AP

In this March 23, 2010 file photo, Marcelas Owens of Seattle, left, Rep. John Dingell, D-Mich., right, and others, look on as President Barack Obama signs the health care bill in the East Room of the White House in Washington.

Affordable Care Act

Political battles create system of healthcare have and have nots

BY RICARDO ALONSO-ZALDIVAR
Associated Press

Having health insurance used to hinge on where you worked and what your medical history said. Soon that won't matter with open-access markets for subsidized coverage open as of Oct. 1 for signups under President Barack Obama's overhaul.

But there's a new wild card, something that didn't seem so critical when Congress passed the Affordable Care Act back in 2010: where you live.

Entrenched political divisions over "Obamacare," have driven most Republican-led states to turn their backs on the biggest expansion of the social safety net in a half century. If you're uninsured in a state that's opposed, you may not get much help picking the right private health plan for your budget and your family's needs.

The differences will be more glaring if you're poor and your state rejected the law's Medicaid expansion. Unless leaders reverse course, odds are you'll remain uninsured. That's because people below the poverty line do not qualify for subsidies to buy coverage in the markets.

> **'This is a** milestone along the path but by no means the end of the road. There's a lot more of a journey to see if it can really succeed,'
>
> **Mark McClellan**
> Former Medicare chief who oversaw the rollout of seniors' prescription drug benefits for Republican President George W. Bush

"We are going to have a new environment where consumers may be victims of geography," said Sam Karp of the California HealthCare Foundation, a nonprofit helping states tackle practical problems of implementation. "If I'm a low-wage earner in California, I may qualify for Medicaid. With the exact same income in Texas, I may not qualify."

The health care law is finally leaving the drawing boards to become a real program with citizens participating. But in many parts of the country the decisions of Republicans opposed to the law will trump the plans of Democrats who wrote it.

Still, there is a new bottom line. Health insurance marketplaces in every state will provide options for millions of people who don't have job-based coverage, who can't afford their own plan or have a health problem that would get them turned down. The feds will run the markets in states that refused to do so.

The coverage won't be free, even after sliding-scale subsidies keyed to your income.

See **ACT** *page E-6*

AP

In this March 27, 2012 file photo, Amy Brighton from Medina, Ohio, who opposes health care reform, holds a sign in front of the Supreme Court in Washington during a rally as the court continues arguments on the health care law signed by President Barack Obama.

Minding the language gap

BY DENISE WILLIAMS
Tribune Staff Writer

Understanding the Affordable Care Act has been a challenge for everyone, governors, state lawmakers and agency officials. But one of the biggest challenges will be delivering the message to America's non-English speaking citizens.

The U.S. Census estimates that more than 55 million people speak a language other than English at home. The vast majority of those — nearly 63 percent — are Spanish speakers. Chinese is the third most commonly spoken language. Five other languages with at least 1 million speakers are Tagalog (from the Philippines), French, Vietnamese, German and Korean.

Even East Tennessee, not necessarily known as the melting pot of the nation, has wide diversity in terms of languages spoken at home.

English-speakers are the overwhelming majority: 29,979 in Claiborne, 32,582 in Cocke, 20,844 in Grainger, 62,422 in Greene, 52,361 in Hamblen, 6,302 in Hancock, 52,243 in Hawkins and 46,622 in Jefferson.

As with the national numbers, Spanish-speakers make up the majority of non-English speakers in the Lakeway Area:

- 153 of Claiborne County's 437 non-English speakers
- 653 of Cocke County's 954 non-English speakers
- 350 of Grainger County's 404 non-English speakers
- 1,853 of Greene County's 2,523 non-English speakers
- 5,257 of Hamblen County's 6,053 non-English speakers
- 49 of Hancock County's 93 non-English speakers
- 919 of Hawkins County's 1,279 non-English speakers
- 1,298 of Jefferson County's 1,556 non-English speakers

According to the U.S. Census report, "2007-2011 American Community Survey Five-Year Estimates," a surprising number of other languages are spoken in homes around the eight-county area, including Arabic, Chinese, French, German, Greek, Gujarati, Hebrew, Hindu, Hungarian, Italian, Japanese, Korean, Laotian, Native North American, Polish, Portuguese, Russian, Scandinavian, Tagalog, Vietnamese and other Asian, Germanic, Indic, Indo-European, Pacific and Slavic languages.

The census data shows that these non-English speakers have varying abilities to speak English "very well."

In certain parts of the country, many of the individuals who will be eligible for federal subsidies in the health care exchange will be people of color or those whose English is limited.

For example, a study by the California Pan-Ethnic Health Network and the UCLA Center for Health Policy Research and the University of California, Berkeley Labor Center, report that the success of health care reform "hinges in large part in how well the state conducts culturally and linguistically competent outreach and enrollment efforts."

According to the U.S. Department of Health and Human Services Office for Civil Rights, organizations that receive federal funding have to provide written notices in English, Spanish and other languages spoken by 5 percent of the population or 1,000 people, whichever is less.

The Health Care Marketplace, which officially opened on Oct. 1, offers information in Chinese, French Creole, Korean, Polish, Portuguese, Russian, Spanish, Tagalog, Vietnamese, but individuals did not have the ability to sign up online in their language on the opening day.

Several days before the system went live, HHS announced that the Spanish-language version of the healthcare.gov website would not be ready to handle online enrollments for a few weeks — something that was estimated to affect 10 million Latinos, nearly half of whom are primarily Spanish-speaking.

At that time, Jennifer Ng'andu, health care policy director for the National Council of La Raza, said, "It's been at least two years since we've known that Latinos are a primary target for enrollment through the ACA, so we would have hoped that the administration would have the rollout ready on day 1."

She added, though, that her group wouldn't object if it took a few more weeks to get things right.

If the nation's Hispanic speakers — the largest minority group in the nation — won't have access to online enrollment for some time, the lesser minority groups may have to wait even longer.

Healthcare.gov provided a toll-free number 1-800-318-2596 for all individuals requesting additional information about the Health Care Marketplace.

How health care coverage will change under the Affordable Care Act

The wide-ranging overhaul of the U.S. health care system known as the Affordable Care Act is expected to touch the lives of most Americans in some fashion. Here are examples of health care consumers who could see benefits and drawbacks under the law:

Person	Single man, 28, employed full time	Single woman, 34, with a pre-existing medical condition	Single man, 40, employed part time	Family of four; mother, 44, employed full time with health benefits	Family of three; father, 51, owns a small business
Job and income	Information technology worker for small startup Earns **$30,000** a year, more than twice the federal poverty level (FPL) for a 1-person household 100% of federal poverty level	Freelance graphic designer Earns **$48,000** a year, more than four times the FPL for a 1-person household	Handyman Earns **$13,000** a year, just over the FPL for a 1-person household	Human resources officer for large firm Earns **$85,000** a year, 3.6 times the FPL for a 4-person household	Restaurateur with 24 full-time employees Earns **$90,000** a year, more than four times the FPL for a 3-person household
Currently insured?	☐ YES ☒ NO Employer does not offer insurance; he is mulling whether to purchase it. He has not seen a doctor since aging out of his parents' policy at age 26.	☐ YES ☒ NO Denied insurance due to pre-existing bipolar disorder requiring medications. She pays cash for medical care and drugs.	☐ YES ☒ NO Employer does not provide health benefits to part-time workers. He forgoes preventive care and visits a local emergency room when necessary.	☑ YES ☐ NO Has a generous coverage plan through employer with low deductibles and out-of-pocket costs. The family has a wide range of doctors and specialists from which to choose for care.	☑ YES ☐ NO Covers family through individual policy; does not provide coverage to workers. The family visits doctors in the plan's network for care.
Eligible for subsidized coverage based on income?	☑ YES ☐ NO	☐ YES ☒ NO	☑ YES ☐ NO	☑ YES ☐ NO	☐ YES ☒ NO
Other benefits under the health overhaul law	■ He could opt to buy a low-cost, high-deductible catastrophic policy available to those under 30 but would not get a premium subsidy for such a policy.	■ She cannot be denied coverage or charged a higher premium based on her condition or her gender. She will also have a cap on out-of-pocket expenses and no lifetime coverage limit. ■ Mental health care and prescription drugs are included in the core benefits of marketplace-based plans.	■ He is eligible for Medicaid, which has expanded in many states for individuals making up to $15,400. ■ Medicaid for new enrollees will offer core coverage including free preventive care.	■ Can keep existing health plan, provided her employer continues to offer it. ■ The plan must offer free preventive services, allow children under 26 to remain on the plan and cap out-of-pocket costs.	■ Because he has fewer than 25 full-time employees, he is eligible for a tax credit of up to 50 percent of his contribution toward workers' health insurance premiums if he covers at least 50 percent of the total premium cost when buying through an exchange. ■ His child could stay on his coverage until age 26.
Drawbacks under the health overhaul law	■ He will be fined for not carrying health insurance: beginning in 2014, 1 percent of his income, eventually growing to 2.5 percent of income or $695, whichever is greater. ■ As a young, healthy person, he may wind up paying relatively more for a premium, since he will be helping defray costs for older and sicker consumers who cannot be charged more based on health status.	■ She makes more than 4 times the federal poverty level for an individual, which means she is not eligible for a government subsidy to lower premium prices. ■ She is required to carry health insurance or pay a penalty, but she would be exempted if the lowest cost coverage available to her exceeded 8 percent of her income, $3,840 a year.	■ If his state doesn't expand Medicaid, he may not be able to afford private insurance through a new marketplace, which, given his income, should not exceed 2 percent of his annual income, $240 a year. ■ If his income drops below $11,490 — the federal poverty level for an individual — he will not be eligible for a premium subsidy, due to a quirk in the law.	■ Considered a "Cadillac Plan" under the law (a plan valued at more than $10,200 for an individual or $27,500 for a family), a tax of 40% will be levied on the value of the plan exceeding those amounts, payable by the insurer. This could lead the insurer to modify the plan, drop it or pass the tax on to the worker through higher premiums, deductibles or copays. The tax will be assessed beginning in 2018.	■ Even with the tax credit, the cost of providing health insurance may be more than he can afford. ■ If he expands his business to employ more than 50 full-time employees, he will be required to provide health insurance or face a fine of up to $2,000 for each employee after the first 30. He could also be fined if he chooses a plan that is not considered comprehensive or affordable. Businesses will not have to comply with this provision of the law until 2015.

SOURCES: Department of Health and Human Services; Kaiser Family Foundation; Robert Wood Johnson Foundation AP

Key consumer questions about the health reforms

By the Associated Press

How do I know whether "Obamacare" applies to me?

Polls show many Americans remain mystified by the Patient Protection and Affordable Care Act, or "Obamacare" as it is commonly known. But there's an obvious starting point: Do you have health care coverage?

