay a 3.8 percent federal tax of the total sales price. Is that true?

This idea, which has been circulating in a chain email for a couple of years, is incorrect. Yes, there is a new 3.8 percent tax on unearned income such as dividends, interest, and capital gains beginning with tax year 2013. But:

1) the tax only applies to people with high incomes - adjusted gross income above $200,000 for an individual or $250,000 for a couple

2) for those affected, only a portion of the profit from a home sale, not the total sales price, is subjected to the tax. As has been the case for years, the first $250,000 of profit ($500,000 for a married couple) is excluded from tax.

According to one analysis, the tax will hit only the top-earning 2 percent of families. So unless you're in that group you won't be affected.

For more details see: http://www.factcheck.org/2010/04/a-38-percent-sales-tax-on-your-home/

Exchanges: New ways to buy insurance. Beginning January 1, 2014, individuals, families and small business owners will be able to shop at health insurance exchanges. These online marketplaces, similar in a way to travel websites, will make it possible to easily compare and buy private insurance and determine if you qualify for premium tax credits and subsidies to make it more affordable. Exchanges will be open for business October 1, 2013, selling coverage that begins January 1, 2014. You may qualify for tax credits to help pay for premiums if your income is from $15,302 to $46,021 for an individual and $31,155 to $93,700 for a family of four (see chart on page TK for how these income estimates were derived). You'll also be able to determine if you qualify for extra subsidies to help with out-of-pocket costs or for government programs such as Medicare, Medicaid and the Children's Health Insurance Plan.

Essential benefits offer minimum level of coverage. A minimum level of coverage, known as essential benefits, must be part of approved plans, effective January 1, 2014. Individual health plans and **those sold to small businesses** – whether sold in or out of the health insurance exchanges – must offer a comprehensive package of essential benefits.

More primary care doctors, coordinated care. With millions more insured Americans on the way, the current national shortage of primary care physicians presents an ongoing challenge to access in the health care system. The ACA has begun to fund training for more primary care physicians and increased resources for community health centers. It also promotes better coordinated care by encouraging the creation of "medical home" practices and increased payment rates for primary care doctors who accept Medicaid or work in rural areas.

Medicaid expansion assists low income Americans. Up to 17 million Americans could be eligible for Medicaid, the federal-state program for the poor and sick. As of January 1, 2014, states that choose to can expand their Medicaid programs to legal residents under age 65 earning less than $15,302 for an individual and $31,155 for a family of four and get federal funding to cover 100% of the costs for the first three years, then 90% thereafter.

Exception: Medicaid expansion was the one part of the law that changed significantly with the U.S. Supreme Court ruling on June 28, 2012. The Justices said states can refuse to expand Medicaid to all low-income adults without fear of losing all federal funding for existing Medicaid programs. This may leave some of the nation's poorest and sickest residents without coverage.

WILL NEW TAX RULES OF 2013 APPLY TO YOU?

Do you itemize taxes?
The rules are changing for those who itemize deductions on their federal income tax return. Beginning 2013, you can claim deductions for medical expenses not covered by insurance when they reach 10 percent of your adjusted gross income, up from the current 7.5 percent.

Do you earn over $200,000?
Two new taxes in 2013 will help fund the Medicare program that covers people over 65. These taxes apply ONLY to income above $200,000 for individuals and above $250,000 for couples who file jointly.

- Extra payroll tax: Employees will pay an extra 0.9 percent Medicare payroll tax on wages over $200,000 (individual) or $250,000 (family)

- New unearned income tax: A new 3.8 percent tax on unearned income, including investments, interest, dividends, annuities, rent, royalties, certain capital gains and inactive businesses. Exemptions include income from tax-exempt bonds, veteran's benefits, and qualified plan distributions such as those from an IRA or 401(k). The new tax does not apply to the sale of your principle residence, expect in rare cases. See ASK NANCY TK

Do you use a flexible spending account?
The rules on flexible spending accounts (FSA), which allow you to set aside tax-free dollars for unreimbursed medical expenses, changed in 2011 when you could no longer use FSA accounts to pay for over-the-counter drugs unless you have a prescription from your doctor. Starting in 2013, there is a new cap, $2,500, on how much you can set aside tax-free in an FSA. In subsequent years, the $2,500 cap will increase by the annual inflation rate.