If your employer provides health insurance for you, it's likely you don't have to do anything on Oct. 1, when enrollment begins. The president has said you will be able to keep your doctor and your plan.

For others — those without insurance — it's more complicated. The law requires virtually all U.S. citizens and legal residents to have coverage or pay a penalty. That will happen either through an expanded government Medicaid program, which would cover costs for lower-income people, or by requiring people without coverage to buy it. Financial help will be available for those who qualify, based on income.

To enroll through Medicaid, an individual would have to have an income that tops out $15,400, or about $31,000 for a family of four.

There are just a few exceptions to the requirement for coverage, including for prison inmates, people who entered the country illegally, those facing financial hardship and religious objectors.

When do I have to decide whether to buy health insurance and what happens if I don't?

Beginning in 2014, virtually all Americans will be required to have health insurance or pay an annual penalty to the government. For an individual, the fine begins at a minimum of $95 in 2014, stepping up annually to a minimum of $695 by 2016. The fine for uninsured children in 2014 is $47.50 for each child, although the maximum a family would have to pay in penalties next year is $285. Those fees climb each year.

Federal researchers predict that about 6 million people could be hit with fines by 2016.

Those who owe penalties would see their tax refunds docked. Not everyone who fails to buy insurance will be forced to pay up — those exempted from the requirement to have insurance, such as prison inmates, would not be penalized, for example. That also would be the case with people who earn so little that they are not required to file a tax return.

People owing the government a fine under the law could try to massage their tax returns to avoid receiving a refund, and thus the government would have nothing to claim. It's also possible people could try to exploit the religious exemption, for example, to avoid buying insurance and getting hit with a penalty.

According to the government, the IRS plans to hold back the amount of the penalty fee from future tax refunds, but there are no liens or criminal penalties for failing to pay.

AP

In this photo taken Tuesday, Aug. 27, cancer patient Bev Veals undergoes chemotherapy treatment as her husband Scott sits by her bedside at Duke Cancer Center in Durham, N.C.

What are health insurance exchanges and how do they work?

Exchanges are the online markets on which individuals and small businesses will buy private health insurance. Think of them as one-stop-shopping destinations similar to Amazon.com that are supposed to give consumers a quick way to compare insurance policies. But they might not be available to some consumers until later. That could leave many who lack job-based coverage to enroll by mail or through call centers. Still, consumers are expected to be able to see all their options in the exchanges and choose their health plans based on price, benefits and other features. Many participants will qualify for federal subsidies in the form of tax credits to help ease the cost. The amount is based on income and is available to individuals making up to $45,960, or $94,200 for a family of four. Shoppers will have different buying experiences depending on who is running their exchanges — the state, federal government or a combination of the two. Enrollment begins Oct. 1, with health care coverage starting Jan. 1.

How will actual health care coverage and services be different under Obamacare?

Coverage in the exchanges will be more comprehensive than what is typically available to individuals in the current health insurance market, which is dominated by bare-bones plans. It will resemble what a successful small business offers its employees. All plans in the exchange, and most outside it, will have to cover a standard set of benefits, including hospitalization, doctor visits, prescriptions, emergency room treatment, and maternal and newborn care. Under the law, insurers can't turn away people or charge them more because of health problems or chronic illnesses. Insurers also are banned from setting different rates based on gender. Middle-aged and older adults can't be charged more than three times what young people pay, but insurers can impose penalties on smokers. Most health insurance plans have to cover certain preventive services. Those include routine vaccinations, vision and hearing tests for children, and screenings for diabetes, high cholesterol, colon cancer and high blood pressure.

I currently have insurance through my employer. Will anything change?

For many people who have health insurance through their employer, the Kaiser Family Foundation says not a lot is expected to happen right away. Some workers may receive a financial break from the new cap on out-of-pocket expenses and free preventive care. But some larger companies, those with 50 or more employees, already are looking for ways to cut costs and avoid getting hit with a new tax set to take effect in 2018 on so-called "Cadillac" insurance plans.

Those are defined as plans valued at $10,200 or more for individual coverage and $27,500 for family policies. United Parcel Service, for example, informed its white collar employees that it will no longer cover spouses if they can get coverage through their own employers. Delta Air Lines, meanwhile, recently predicted its workers may have to help shoulder the cost of various new mandates under the Affordable Care Act, such as coverage for employees' children until they are 26 years old and coverage for workers who had previously opted out but will now be required to have health insurance.

Will I be forced to change doctors or health plans even I don't want to, and will my choices for both be limited?

Probably not. You can maintain your current providers if you have job-based insurance and can choose any available primary care provider in your insurance plan's network. However, the influx of patients who will be newly insured under the Affordable Care Act could overwhelm the health care system in some areas. That could mean you will see a physician assistant or nurse practitioner, rather than an actual physician.

In general, the Obama administration says the law offers new rights and protections whether you have coverage or need it, but there are some exceptions. The new rights do not apply to health plans created or bought before March 23, 2010.

The government has delayed the large-business mandate for a year, but what will the law mean for owners of smaller businesses?

Under the Affordable Care Act, a small business is defined as having anywhere from two to 50 employees. Those firms are not required to provide their workers with health insurance. But businesses with employment levels close to the 50-employee threshold have until 2015 to

See **REFORMS** *page E-6*

Applying for health insurance? Homework involved

WASHINGTON (AP) — Getting covered through President Barack Obama's health care law might feel like a combination of doing your taxes and making a big purchase that requires research.

You'll need accurate income information for your household, plus some understanding of how health insurance works, so you can get the financial assistance you qualify for and pick a health plan that's right for your needs.

The process involves federal agencies verifying your identity, citizenship and income, and you have to sign that you are providing truthful information, subject to perjury laws.

You heard it was going to be like buying airline tickets online? Not quite. But even if the process triggers some anxiety, it's not the government poking in your medical records, as "Obamacare" foes have suggested.

After state health insurance markets opened Oct. 1, consumers were able to apply online, via a call center, in person or by mail. Trained helpers are supposed to be available, but there may not be enough of them.

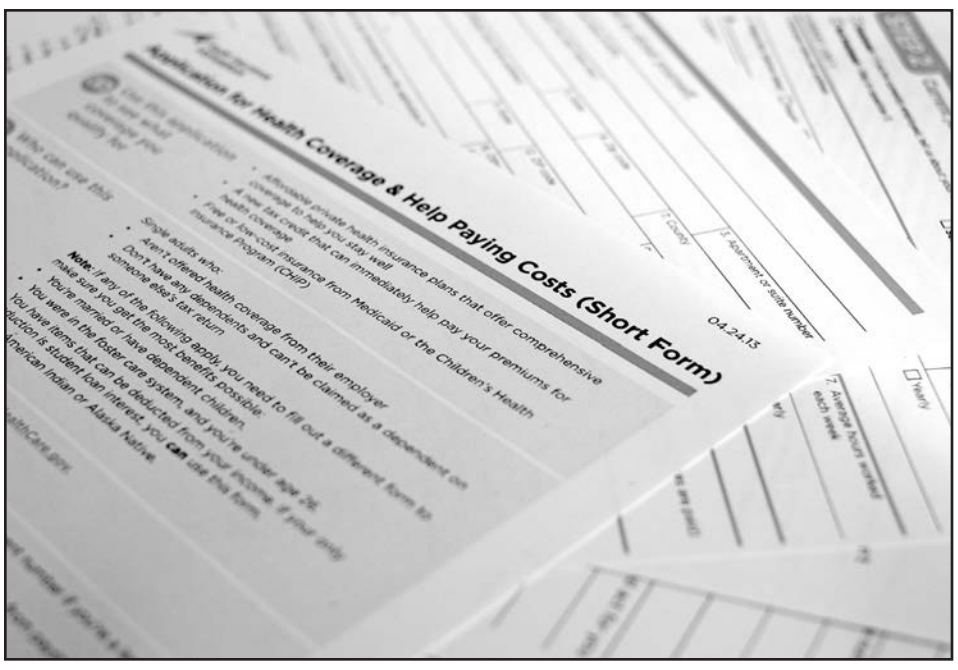
The main steps are:

— Identify yourself and your family members.

— Provide current information on income, jobs and any available health insurance options.

— Learn how much financial assistance you're entitled to.

— Shop for a health plan and enroll.



AP

This April 30, file photo shows the short form for the new federal Affordable Care Act application in Washington. Getting covered through President Barack Obama's health care law might feel like a combination of doing your taxes and making a big purchase that requires some research. You'll need accurate income information for your household, plus some understanding of how health insurance works, so you can get the financial assistance you qualify for and pick a health plan that's right for your needs.

Many people, ranging from lower-income workers to the solid middle class, will qualify for tax credits to help buy a private plan through the state markets. The government will send money directly to your insurer, and you'll make arrangements to pay any remaining premium.

The poor and near-poor will be steered to Medicaid in states that agree to expand that program.

Here's an overview of what to expect applying online, with tips:

Go to healthcare.gov and click on "Get Insurance." The site has links to every state market. You'll set up an account and password. You'll provide your contact information and the best way to reach you.

Tip — Treat your password like a bank account or credit card password. It's not a good idea to set it as "1234567."

Now you can tackle the actual application. You'll need birth dates and Social Security numbers for yourself and other family members listed on your federal tax return.

You'll also be asked if you're a citizen. Legal immigrants will need their immigration documents.

Tip — You don't have to plow through the entire application in one sitting. You can save your work and come back later.

Next, you'll be asked about income.

You may need your most recent tax return, pay stubs and details on other kinds of income, such as alimony, pensions and rents. You can still apply if you haven't filed a tax return. You'll also be asked about access to health insurance through your job. You may be required to take that insurance if available.

Your personal and income details will be routed through a new government entity called the data services hub, which will ping agencies like Social Security, Homeland Security and the Internal Revenue Service for verification. The feds will also rely on a major private credit reporting company to verify income and employment.

How smoothly all this works is one of the big unknowns. It could get tedious if discrepancies take time to resolve.

Tip — Provide the most accurate estimate of your expected income for 2014. Lowball the number, and you might see a smaller tax refund in 2015. Overestimate and you won't get as big a tax credit now.

If you're like most people, you'll be getting a tax credit to help pay your premiums. The credits are based on your income and keyed to the premium for a benchmark plan known as the "second-lowest cost silver plan" in your area.

With your tax credit, you can finally shop for insurance. Beware: you'll probably have to live with your decision until the next annual enrollment period.

You'll have up to four levels of coverage to consider: bronze, silver, gold and platinum. Plans at every "metal level" cover the same benefits and have a cap of $6,350 a year in out-of-pocket expenses for an individual, $12,700 for families.

Bronze plans generally have the lowest premiums, but cover only 60 percent of medical costs on average. Policyholders will pay the difference, up to the annual out of pocket cap. Platinum plans have the highest premiums, but cover 90 percent of costs. Young adults up to age 30 can pick a skinny "catastrophic" plan — but you can't use your tax credit on a catastrophic plan.

Tip — Make sure your doctors and hospitals are in the plan you pick. You may have to check the plan's own website, or call your doctor.

Tip — Your share of the premium could be lower — even zero — if you apply your tax credit to a bronze plan. It's because the credit is keyed to the cost of a silver plan, which is generally more expensive.

Tip — Check if you are eligible for "cost-sharing subsidies," in addition to your tax credit. Extra help with out-of-pocket costs is available to people with modest incomes. But only with a silver plan.

Head spinning?

Richard Onizuka, director of the Washington state market, says picking a plan could be the most difficult step. Most of his customers were previously uninsured, so insurance jargon could seem like a foreign language.

"The biggest challenge for consumers will be understanding health insurance and how to purchase it," he said.

ABCs of Obamacare: A Glossary for Consumers

The Associated Press

Major new laws come with their own jargon, and President Barack Obama's health care overhaul is no exception. With the first open enrollment season kicking off for the uninsured, here are some terms consumers might want to get familiar with:

Affordable Care Act — The most common formal name for the health care law. Its full title is the Patient Protection and Affordable Care Act. Opponents still deride the law as "Obamacare," but Obama himself has embraced that term, saying it shows he cares.

Employer mandate — A federal requirement that companies with 50 or more workers pay a penalty to the government if one of their workers obtains taxpayer subsidized coverage through the law. Delayed one year to Jan. 1, 2015. Intended to keep companies from "dumping" employees into public coverage.

Individual mandate — A federal requirement that virtually everyone in the United States has health insurance, either through an employer, a government program or by buying his own plan. Effective Jan. 1, 2014. Exemptions for financial hardship and religious objections. Does not apply to immigrants living in the U.S. illegally. People who ignore the mandate will face fines from Internal Revenue Service.

Essential health benefits — Basic health benefits that most health insurance plans will have to cover starting in 2014. They include office visits, emergency services, hospitalization, rehab care, mental health and substance abuse treatment, prescriptions, lab tests, prevention, maternal and newborn care, and pediatric care.

Marketplaces — Online health insurance markets in each state where consumers can get private health insurance, subsidized by the government. They used to be called "exchanges," but the feds decided that was too confusing and started calling them "marketplaces." Still, some states stuck with the original name. Open enrollment starts Oct. 1, and the coverage takes effect Jan. 1, 2014. Fifteen states and Washington, D.C., are running their own marketplaces, according to a tally by The Associated Press. The Obama administration is taking the lead in 35 states, in some cases partnering with the state government. All the marketplaces can be accessed online through healthcare.gov. Small businesses will have their own marketplaces.

Medicaid expansion — The health care law also expands the federal-state safety-net program to cover more low-income people. Medicaid is expected to account for about half the 25 million uninsured people who, the Congressional Budget Office estimates, eventually will gain coverage through the law. The federal government will pay the full cost of the new coverage from 2014-2016, then phase down to 90 percent. Twenty-four states plus Washington, D.C., have accepted the expansion, according to AP's count. Eight states are still considering it. And 18 have rejected it, including Texas and Florida, which have many uninsured residents. Many adults below the poverty level will remain uninsured in the refusing states. A state can change its decision at any time, but the full federal payment for the expansion is only available through 2016.

Metal levels —The four levels of coverage available through exchange plans, called bronze, silver, gold, and platinum. Bronze plans feature the lowest monthly premiums, but cover only 60 percent of average costs. Platinum plans have higher premiums and cover 90 percent of expected costs.

Pre-existing condition — An ongoing or past health problem. Currently insurers can use pre-existing conditions to deny or restrict coverage, or charge more. Those practices will be barred by federal law starting Jan. 1, 2014, and insurers will have to accept all applicants.

Tax credits — Government health insurance subsidies for individuals will come in the form of tax credits. The money will be paid directly to the consumer's health plan, to help cover premiums. The subsidies are on a sliding scale based on income. Each year, people will have to "true up" with the IRS to make sure they got the right amount. People who receive too generous a tax credit may owe money back to the government.

Tax penalty — The fine levied on individuals who disregard the individual insurance mandate. It starts small and gets bigger in subsequent years. In 2014 it's $95 or 1 percent of taxable income. By 2016, it's $695 or 2.5 percent of taxable income, whichever is greater. Thereafter it's adjusted for inflation.

Exchanges create confusion for Medicare recipients

MIAMI (AP) — Dear seniors, your Medicare benefits aren't changing under the Affordable Care Act. That's the message federal health officials are trying to get out to some older consumers confused by overlapping enrollment periods for Medicare and so-called "Obamacare."

Medicare beneficiaries don't have to do anything differently and will continue to go to Medicare.gov to sign up for plans. But advocates say many have been confused by a massive media blitz directing consumers to new online insurance exchanges set up as part of the federal health law. Many of the same insurance companies are offering coverage for Medicare and the exchanges.

Medicare open enrollment starts Oct. 15 and closes Dec. 7, while enrollment for the new state exchanges for people 65 and under launched Oct. 1 and runs through March.

"Most seniors are not at all informed. Most seniors worry they're going to lose their health coverage because of the law," said Dr. Chris Lillis, a primary care physician in Fredericksburg, Virginia. "I try to speak truth from the exam room but I think sometimes fear dominates."

AP

In this image made available by AARP shows Ida Gall, right speaking to an unidentified customer at the Connecticut Women's Expo on Saturday, Sept. 7, in Hartford, Conn. AARP Connecticut volunteers Ida Gall and Sophia Forbes, seated, talked to women about the Affordable Care Act. Federal Health Officials are assuring medicare recipients that their benefits will not change when the Affordable Care Act starts. Many are confused by overlapping enrollment periods for Medicare and the Affordable Care Act.

In October, roughly 50 million Medicare beneficiaries will get a handbook in the mail with a prominent Q&A that stresses Medicare benefits aren't changing. Federal health officials have also updated their training for Medicare counselors, and are prepping their Medicare call center and website.

"We want to reassure Medicare beneficiaries that they are already covered, their benefits aren't changing, and the marketplace doesn't require them to do anything different," said Julie Bataille, spokeswoman for the Centers for Medicare and Medicaid Services.

But she said call centers for the state exchanges are already fielding questions from Medicare recipients and rerouting them to the Medicare line.

Bob Roza attended several meetings trying to figure out exactly what the Affordable Care Act means for him and his 69-year-old wife Gail, who has diabetes.

"At that time, I didn't know if Medicare would be secondary to some Affordable Care Act option. It was just a myriad of concerns and not knowing," said the 72-year-old Roza, a retiree who lives in Oakdale, Calif., and is recovering from hip replacement surgery earlier this year.

He now knows that his Medicare coverage won't change, but says he's now worried about the impact on the $614 a month he pays for Medicare supplemental insurance. Federal health officials said seniors will not be able to purchase Medicare supplemental insurance or Part D drug plans through the state exchanges.

Jodi Reid, executive director of the California Alliance for Retired Americans, worries there hasn't been enough outreach to seniors and that advocacy groups are spending the bulk of their advertising funds targeting those impacted by the exchange. Her organization, which represents nearly 1 million seniors in California, is putting together a one-page fact sheet to help dispel myths.

"Nothing has been done that I have seen to deal with the 4.4 million people in California who are on Medicare who are not going to be impacted the same way as the rest of us so it's causing a lot of confusion," she said.

AARP officials said they anticipate a spike in calls after the October launch date for the new state exchanges. To help clarify everything for seniors, the organization is holding various events around the country, such as a senior day next month at the state fair in Columbia, S.C. Next month, the group is also hosting 21 telephone town halls, which will include hundreds of thousands of phone calls to seniors.

"Usually the marketing is just targeted to the Medicare

See **CARE** *page E-6*

Doctor gap to widen?

Areas with doctor shortages expect those to increase under ACA

BY DENISE WILLIAMS
Tribune Staff Writer

AP

In this March 28, file photo, medical resident Stephanie Place examines two-month-old twins Abigale, left, and Valeria Lopez as their mother Carolina Lopez, left, helps, at the Erie Family Health Center in Chicago. As clinics gear up for the expansion of health insurance, they're recruiting young doctors.

A shortage of primary care physicians in some parts of the country are expected to worsen as millions of newly insured Americans gain health insurance coverage in January when the Affordable Care Act goes into effect.

Physicians could face a backlog and patients could find it difficult to get quick appointments.

Tennessee ranks 30th in the nation terms of physicians per capita with less than 5,000 physicians to treat the state's 6.3 million residents.

Nearly one in five Americans already lives in a region designated as having a shortage of primary care physicians. The number of doctors entering the field isn't expected to keep pace with demand.

Morristown's two hospitals are already feeling this shortage months before the new law goes into effect.

"Published data shows we currently have a deficit of 11 primary care providers in Hamblen County," said Gordon Lintz, chief administrative officer at Morristown-Hamblen Healthcare System. "With more individuals having health coverage, more physicians will be needed. MHHS is already working collaboratively to recruit more physicians to our community."

Clyde Wood, chief executive officer at Lakeway Regional Hospital, said because of the area's hospitals, the Lakeway Area may be in a better position than some.

"While the Affordable Care Act may not directly tie with physician recruitment, communities with well-functioning health systems will be in good positions to attract providers that can build and sustain long-lasting medical practices," Wood said.

> **'While the Affordable Care** Act may not directly tie with physician recruitment, communities with well-functioning health systems will be in good positions to attract providers that can build and sustain long-lasting medical practices,'
>
> **Clyde Wood**
> CEO Lakeway Regional Hospital

The nationwide shortage of primary care physicians are attributed to a number of factors: the population is getting older and becoming more chronically ill, the number of doctors entering the field isn't expected to keep pace with demand, doctors and clinicians are migrating to specialty fields for higher pay and better hours.

According to the Association of American Medical Colleges, there are an estimated 250,000 primary care doctors in the United States now. The shortage will reach almost 30,000 in two years and will grow to about 66,000 in more than a decade.

Many of these providers are still in the dark about how the ACA will impact their practices.

A lot of the influx of new patients will be dependent on co-pays and deductibles, said Joel Hornberger, chief operating officer of Cherokee Health Systems, a primary care provider with more than

See **GAP** *page E-6*

A state-by-state breakdown of primary care doctors

The Associated Press

A look at the number of active primary care physicians by state, the rate per capita and each state's ranking nationally, according to a 2011 report by the Association of American Medical Colleges. The doctors represent those who self-reported dealing directly with patients, as opposed to primary care physicians who are teaching, involved in research or doing mostly administrative work. Updated information is expected to be available in November.