3. How the "mandate" will affect you

The Supreme Court decision upheld one of the most controversial portions of the health-care law – the "individual mandate," which requires most Americans to purchase health insurance starting January 1, 2014 or pay a tax if they do not comply.

Despite the hoopla surrounding the mandate, the mandate will likely concern only about 7.3 million Americans, or two percent of the population. That's because most Americans either already have insurance, are exempt under the law, would qualify for Medicaid, or would use tax credits to buy policies in the exchanges, according to an analysis by the Urban Institute, a Washington think tank.

Members of Congress will also get their insurance in exchanges.

Why the mandate? Think of it this way: You can't buy homeowners insurance when your house is on fire, or car insurance that covers damage that has already happened. Requiring health insurers to accept anyone who wants insurance regardless of pre-existing conditions without requiring everyone to buy insurance would drive the cost of coverage to even more unaffordable levels.

You are exempt from the mandate tax if:

- You have insurance through your employer or purchase individual insurance on your own.

- You have insurance through Medicare, Medicaid, Children's Health Insurance Program (CHIP), Veteran's Administration and/or Tricare for active duty and re-

tired military, Indian Health Services or Health-care sharing ministry.

• You would have to spend more than 8 percent of your household income on the cheapest qualifying health insurance plan, even after tax credits and subsidies.

• Your income falls below the threshold for filing federal income tax.

• You live abroad

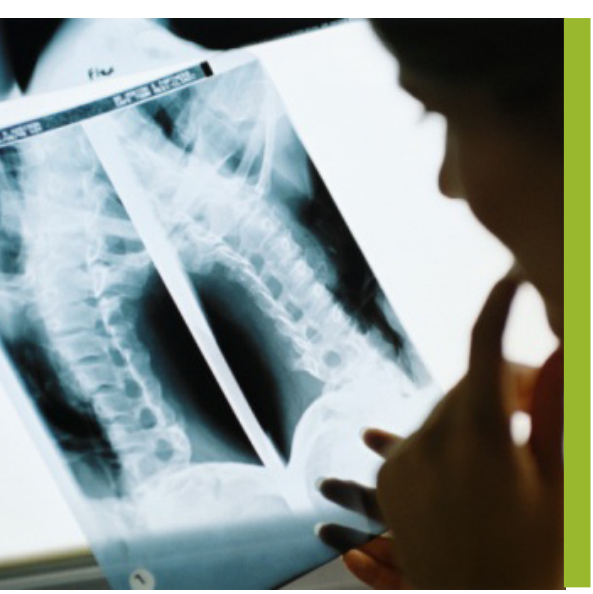
How much is the tax for not having insurance?

In 2014, people who can afford to but do not purchase health insurance will pay a tax. For an individual, the tax starts at $95 a year or up to 1 percent of income, whichever is greater, and by 2016 rises to $695 per individual or 2.5 percent of income. For a family, the penalty is capped at triple the per-person tax, or $285 in 2014 and rises to $2,085 or 2.5 percent of income in 2016.

The Internal Revenue Service will collect the penalty via your tax return. In 2014, federal tax returns will include a new form to list your source of health insurance.

"I probably will pay the tax rather than buy insurance. I have never had insurance. It's too expensive."