	Total Population	# of Doctors	Rate per 100,000	Rank
United States	309,050,816	245,367	79.4	NR
Alabama	4,729,656	3,120	66.0	44
Alaska	708,862	667	94.1	8
Arizona	6,676,627	4,544	68.1	43
Arkansas	2,910,236	2,026	69.6	40
California	37,266,600	29,968	80.4	26
Colorado	5,095,309	4,229	83.0	21
Connecticut	3,526,937	3,172	89.9	12
Delaware	891,464	755	84.7	20
D.C.	610,589	1,110	181.8	N.R.
Florida	18,678,049	14,582	78.1	29
Georgia	9,908,357	6,516	65.8	45
Hawaii	1,300,086	1,358	104.5	4
Idaho	1,559,796	987	63.3	47
Illinois	12,944,410	10,591	81.8	22
Indiana	6,445,295	4,588	71.2	36
Iowa	3,023,081	2,288	75.7	31
Kansas	2,841,121	2,128	74.9	32
Kentucky	4,339,435	3,028	69.8	39
Louisiana	4,529,426	3,094	68.3	42
Maine	1,312,939	1,459	111.1	2
Maryland	5,737,274	5,427	94.6	7
Massachusetts	6,631,280	7,144	107.7	3
Michigan	9,931,235	8,487	85.5	18
Minnesota	5,290,447	4,938	93.3	9
Mississippi	2,960,467	1,732	58.5	49
Missouri	6,011,741	4,441	73.9	35
Montana	980,152	792	80.8	24
Nebraska	1,811,072	1,356	74.9	33
Nevada	2,654,751	1,691	63.7	46
New Hampshire	1,323,531	1,308	98.8	5
New Jersey	8,732,811	7,506	86.0	15
New Mexico	2,033,875	1,626	79.9	28
New York	19,577,730	17,989	91.9	11
North Carolina	9,458,888	7,011	74.1	34
North Dakota	653,778	561	85.8	17
Ohio	11,532,111	9,227	80.0	27
Oklahoma	3,724,447	2,571	69.0	41
Oregon	3,855,536	3,589	93.1	10
Pennsylvania	12,632,780	10,749	85.1	19
Rhode Island	1,056,870	1,009	95.5	6
South Carolina	4,596,958	3,231	70.3	38
South Dakota	820,077	660	80.5	25
Tennessee	**6,338,112**	**4,872**	**76.9**	**30**
Texas	25,213,445	15,633	62.0	48
Utah	2,830,753	1,654	58.4	50
Vermont	622,433	694	111.5	1
Virginia	7,952,119	6,446	81.1	23
Washington	6,746,199	5,971	88.5	13
West Virginia	1,825,513	1,568	85.9	16
Wisconsin	5,668,519	4,887	86.2	14
Wyoming	547,637	387	70.7	37

AP

In this March 11, file photo, Michelle Adams, left, a case manager at the West Division Family Health Center in Chicago, speaks with Shavonne Bullock, a recovering heroin addict during an appointment. Bullock, who has been drug free since 2006 when she started treatment at the center, pays for her own treatment because she's uninsured.

Local drug treatment, mental health agencies prep for changes

BY DENISE WILLIAMS
Tribune Staff Writer

There are an estimated 408,000 Tennesseans — approximately 8.3 percent of the population — who need treatment for substance abuse.

Slightly more than 10 percent of that number — an estimated 47,000 — are currently receiving treatment in one the state's various intensive outpatient, individual and inpatient programs.

When the Affordable Care Act goes into effect on Jan. 1, an additional 57,918 Tennesseans with substance abuse problems will be eligible for health insurance. While it is a drop in the bucket compared to what is needed, these newly insured drug addicts are sure to tap an already over-burdened system.

In the 60 years since the medical profession recognized addiction as a treatable disease, there is still a huge gap between need and access to care.

It is estimated that only one cent of every health care dollar in the United States goes toward addiction and few alcoholics and drug addicts receive treatment.

It is estimated that 180,000 Tennesseans will be eligible for coverage through the health insurance exchanges beginning on Jan. 1, 2014.

One of the tenets of the ACA is that mental health and substance abuse treatment are part of essential services that are identified, said Andy Black, chief executive officer of Helen Ross McNabb, which provides mental health, substance abuse and social services to more than 21,000 adults and children each year.

Black said while the mental health system "is in pretty good shape," for people with substance abuse problems, "the system is woefully inadequate. It's always been woefully inadequate."

So how will the already strapped agencies help the thousands of new patients who will come through the doors with their new insurance cards in hand?

"I think we'll be able to hire up to meet the needs of the patients," Black said.

Randy Jessee, senior vice president of special services for Frontier Health, which serves 50,000 patients per year in eight East Tennessee counties — including Hancock, Hawkins and Greene counties — and four counties in Southwest Virginia, said his agency is reimbursed by a federal block grant for the treatment of uninsured patients.

"There is a waiting list for services," he said. Patients have to meet certain criteria to determine if they'll be put on the waiting list or if they qualify for immediate treatment. He said that, for example, a IV-using, drug-addicted pregnant woman would get priority treatment.

"We really don't know how that's (the ACA) going to shake out," Jessee said. "We know what services we have available now."

The problem, he explained, is that just

See **ADDICTION** *page E-6*

Reforms

(Continued from page E-3)

calculate whether it's worth reducing their workforce or cutting workers' hours to avoid a series of escalating penalties that kick in if just one of their employees ends up receiving government-subsidized health care. Meanwhile, many smaller businesses appear to be taking a wait-and-see approach before determining whether to buy coverage through health insurance marketplaces geared toward their needs. In some states, they won't be able to compare rates with their current insurance plans until open enrollment begins in October. The business-to-business outreach manager at Connecticut's health insurance exchange, for example, predicts the plans will ultimately be attractive to smaller businesses that did not always offer insurance coverage.

If I currently buy my own insurance, can I keep it or do I have to change?

If you have individual insurance — a plan you bought yourself rather than what you get through an employer — you should be able to change to a new plan if you choose.

It also will be illegal for insurance companies to cancel your coverage if you make simple mistakes on forms, but you still can be cancelled for intentionally making false claims. If you have COBRA continuation health coverage, you can maintain it or decide to buy a new insurance plan. If you select a plan by Dec. 15, you can have coverage starting Jan. 1.

I keep hearing about bronze, silver, gold and platinum. What does that mean?

Bronze, silver, gold and platinum refer to the types of insurance policies available to businesses and individuals under the exchanges created by the health care law. The categories reflect how much premiums will cost each month and the amount you will pay for such things as hospital visits and prescription medications. The percentage covered by the plan increases from bonze to platinum. The lowest-cost plan is bronze, in which the insurance company covers 60 percent of the expenses and the individual will pay 40 percent. The highest-cost tier is platinum, in which the insurer covers 90 percent of the expenses and the individual pays 10 percent.

Is "Obamacare" available for immigrants?

It depends on whether they are in the country legally. Legal immigrants will be required to buy health insurance or pay a tax penalty if they don't. They can buy insurance through the health care exchanges and are eligible for the subsidies. Most legal immigrants cannot enroll in Medicaid if they have been in the U.S. for less than five years, although states have the option to waive the waiting period for pregnant women and children. Some legal immigrants will not be eligible for Medicaid, regardless of the amount of time they have been in the country.

Immigrants who are in the country illegally will not be eligible to buy insurance through the exchanges. They also are ineligible for Medicaid, although they remain eligible for emergency care under the law. Young immigrants who had been granted "deferred action" status by the Obama administration to avoid deportation by obtaining temporary work permits also will not be eligible for the exchanges or Medicaid.

Care

(Continued from page E-4)

beneficiary, this time it's going to be spread out a little bit more. If they call the wrong places, we're doing our very best to make sure they're guided back to the correct place," said Nicole Duritz, vice president of health education.

In Illinois, it's not only seniors who are confused, but also the social workers who help them, said Erin Weir of AgeOptions, suburban Cook County's lead agency on aging. The agency coordinates a statewide training program for groups that work with older adults.

During these trainings, Weir said, she's repeatedly heard questions from social workers who think seniors will be able to sign up for Medicare programs on the new marketplace websites, even though they cannot.

"We've been focusing on people who are already on Medicare, calming them down and saying, 'You don't have to do anything, you're fine,'" Weir said.

Advocates are also warning of scams that may pop up alongside legitimate door-to-door outreach about the Affordable Care Act ramps up and advising seniors not to give out personal information.

Addiction

(Continued from page E-5)

because patients now have access to care, it doesn't mean the infrastructure is in place to provide care.

"There are limitations in how you deliver care," Jessee said.

One of the services Frontier Health provides is medically monitored detox, which requires nurses and doctors available around the clock.

He explained that any treatment requiring 24/7 care is going to cost more.

The limiting factor, in addition to staff, is the number of available patient beds.

Frontier currently only has 12 female and 11 male beds.

"If we get 10 percent more people applying for care, I'm in trouble," he said. "I don't have the capacity to deal with it."

Jessee said that an increase of only 15 to 20 percent would require Frontier to assess the financial costs to provide services for additional people. He estimated it could cost $1 million in operating costs alone for each additional 15 beds.

"It could be a lot higher than that," he said.

The problem, according to Treatment Research Institute CEO Tom McLellan, who was President Barack Obama's former deputy drug czar, is that the system in place for the treatment of drug abuse was built at a time when the medical community didn't understand addiction was an illness.

The system is already full to overflowing in many places. In more than two-thirds of the states, treatment clinics are already at or approaching 100 percent capacity.

"As the health insurance exchange progresses, we're going to be responsive to it and participate and literally thousand of people will have additional opportunities to access care," Black said.

While Tennessee has opted not to increase Medicaid enrollment, Jessee said the Volunteer State is one of the lucky ones. Gov. Bill Haslam and the mental health commissioner have increased resources into the area.

"It's still painfully inadequate," he said.

Gap

(Continued from page E-5)

50 physicians.

"It is likely there will be an increased demand," Hornberger said. "We're hiring additional staff to gear up for that."

CHS is also actively recruiting family nurse practitioners and physician's assistants.

"We have 670 employees now," Hornberger said. "We expect that next year at this time, that could be significantly higher. The challenge is to find quality applicants."

He said CHS has a great working relationship with the regional colleges and universities that routinely train health care professionals, including the medical schools at the University of Tennessee, Lincoln-Memorial University and East Tennessee State University.

They also work with the nursing program at Walters State Community College.