Susan Cook, 60, of Driftwood, Texas, who owns a landscaping business and has no plans, as of now, to purchase health insurance in 2014



"ESSENTIAL BENEFITS," DEFINED

Effective January 1, 2014, all individual health plans and those sold to small businesses must offer a comprehensive package of benefits that includes:

- Emergency services
- Hospitalizations
- Laboratory services
- Maternity care
- Mental health and substance abuse treatment
- Outpatient, or ambulatory care
- Pediatric care
- Prescription drugs
- Preventive care
- Rehabilitative and habilitative (helping maintain daily functioning) services
- Vision and dental care for children

4. Exchanges: New ways to buy and afford insurance

Beginning in January 1, 2014 a new way to buy insurance will be available. You will still be able to purchase insurance on your own directly from an insurance company or through a broker. But you will also be able to use the new state-based health insurance exchanges. There are two big advantages to using the exchange. One, you can make side-by-side, "apples to apples" comparisons of all the available plans, and use an online calculator to find the best buy. Two, you may qualify for an upfront tax credit to help pay for your premiums, and you might also get help with your out-of-pocket costs.

Anyone without insurance through work can purchase private health insurance from the insurers participating in your state exchange. And, you can also use the exchange if your coverage at work costs you more than 9.5 percent of your income or your employer's plan does not meet the law's minimum standards. (Future guidance will define when employer-provided family coverage is considered affordable.)

Exchanges will be open for business October 1, 2013, offering coverage that starts January 1, 2014. States must decide whether to build their own exchange or partner with the federal government. Some states will end up letting the federal government run their exchanges.

How the exchange works

- You'll be able to purchase health plans offered by private insurers and, in some states, co-ops of doctors and nonprofit organizations that meet state insurance regulations. Health plans in the exchange will be divided into four different categories – platinum, gold, silver and bronze – based on how generous the coverage is.

- A streamlined "one stop" process will allow you to fill out one application to find out if you qualify for premium tax credits, subsides for out-of-pocket expenses, or coverage under government programs such as Medicare or Medicaid.

- In many cases, in a single session you'll be able to receive an eligibility determination and enroll in a health insurance plan that's right for you or your family.

- You will also be able to update any changes that might affect your eligibility (including marriage, divorce or a job change) and to keep your coverage from year to year through the exchange.

WHO WILL QUALIFY FOR TAX CREDITS OR SUBSIDIES

The ACA uses an income measure called the "Federal Poverty Level" (FPL) to show who will get different kinds of financial help in buying insurance or will qualify for Medicaid. FPL refers to the minimum income a person or family needs for food, clothing, transportation, shelter and other necessities in the US. The amount varies depending on family size and is adjusted for inflation each year. The FPL income amounts used in this Guide are PROJECTED ESTIMATES for 2014, to give readers an idea of what insurance financing options will be available to families at different income levels. Amounts will vary by family size. We choose two sample family sizes – individual and family of 4.

% of Federal Poverty Level (estimated for 2014)		
	Single Person	Family of 4
100%	$11,505	$23,425
133%	15,302	31,155
250%	28,763	58,562
400%	46,021	93,700

Source: Kaiser Family Foundation Subsidy Calculator at http://healthreform.kff.org/SubsidyCalculator.aspx

5. Help paying for health insurance

Probably the biggest concern for Americans is: if I have to buy health insurance, will I be able to afford it? From tax credits and subsidies to specially designed plans for young adults, the heath-care law provides many measures to help make insurance more affordable for people with low and moderate incomes. But just how all of this affects you will depend on many factors.

Tax credits to help pay premiums. If you earn between $11,505 to $46,021 for an individual or $23,425 to $93,700 for a family of four – and you don't have coverage from your employer – you can qualify for an upfront tax credit if you buy health insurance in the exchanges. To get an estimate of the tax credit you might have coming to you, visit the Kaiser Family Foundation online calculator at healthreform.kff.org/subsidycalculator.

You will provide relevant information to the exchange and it will determine how much, if any, tax credit you can get. The credit itself is tied to your family income, family size and the cost of a standard plan in the exchange. Then an advance payment of the tax credit amount will go directly to the insurer you choose to help pay the full premium upfront.

Subsidies for out-of-pocket expenses. If you earn less than $34,516 for an individual or $70,275 for a family of four and purchase your policy on the exchange you also can get subsidies to lower out-of-pocket costs, such as deductibles and co-payments.

"I got stuck with a $120,000 medical bill that I'm still struggling to pay off. I'm using money that could be going toward my education to pay these bills. I'm doing my best. But it's tough."

— Edith Gonzalez, 26, of San Francisco, Calf., who was denied coverage for gall bladder surgery because her insurance company determined she had a pre-existing medical condition. The hospital eventually forgave about $82,000 and she is now paying off the rest.

Medicaid for those with limited incomes. If you earn less than $15,302 for an individual and $31,155 for a family of four, you will qualify for Medicaid in 2014, but only in those states that decide to go along with the federal expansion of the program. In states that don't expand Medicaid, households with incomes between 100 percent and 133 percent of poverty (see chart pp TK) will be allowed to purchase coverage on the exchange and receive tax credits, but there may not be a coverage option for adults earning less than poverty level.

The heath-care law provides many measures to help make insurance more affordable for people with low and moderate incomes.

Several options for young adults. You can now join or remain on your parents' health insurance plans until age 26, regardless of whether you live at home, have a job, are married, or attend school.

Beginning in 2014, you'll have additional options. You can buy subsidized private insurance in the state-based exchanges if your individual income is between $11,505 to $46,021. If you earn less than $15,302 as an individual you may qualify for Medicaid if your state expands Medicaid.

Adults under age 30 can buy a catastrophic health plan that covers essential health benefits and three primary care visits per year. These plans will likely have lower premiums but higher cost-sharing expenses than other plans in the exchanges. Preventive services and three primary care visits per year are excluded from cost sharing. People over age 30 who can not find a plan with a premium that is 8 percent or less of their income would be able to purchase the catastrophic plan, too.

6. Changes for large and small employers

It's impossible to be certain, but most Americans are likely to continue to get health insurance through their jobs as health care reform unfolds in the next few years. The federal law builds on the current employer-based private insurance system, which provides coverage to about 160 million Americans. And reforms help small business better afford to offer good health insurance.

Most employers, large and small, say they do not intend to drop health benefits recognizing their value in attracting and keeping good employees, according to the Congressional Budget Office. But business can change the price and terms of your employer-based plans, as many have in recent years, shifting more of the premium and other costs to employees.

New employer responsibilities

The law does not require employers to offer health insurance to employees. But businesses with 50 or more employees who do not offer coverage, or who offer insurance that is too expensive or does not meet minimum standards, may have to pay to help employees afford coverage in the exchanges.

With more than 96 percent of the nation's firms with 50 or more employees already offering health insurance to their workers, only a small percentage of businesses face these potential fines.

What about small businesses?

Companies with fewer than 50 employees won't face any penalties if they don't offer coverage to employees. These small employers represent about 75 percent of all the firms in the United States and employ nearly 34 million people.

Tax credits for small businesses. A tax break is now in place to make it more affordable for small businesses and nonprofits to offer health insurance to their employees. For-profit businesses with 25 or fewer employees can apply today for tax credits to cover up to 35 percent of the cost of premiums for their employees. To qualify, businesses must pay for at least 50 percent of their employees' premiums and workers annual salaries must be no more than $50,000, on average.

The tax credit increases to 50 percent in 2014 for small employers who purchase plans in the state-based health insurance exchanges.

Non-profit organizations can now apply for tax credits of up to 25 percent to help pay for employee premiums, increasing to 35 percent in 2014.

Small businesses can also use the exchange. Small employers with up to 100 employees (50 or fewer in some states) will be able to compare and buy heath insurance plans for their employees.

"In my experience, the Affordable Care Act is really a job creator. The law has been very important to us."

– Mark Hodesh, owner of Downtown Home and Garden in Ann Arbor, Mich., who received $17,628 in tax credits for providing health insurance to his employees and used the money to help hire an additional worker.