The federal health care law attempt to address anticipated shortages by including incentives to bolster the primary care workforce and boost training opportunities for physicians' assistants and nurse practitioners. If offers financial assistance to support doctors in underserved and increases the level of Medicaid reimbursements for those practicing primary care.

Act

(Continued from page E-1)

That's significant because starting next year most Americans will also have a legal obligation to get covered or face fines.

Some people who now purchase bare-bones individual plans will complain the new ones cost too much. Others, in good health, may resent the government telling them to purchase insurance they don't think they need.

Nonetheless, the number of uninsured people is expected to drop markedly, bringing the United States closer to other economically advanced countries that guarantee coverage.

The combination of subsidized private insurance through the new markets, plus expanded Medicaid in states accepting it, could reduce the number of uninsured by one-fourth or more next year. Current estimates of the uninsured range from around 49 million to well over 50 million.

As Americans get more familiar with the law — and if more states accept the Medicaid expansion — millions more should gain coverage. Many of the remaining uninsured will be people living in the country illegally. They are not entitled to benefits.

In Texas, Republican Gov. Rick Perry has vowed not to facilitate "Obamacare." But Cecilia Fontenot of Houston is looking forward to the opening of that state's federally run insurance market.

A part-time accountant in her early 60s, Fontenot is uninsured and trying to stay healthy while coping with diabetes, high blood pressure and high cholesterol. She walks twice a day, early in the morning before it gets hot, and in the evenings.

Also on her mind is a breast lump detected about a year ago. Her doctor recommended a digital mammogram, but she has not been able to afford the more involved test.

"I try not to worry and just pray on it," said Fontenot.

Because of her pre-existing conditions, Fontenot would have a tough time finding affordable individual coverage today. But starting Jan. 1, insurers will no longer be able to turn away people with health problems or charge them more.

And the government will provide sliding-scale tax credits that can make premiums more affordable for households earning between 100 percent and 400 percent of the federal poverty line. That's $11,490 to $45,960 for an individual, $23,550 to $94,200 for a family of four.

People on the low end of the income scale get more help, as will older people, whose premiums are higher.

With an annual income of about $23,000, Fontenot makes too much to qualify for Medicaid. And her state decided not to expand the program, an option the Supreme Court granted last year as it upheld the rest of Obama's law.

But she would qualify for subsidized private coverage in the federally run Texas marketplace. She could apply online, through a call center, by mail or in person.

After the government verifies her identity, legal residence and income, Fontenot would be able to take her tax credit and use it to pick an insurance plan. Coverage takes effect Jan. 1.

She'd have up to four levels of coverage to choose from: bronze, silver, gold and platinum. All cover the same benefits, but platinum has the highest premiums and lowest out-of-pocket costs, while bronze has the lowest premiums and highest out-of-pocket costs.

Fontenot's share of premiums would be capped at 6.3 percent of her income, or $1,450 a year for a benchmark silver plan. She'd have to squeeze about $120 a month out of her budget, and that doesn't include her annual deductible and copayments.

"If I want to stay alive, I'm going to have to budget that in," said Fontenot.

With insurance, she'd switch to a brand-name diabetes drug that does a better job of controlling her blood sugars — and get that mammogram.

"I am not asking for free stuff," she added. "I am willing to do my part."

Like Fontenot, many of the people who'll access the markets Oct 1 will have health problems. It's where the greatest need is.

But two other groups are critical to the program's success: Healthy uninsured people, many of them in their 20s and 30s, and insured people who will switch over from existing individual policies.

Healthy individuals are needed to help pay for the sick.

And with instant feedback via social media, reviews by people switching from existing individual plans could define early consumer sentiment.

Some of those transitioning will be looking for better deals. Others will be there because their insurers canceled policies that didn't meet the law's minimum standards, and they may be upset.

Consumers don't have to decide on Oct. 1. You have until Dec. 15 to sign up if you want coverage by Jan. 1. And you have until next Mar. 31 if you want to avoid penalties for 2014. Fines start as low as $95 the first year but escalate thereafter.

Procrastinate beyond Mar. 31, and you'll have to wait until the next open enrollment period in Oct. 2014, unless you have a life-changing event like job loss, divorce or the birth of a child.

Former Medicare chief Mark McClellan, who oversaw the rollout of seniors' prescription drug benefits for Republican President George W. Bush, says his advice is not to sign up right away, but not to wait too long either. In other words, check things out. Buying health insurance is not as simple as shopping on Amazon.

"This is a milestone along the path but by no means the end of the road," said McClellan. "There's a lot more of a journey to see if it can really succeed."

Three key things to watch for are premiums, choice and the consumer shopping experience.

Premiums so far are averaging lower than what government experts estimated when Congress was debating the law. That's important for policy types, but it may not mean much to consumers. Current low-cost individual market policies are difficult to compare with the new plans, which offer better financial protection and broader benefits.

Plan choices seem adequate, but networks of hospitals and doctors may be tightly restricted to keep premiums low.

The biggest unknown is how consumers will feel about the whole experience. Many will be unfamiliar with health insurance basics, and applying for subsidies may feel like plodding through tax forms.

Still, after years of polemic debate and a Supreme Court decision — and even as congressional Republicans keep trying to repeal it — "Obamacare" will finally be in the hands of American consumers.

State of the health care overhaul

Beginning Oct. 1, uninsured Americans can apply for subsidized health care coverage through new online marketplaces known as exchanges. It's a core provision of the Affordable Care Act, which went into effect in 2010 and has been the subject of political and legal battles since. Some milestones and potholes along the way since the law was passed:

March 23: President Barack Obama signs the Affordable Care Act. Within minutes, lawsuits are filed in federal courts challenging the law.

Jan. 13: The GOP-controlled House votes to repeal the law on a party-line vote; the measure fails in the Senate. (Since then, the House has made dozens of attempts to repeal, defund or scale back the law.)

Nov. 14: The Supreme Court says it will take up the challenge to the law.

June 28: The Supreme Court rules the individual mandate is constitutional but that states can decide whether to expand their participation in Medicaid, a key provision to cover the poor.

Nov. 8: House Speaker John Boehner, R-Ohio, says in an interview that "Obamacare is the law of the land." His spokesman adds that Boehner remains "committed to full repeal."

June 28: Facing lawsuits by religious groups, the administration issues compromise rules for faith-based nonprofits that object to covering birth control in their employee health plans.

2010 | 2011 | 2012 | 2013

Nov. 2: Republicans win control of House of Representatives, partly on a platform to "repeal and replace" the law.

Jan. 31: A federal judge in Florida rules the entire health overhaul unconstitutional, handing a victory to the 26 states challenging the law.

Aug. 1: HHS Secretary Kathleen Sebelius declares that most health plans will have to cover birth control for women as a preventive service, free of charge, beginning in 2013.

March 26-28: Supreme Court hears three days of oral arguments on separate aspects of the law.

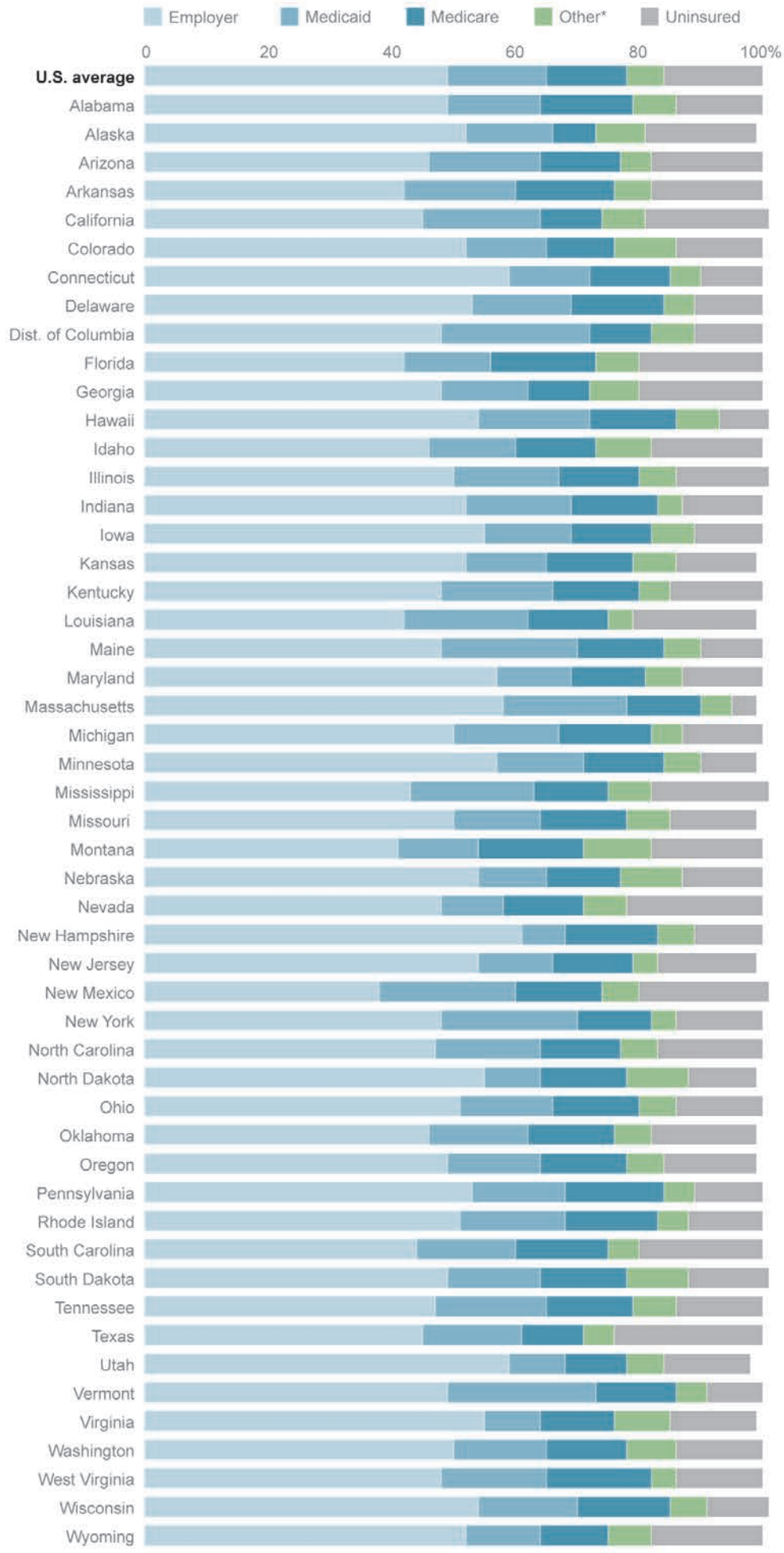
Nov. 6: Obama is elected to a second term and Democrats retain control of the Senate, dimming Republican hopes of repeal.