7. More people will be eligible for Medicaid

Medicaid is a joint federal- and state-funded program that currently provides health care for 60 million low-income Americans, mostly children, pregnant women, individuals with disabilities and elderly who need help at home or live in nursing homes. While state eligibility rules differ quite a lot, most low-income adults under 65 cannot receive Medicaid, no matter how poor.

The original health law passed in 2010 required states to cover all very low-income people with their Medicaid programs, including adults without dependent children with income below $15,302 for an individual and $31,155 for a family of four. If a state refused to expand coverage, the state would lose all their federal Medicaid funds.

The U.S. Supreme Court overturned that requirement, saying EACH state can decide whether or not to expand their Medicaid programs, without losing their current federal Medicaid funding.

Approximately 16 [CK] million Americans were expected to gain Medicaid coverage through the expansion, but now that may fall short and leave millions of the nation's poorest citizens without any way to get insurance come 2014.

Why it matters

The ACA intended about half of the newly insured Americans would gain coverage through Medicaid, with 90 – 100% of the new costs covered with federal funds. If a state decides against doing the expansion, then their very low-income residents will have no other option to get insurance. As the law stands today, if their household income is less than 100 percent of the poverty level (see chart pp XX) they can not get a tax credit to buy in the exchanges.

If states don't provide coverage for their poorest residents, hospitals and other health care providers will have to provide more uncompensated care than anticipated and may shift costs to those who have coverage. Or, other ways will need to be found to cover these unfunded costs, such as increasing local property taxes.

Who's eligible under Medicaid expansion?

Whether you qualify for Medicaid will depend on your income and where you live. Beginning January 1, 2014, all legal residents who earn less than $15,302 for an individual and $31,155 for a family of four can receive Medicaid. However, if you live in a state that refused to take part in the Medicaid expansion, you can't apply for Medicaid assistance even if you meet the new federal eligibility standards.

New federal eligibility standards include previously ineligible people, such as:

- Low-income adults without dependent children
- Low-income adults with disabilities who don't meet eligibility requirements for Social Security Supplemental Disability Insurance (SSDI) or Supplemental Security Income (SSI)
- Low-income children who lose their Medicaid benefits when they are reclassified as adults at 19 years old

What's next?

States have until summer 2013 to decide whether to expand Medicaid. In the meantime, the federal government is boosting funding to community health centers and increasing rates paid to primary care physicians who accept Medicaid in preparation for the growing number of newly insured people who will be seeking care. To learn more about the Medicaid program in your state, visit Medicaid.gov.

THE ROAD AHEAD

When fully implemented, the ACA will offer many more people of all ages the chance to have good health insurance, no matter what happens to their job, health status, or family circumstance. However, there are likely to be people who will fall between the cracks of the regulations – either because their state does not implement Medicaid expansion, or because what the system deems 'affordable' health insurance is not actually affordable for them. In some areas of the country, the shortage of family physicians or specialists may make it hard to access care. No doubt, the ACA will need some adjustments and fine tuning in the future to help it fulfill its mission.

Importantly, much more must be done to bring the cost of health care under better control, as it continues to grow at an unsustainable rate. And patient safety and quality of care are areas where continuous improvement is necessary. Consumer Reports has long been committed to working in all of these areas to ensure a fair and just healthcare marketplace for all consumers.

Still have questions?

Healthcare.gov

This site provides useful information about insurance options available to you and changes created by health-care reform.

Kaiser Family Foundation, http://healthreform.kff.org/

This site provides in depth information on key health policy issues, plus interactive tools to determine how health-care reform will impact you. It also allows you to find out about the exchange in your state, at http://healthreform.kff.org/State-Exchange-Profiles-Page.aspx

Consumer Reports, ConsumerReports.org

This site offers a range of resources from understanding health insurance and reform to help navigating Medicaid and Medicare to advice on maximizing your insurance options.

Consumers Union, ConsumersUnion.org/health

Learn about health-care policy issues and advocacy efforts at this site run by the publishers of Consumer Reports.

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