Jan. 1: Tax increases to finance the law take effect on high-income earners.

March 12: A draft of the application for subsidized coverage surfaces; the 15-page, 21-step form is widely jeered for its complexity. A simplified form debuts a month later.

July 2: Obama delays until 2015 the requirement that companies with more than 50 employees provide coverage for their workers or face fines.

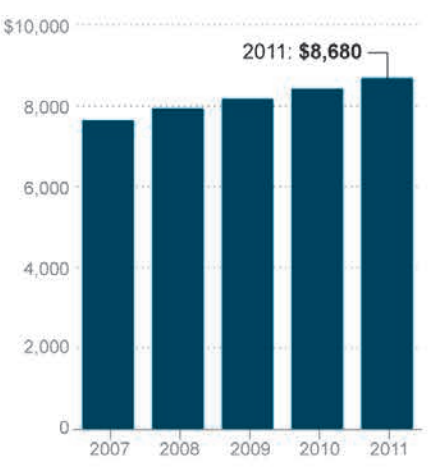
Where Americans get their health insurance:



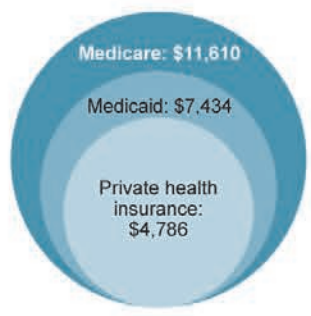
NOTE: Numbers may not equal 100 due to rounding. *Includes other public insurance programs and the self-insured

How much they spend on health care:

Average per-person health spending since 2007:

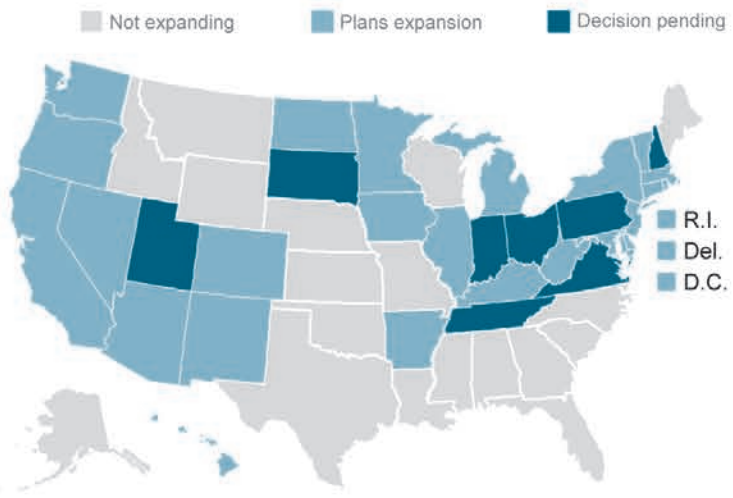


Average per-person spending by insurance source in 2011:



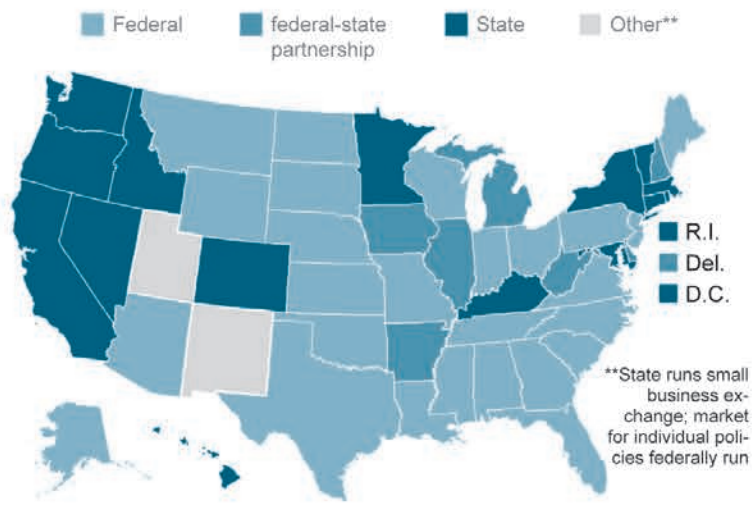
Medicaid expands in about half of states

The Supreme Court ruled that states can decide whether to participate in the expansion of Medicaid, the federal-state health insurance plan for the poor. While the expansion is a key part of the plan to extend coverage to low-income Americans, millions live in states that have opted not to broaden the program. Status of the states as of Sept. 10:



Patchwork of new health care marketplaces

States have their choice whether to operate their own insurance enrollment systems known as exchanges, let the federal government do it or enter into a state-federal partnership:



SOURCES: Department of Health and Human Services; Kaiser Family Foundation; Urban Institute AP

Archetype: Middle class family braces for higher premiums

(AP) - As many as nine in 10 Texans buying health insurance on the new federally run exchange will get a break on costs, according to federal health officials. Steve and Maegan Wolf won't be among them.

The Wolfs, who live in an upscale area outside Austin, make too much money to qualify for tax credits that will help other people afford coverage. That leaves them wondering how much they'll wind up paying.

Steve Wolf, 50, coordinates stunts and special effects for feature films and TV shows. Last year, he helped the Discovery Channel blow up scale replicas of the Hindenburg. He owns Stunt Ranch, where schoolchildren come to learn about the science and math of movie stunts.

His wife, 34, is a full-time mom who spends many hours each week getting their three boys, 16-year-old Clayton, 12-year-old Paxton and 8-year-old Dashton, to school, swim lessons, speech therapy and math tutoring appointments.

Like many who run family businesses, the Wolfs' annual income varies, but it's typically $115,000 to $140,000. That means they make too much to be eligible for the tax credits that will help some Americans pay for health insurance under the Affordable Care Act. They also worry that changes in coverage required by the law will mean their premiums will increase. That includes setting minimum coverage requirements for insurance companies that go well beyond what many offer now and prohibiting insurers from banning those with pre-existing medical conditions.

The Wolfs have purchased their family's health insurance on the individual market for about 12 years, during which time their premiums have risen steadily.

They now pay about $650 a month for insurance. And while their general health is excellent, each of them has had their share of medical expenses. Their policy has a $5,000 annual deductible for each adult, meaning the Wolfs in many years have had to pay $10,000 out of pocket toward medical bills on top of the $25 copays for doctor visits and $20 copays for covered generic medicine.

Next to their mortgage ($2,300 a month with property taxes), their health insurance is one of their biggest expenses. Private school for two of the three boys adds nearly $3,000 per month. One of the boys is both dyslexic and has celiac disease, requiring additional educational and grocery expenses. There also are bills for life insurance, orthodontia, utilities, cellphones, car insurance for a teenage driver, and home and auto maintenance.

AP

This Aug. 25, photo shows Steve Wolf, a self-employed stunt and special effects coordinator for film and television, who lives with his wife Maegan and their sons Clayton, 16, Paxton, 12, and Dashton, 8, in Austin, Texas. The Wolf family worries their income is too high to qualify for new tax credits implemented under the Affordable Care Act.

"When all is said and done, we live well, but there is no money left over," Steve Wolf said. "Any increase in health insurance costs will create a financial strain.

"But I keep it all in perspective. Unlike most people on the planet, we've never missed a meal, been unable to find safe drinking water, lacked for a home to sleep in or had to go without medical care. So while this pinches us in the pocket, I'm very lucky to have these problems."

Based on the Kaiser Family Foundation's online calculator, the Wolf family's annual premium costs for health insurance would be almost double their current costs if they purchase a benchmark plan through the federal exchange that will be offered to Texas residents.

If a yearly income of $130,000 is assumed, the Wolfs would pay an annual premium of $14,804 for the mid-range insurance plan, called a Silver Plan. Their current annual premium is about $7,800.

Instead, they could buy a less comprehensive Bronze plan for $12,270 a year. Or they would be eligible to purchase catastrophic coverage for even less, although it's not clear how much this type of coverage would cost the Wolfs. A catastrophic plan would cover only preventive care. All the plans would come with an annual cost-sharing limit of $12,700 for the family, meaning they wouldn't have to pay more than that out-of-pocket after paying their premiums.

Many health care expenses aren't predictable and there is risk inherent in choosing a plan with a higher out-of-pocket costs and lower premiums, but the Wolfs are willing to take their chances.

"Despite our experience, we continue to hope that we'll have low out-of-pocket expenses, so we'd rather have a lower premium and the possibility of low costs than to be locked in to higher premiums that cover services that we might not use," Steve Wolf said.

Archetype: Health costs likely rising for many self-employed

SEATTLE (AP) — President Obama's health care reforms will be a huge boost to the working poor but are likely to make life more expensive for Aaron Brethorst and others like him.

The Seattle software developer and consultant doesn't have a problem with that because he figures he'll be able to afford quality insurance.

He says his annual income is in the low six-figures, and he expects to receive better coverage once the Affordable Care Act kicks in.

The 31-year-old says the ability to buy his own health insurance, because he is relatively young and healthy, has given him the creative freedom to start his own companies and explore new ideas.

He spends a little more than $300 a month on catastrophic coverage with a high deductible.

He recently got an email from his health insurance company informing him that the plan he bought on the individual market is going to be cancelled.

Brethorst said he does not know whether he will buy his next policy from the same company — a local version of Blue Cross — or through the state insurance exchange, the Washington HealthPlan finder. He does expect to add a better dental and vision plan in the new year, however.

"I'm not worried about it, quite frankly," Brethorst said. "My income today is more than enough to pay for health insurance."

That outlook is not likely to be universal among those who are self-employed.

The income threshold for a government subsidy offered on the state exchanges varies based on a number of factors, but generally tops out at $46,000 a year for an individual.

Depending on their health, age, family circumstances and income, the cost of insurance could become a burden for those who make too much money for government subsidies but not enough to be considered well-off.

Insurance companies say the cost of their polices will have to reflect the new government mandates under the Affordable Care Act, including the requirement to cover all people, regardless of their medical condition, and to provide coverage for 10 new essential benefits that include mental health treatment and maternity care.

Glen Melnick, a health economist at the University of Southern California, said he believes many younger singles who are self-employed will decide against buying health insurance despite the government mandate, opting instead to pay the fine.

"They're going to decide not to play. They are risk-takers to begin with," he said.

AP

Aaron Brethorst poses for a photo while walking his dog, Moxie, in Seattle on Monday, Sept. 9.

Yet the additional benefits under the law could outweigh the added costs for some, said Dylan Roby, assistant professor and researcher at the University of California, Los Angeles Center for Health Policy Research. Another positive of the federal reforms is the ability to more easily comparison-shop between insurance companies and policies, he said.

Brethorst said the Affordable Care Act is likely to provide freedom to those who currently cannot afford to escape employer-based coverage to pursue their own dreams.

The iPhone app developer and business consultant cites as an example a friend and colleague with asthma.

They started a new company together a few years ago while his friend was buying his insurance from a former employer through the federal COBRA plan.

When the venture capital funding they were seeking fell through before his access to company health insurance ran out, Brethorst's friend left for another company job where he could get health insurance as an employee.

"We've been talking about working together again at some point," Brethorst said. "Once these provisions go into effect, it's going to be significantly easier to go off and pursue his entrepreneurial dreams."

Archetype: Health insurance within reach for bipolar sufferer

MIAMI (AP) — Before she was diagnosed with bipolar disorder, 32-year-old Jessi Spencer-Hammac thought she was just a moody, restless dreamer who had trouble finishing projects.

At times, she alternated between being hyper-social and abruptly ending relationships. She also made rash decisions, such as moving across the country and losing contact for a couple years with her young daughter, who was living with the girl's father at the time.

Up one day, she could swing quickly to sad and withdrawn.

Spencer-Hammac said she did not seek mental health treatment until a few years ago. Because she cannot afford health insurance, she pays for the counseling and prescriptions out-of-pocket.

But under the Affordable Care Act, insurers will be prohibited from turning away Spencer-Hammac and millions of other Americans with pre-existing medical conditions, as they can now. Insurers that do offer coverage to those with existing conditions typically charge such high premiums that the cost makes it unaffordable.

For Spencer-Hammac, the provision in the federal health care law could mean an end to buying her $100-a-month mood-stabilizing medication at a discounted price in Canada, as well as the chance to see her therapist more regularly.

Her husband Chris, a 40-year-old bartender who makes about $35,000 a year, has health insurance through the Veterans Administration, but his policy does not cover family. He was recently diagnosed with testicular cancer and underwent surgery in August, further stressing the family's finances. Their 12-year-old daughter, Marley, has coverage through her step-mother's job.

The National Institute of Mental Health estimates that 6 percent of Americans live with a serious mental illness. One in four adults, or about 57.7 million Americans, experience a mental health disorder in a given year. Many don't have access to treatment or lack insurance plans that cover mental illness.

The Tampa mom tried to get health insurance about eight months ago and was told by one consultant that she would never get coverage for mental illness as an individual. She searched for plans online but was inundated with phone calls from insurance companies she said were so manipulative that she gave up.

"I felt marginalized, like I didn't matter, and mad ... that my struggle and the things that I deal with don't matter," she said.

Spencer-Hammac, who is about to start working again as a waitress, pays $40 for a family physician

See **BIPOLAR** *page F-3*

AP

Tim Holmes, left, and his wife Colleen Holmes, who own and operate Wheatfields Restaurant, stand outside their business in Clifton Park, N.Y. on Tuesday, Sept. 10.

Archetype: Health care law perplexing to business owners

ALBANY, N.Y. (AP) — Restaurant owners Colleen and Tim Holmes were considering opening a third business in a growing upstate New York suburb but decided against it. One factor was the risk from expanding their staff beyond 50 full-time employees and having to provide them federally mandated health coverage.

Despite knowing the penalty for that part of the Affordable Care Act had been postponed for a year, the couple said their margins are thin and the requirements and costs under the law remain unclear.

They also face some disruption from their current health plan, with some coverage moving to the new insurance exchange after this year.

They've discussed whether they need to hire a consultant to help them understand what the law means for the owners of small businesses, but it's an expense they'd rather not have. Yet they have little time to research the act on their own, since they already work more than 70 hours a week.

"As small-business owners we take all the risk and we employ a lot of people, so any additional cost is difficult for us to justify without having additional revenue," Colleen Holmes said.

Even though they offer health insurance, the couple said most of their employees refuse it because of the cost of premiums and because most are young and feel they don't need it or can now get coverage under their parents' policies through age 26.

At costs ranging from $300 to $500 a month for one healthy employee, the business could not afford to pay a fraction of the premiums, they said. At even $100 a month, it would be $5,000 monthly for 50 workers.

"Where's that money going to come from?" Colleen Holmes said.

Her husband said it would be more advantageous for their employees to go directly to the new health exchange for individual coverage because it can be subsidized by the government.

Since 2004, they've owned and operated Wheatfields Restaurant and Bar in Saratoga Springs, an upscale city with a thoroughbred track, performing arts center and Skidmore College. In 2009, they opened a cafe in the nearby Albany suburb of Clifton Park and more recently considered opening a third restaurant in between in Malta, a town that's been growing with a new semiconductor manufacturing center.

"There's a lot of other issues out there, but the health care definitely made us reevaluate our business strategy in expanding," Colleen Holmes said.

Another was New York lawmakers this year boosting the state's minimum wage, which will rise incrementally from $7.25 an hour to $9 an hour in 2016.

In addition to the New York health exchange, a separate one will serve small businesses, defined as having 50 or fewer eligible employees. Many owners expect to rely on brokers to help them find the best deal.

The definition of a small business will increase from 50 to 100 full-time employees in 2016 in New York, expanding access to the state-run exchange and possible tax credits for providing coverage.

However, businesses with 50 or more full-time staff still will be required to provide affordable coverage or face tax penalties, which start in 2015. Employee premiums cannot exceed 9.5 percent of gross income.

Several city and regional chambers of commerce, which have traditionally offered pooled insurance coverage for small businesses, plan to continue. However, sole proprietors now will have to go to the exchange.

For now, the Holmes and other small-business owners are trying to understand the law's effect on them and their employees, as well as figure out what the related costs might be.

"When you can't pinpoint your costs," said Tim Holmes, "you can't make strategic decisions regarding your business."

AP

In this Wednesday, Sept. 4, photo, 32-year-old Jessi Spencer-Hammac poses with her dog Rocco, in Tampa, Fla.

Bipolar

(Continued from page F-2)

to write the prescription for her mood stabilizer. She can't use the generic brand, so she buys it in Canada and orders several months' worth to avoid high shipping costs. Sometimes, she worries the order will not arrive on time, so she regulates her dosage.

"If I stop it abruptly, I'm looking at being very unstable. That's always been a stressor," she said.

When she's feeling overwhelmed and needs to talk to her therapist, it costs about $100. That's why she's only been twice in the past five months.

A few months ago, she attended a town hall meeting and learned she might be able to get affordable insurance through the new state health insurance exchange under the Affordable Care Act. She also might also qualify for a federal subsidy to help offset the cost.

"I know I'll feel relieved," she said. "It's a burden to walk around and hope that nothing happens to you, and then with bipolar that you don't do anything drastic and stupid."

Archetype: Costs worry woman, 26, who wants health insurance

PHOENIX (AP) — Helena Gudger is the type of person health insurance companies need on the books as the federal Affordable Care Act begins to roll out: Young, relatively healthy and hungry for coverage.

The 26-year-old Phoenix resident has gone the past four years without health insurance, using clinics and the county hospital for checkups, routine tests and visits to a gynecologist. She pays cash, checks prices and tries to go when doctors are offering discounts.

But she also is aware that she will be in a lurch if she gets sick. She does her best to avoid crowds where she could pick up an infection and even researches the local lake for outbreaks when her friends plan an outing. She planned to sign up for private health insurance as soon as the new federal marketplace opened in October.

"I know I have to plan ahead with certain events. I try to avoid crowded places where a lot of exchange of germs may transpire — I don't want to get sick," Gudger said. "It definitely makes you more aware of your surroundings. It's a constant factor in the back of your mind."

Insurance companies need young, healthy adults to buy insurance because new mandates under the federal health care reforms mean they can no longer turn away people with pre-existing medical conditions or charger older people much higher premiums.

They now must offer policies to everyone, no matter their health, and face limits on prices for older customers.

The twentysomethings and those in their early 30s who are most coveted by the insurance industry have a difficult decision to make as the health insurance exchanges begin accepting enrollment in October: Should they pay the $100 annual penalty for not having insurance or pay monthly premiums for coverage that might have high deductibles and out-of-pocket expenses?

Some six million people of various ages will pay the tax penalty for not having insurance next year, the Affordable Care Act's first full year of implementation, according to the Congressional Budget Office.

Some younger people argue they don't need insurance and will opt to pay the penalty, although by 2016 the fine jumps to $695 a year or 2.5 percent of taxable income, whichever is more.

Gudger said she is not in that category. A student at two-year Phoenix College who hopes to eventually earn a four-year environmental science degree, she just started a $13-an-hour, part-time job for a company selling solar panels. She has spoken with her mother about how the law will help her get insurance.

AP

Helena Gudger, 26, pauses as she works on homework while taking a break between classes at her college in Phoenix on Tuesday, Sept. 10.

But she has little information about how the new federal marketplace — Arizona chose not to run a state program — will work, let alone the exact coverage the plans might provide. And while she may qualify for insurance through her employer in six months, that's a long way off for her and she wants to know her options now, and for the future.

"What I know is pretty much I believe in the next year or so everybody's going to have health care, whether you have kids or not," she said. "Everybody needs to have health care in some form or another."

Based on her income, Gudger will qualify for federal subsidies that will pay nearly half the premium for a midpoint "silver" plan, which covers 70 percent of costs and includes co-pays. An online calculator created by the Kaiser Family Foundation estimates her annual premium at $3,163 and the federal subsidy at $1,434, leaving her with a premium of $1,729, or $144 a month.

Even with the federal subsidies, that estimated cost is higher than what she hoped to see. And because she wants a decent insurance policy, not the bare-bones coverage cheaper plans offer, she's still not sure just how she'll proceed.

"If I was to be able to be offered affordable health insurance, I would say I would probably afford anywhere between $60 and $100 a month," Gudger said. "I wouldn't want to pay more than $75, considering I'd have to pay for prescriptions and copays if I have to see a doctor."

Archetype: Mich. smoker may stay uninsured unless he quits

LANSING, Mich. (AP) — Eric Jones has an incentive to end his trips to the party store for cigarette tubes and tobacco, the roll-your-own supplies used to fill his pack-a-day habit.

The 40-year-old has no health insurance from his $9-an-hour job at an ice-manufacturing plant in Lansing. Under the federal health care law, he's eligible for help from the government to buy insurance.

But to qualify, he'll almost certainly have to quit smoking.

A baseline insurance plan could cost Jones, who makes $22,000 working seasonally from February to November, $775 a year in premiums. Or he could pay no premiums in the cheapest plan, which has higher deductibles and copayments.

Yet if he keeps smoking, he could face an annual financial penalty ranging from $1,600 to $1,900 that will make coverage unaffordable. The numbers were estimated using the online Kaiser Health Reform Subsidy Calculator.

"I'd rather have health coverage than cigarettes, if it comes down to it," Jones said.

The law requires insurers to accept all applicants regardless of pre-existing medical problems. But it also allows them to charge smokers premiums that are up to 50 percent higher than those offered non-smokers — a way for insurers to ward off bad risks.

Jones is not without health problems. He said he should be taking medications for gout, high blood pressure, high cholesterol and severe acid reflux but instead just suffers through his conditions.

AP

In this Aug. 29, photo, Eric Jones is seen outside of a party store after purchasing cigarette tubes and tobacco, the roll-your-own supplies used to fill his pack-a-day habit, in Lansing, Mich.

"I can't afford them," he said. "So I just don't take them."

Jones, who first smoked at age 12, has tried quitting. He stopped about four years ago with no help from nicotine patches or gum. But he started up again this year.

"Everybody around me was smoking except my wife. Everywhere. All my friends," he said.

Nearly one of every five U.S. adults smokes. That share is higher among lower-income people such as Jones, who are more likely to work in jobs that do not offer health insurance and are a major reason the law was enacted. The smoking penalty has drawn criticism for effectively pricing people out of insurance.

Jones already is worried that he won't be able to afford insurance even if he does quit. He has trouble paying the rent. He takes the bus from rural Charlotte 20 miles each way to work in the city every day.

Yet if Jones keeps smoking, he said there is no way he could afford the estimated $1,600

See **SMOKER** *page F-4*

Archetype: Medicaid expansion happy surprise for Colorado man

DENVER (AP) — He makes just $10,000 a year as a clinical professional counselor, so Morgan Kinney decided to spend what little extra money he had this year paying down student debt rather than buying health insurance.

The 31-year-old Denver man figured he would have no choice but to buy insurance next year to comply with the new federal health insurance mandate, so last month he entered his personal information into the online calculator of the Colorado insurance exchange.

Yet instead of a cost estimate, he received a rejection notice saying he was not eligible to shop on the exchange.

"I was telling my girlfriend, 'This thing is broken, it won't let me in,' and she looked and said, 'I think it's because you're supposed to be on Medicaid.' I said, 'No, that's for poor people.' Well, sure enough, that was me."

Colorado is one of at least 24 states expanding Medicaid access for adults under the Affordable Care Act. In Colorado, that means single adults who earned less than $15,400 last year will have access to Medicaid. Childless adults in the state currently qualify for Medicaid only if they make less than $95 a month. Colorado estimates about 160,000 people will be added to state Medicaid rolls under the new guidelines.

Medicaid expansion is a major plank of the administration's plan to get every American covered by health insurance. But the U.S. Supreme Court last year limited the federal government's ability to penalize states that decide against the expansion, leading to a patchwork of Medicaid eligibility standards. The Congressional Budget Office has projected 11 million Americans will get coverage through the Medicaid expansion by 2022.

AP

In this Aug. 29, photo, Morgan Kinney, 31, a clinical professional counselor working part-time while his girlfriend finishes medical school, sits on his couch in his his apartment in Denver.

Kinney said he feels incredibly fortunate to live in a state where he will receive basic coverage through the government program. He has seen firsthand just how expense medical expenses can be.

He broke his leg last April in a car accident heading home from a cross-country skiing trip. But the other driver was at fault, sparing Kinney from having to pay the hefty medical bills for his treatment.

Kinney said he is thankful every time he sees the tab for his care: $500 for the ambulance ride; $150 just to consult with a doctor by telephone; $100 for a pill.

"Even though I know I'm going to get my bills paid, it's incredibly scary watching the number of zeros on the letters that roll in saying these are the bills we owe," said Kinney, who is working part-time while his girlfriend finishes medical school.

He is just beginning his career with a startup counseling company and expects to increase his earnings significantly in the years ahead.

For now, though, Kinney said he is happy to be caught in the Medicaid safety net because Colorado opted for the expansion. The cost will be covered entirely by the federal government for the first few years, with that share eventually falling to 90 percent.

He wants a checkup and maybe a trip to the dentist.

"Until now, I've used delusion and denial to pretend something wouldn't actually happen to my health," Kinney said. "So now it's nice to think about actually having coverage. It didn't click when I saw all the 'Obamacare' stuff on the news; it was just people yelling at each other. ... It was just politics. Now it feels real."

Changes to health care under the law

An overview of some of the key changes to health care services under the Affordable Care Act:

ESSENTIAL HEALTH BENEFITS

Under the law, health insurers must cover 10 essential benefits. This will make health plans more costly, but also more comprehensive. Starting next year, the rules will apply to all plans offered to individuals or through the small-group market to employers with 50 or fewer workers. The essential-benefits requirement does not apply to plans offered by larger employers, which typically offer most of these, already.

The covered benefits are: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative services and devices; laboratory services; management of chronic diseases, and preventive and wellness services; and pediatric services, including dental and vision care.

People will be able to pick from insurance plans with differing levels of coverage and varying costs for co-pays and premiums. But insurers will have to cover a certain percentage of the services' cost.

"Most of the important services people need are covered, though there may be a slight variation (from state to state)," says Jennifer Tolbert, director of state health reform for the Kaiser Family Foundation.

DENTAL-VISION

Need a teeth-cleaning or eye exam? You still could be reaching into your own wallet to cover the cost even after the Affordable Care Act takes full effect next year. Dental and vision care is considered an essential benefit for children aged 18 and younger whose parents or guardians get insurance through the individual or small-group plans.

The law does not mandate this coverage for adults, but some states could choose to have them covered.

Still, getting dental coverage for children and teenagers might be a bit complicated depending on where you live. States can choose to offer those items as stand-alone plans, and federal subsidies would not help pay for the costs.

AGE 26

One popular provision of the health care law already is part of most insurance plans — allowing young people to stay on their parents' insurance plans until age 26.

This also covers dependents, including step-children, adopted children and some foster children.

This benefit will be required of all plans that provide dependent care. Starting in 2014, younger people can remain on a parent's or caregiver's plan even if they have an employer option of their own.

PRE-EXISTING CONDITIONS

This is a major change under the law. Starting in 2014, most plans — whether obtained through an employer or on the marketplace — cannot deny coverage or charge more money because of a pre-existing health conditions.

However, if you have what is known as a grandfathered individual plan — a plan you buy yourself that was in existence before March 23, 2010, and has remained unchanged — then this rule would not apply. So check the details on your plan and consider shopping around.

OUT-OF-POCKET SPENDING LIFETIME LIMITS

Under the law, the amount of money people will have to pay out-of-pocket each year for medical and prescription drug costs will be capped at $6,350 for individuals and $12,700 for a family. These limits are separate from the monthly premiums people pay.

The limits take effect in 2014 for those buying insurance on the state health insurance exchanges.

For those with employer-based coverage, the restrictions will be fully in place in 2015.

In addition, most insurance plans will be prohibited from setting lifetime cost limits on coverage for essential health benefits.

This means your insurer cannot deny you coverage because your medical bills have gone over a certain amount.

AP

Chris Gatliff stands outside his home in Lawton, Okla, on Wednesday, Aug. 28. In mid-September, Oklahoma Gov. Mary Fallin announced a temporary reprieve for the 30,000 Oklahomans like Gatliff who receive coverage through Insure Oklahoma, saying the program would remain operating for one more year. Gatliff, a part-time worker at a pizza restaurant, said he was grateful for the temporary extension but said he felt like a victim of Oklahoma's resistance to implementing the Affordable Care Act.

Archetype: Medicaid politics affect low-wage pizza employee

LAWTON, Okla. (AP) — Chris Gatliff, a 38-year-old diabetic, says he feels like a victim of politics.

His home state, Oklahoma, opted against accepting the expansion of Medicaid under the Affordable Care Act. The result is that thousands of Oklahomans who would have qualified under the expanded program are left in limbo about their health insurance.

At the same time, a Medicaid-linked program called Insure Oklahoma that provides Gatliff with his current coverage was due to expire Dec. 31. That left him facing the prospect of having no insurance at the end of the year, so the part-time pizza shop employee began planning to stockpile his medications.

In mid-September, however, Oklahoma Gov. Mary Fallin announced a temporary reprieve for the 30,000 Oklahomans who receive coverage through Insure Oklahoma, saying the program would remain operating for one more year.

Gatliff said he was grateful for the temporary extension but said he felt like a victim of Oklahoma's resistance to implementing the Affordable Care Act.

"I'm glad she did it," said Gatliff, who makes between $7,000 and $9,000 annually. "It's a year, which is good, but it's still only a year. After that, I'll have to worry about it."

He said he believed the governor should have simply accepted the Medicaid expansion that was offered to states under the federal health care reforms. The federal government pays for the full expansion for the first few years and 90 percent thereafter.

Opting for the Medicaid expansion under the federal law would have provided medical coverage to as many as one-third of Oklahoma's 636,000 uninsured residents, about 17 percent of the state's population.

But for Fallin, agreeing to an expansion of Medicaid would be politically dangerous. She voted against the Affordable Care Act when she served in Congress, railed against it during her campaign for governor and consistently opposed it during her first term.

She said she is concerned the expansion could cost Oklahoma $850 million through 2020.

Although the Insure Oklahoma program was pushed by former Democratic Gov. Brad Henry and uses federal Medicaid dollars, Republicans prefer it to a Medicaid expansion because thousands of small businesses use it to provide coverage to their employees. Recipients also are required to make modest premium payments and medical co-pays.

"There's some personal responsibility in the plan," Fallin said.

Gatliff would have qualified for the Medicaid expansion offered under the Affordable Care Act, which gives eligibility to those making up to 138 percent of the federal poverty level, or $15,400 for an individual and about $31,000 for a family of four. Under Insure Oklahoma, he currently pays a $27 monthly premium as well as co-pays for doctor visits and the five medications he takes regularly.

"I don't mind paying it," Gatliff said from the mobile home he shares with a friend at the Sherwood Village Manufactured Home Community in Lawton, about 90 miles southwest of Oklahoma City. "I'm not looking for a handout. I want to pay something."

If Insure Oklahoma had not been extended for a year, Gatliff would have been caught in a coverage gap: He would not have qualified for Medicaid, but he also did not earn enough to qualify for tax subsidies to purchase insurance on the federal exchange.

The gap exists because the Obama administration did not anticipate a U.S. Supreme Court ruling giving states the option to reject the Medicaid expansion. Individuals with an income of 100 percent to 400 percent of the federal poverty level would be eligible for government subsidies on the exchange, but Gatliff does not qualify because he earns less than 100 percent of the federal poverty level.

He hopes the decision to extend Insure Oklahoma for one year gives the first-term governor a chance to change her mind and agree to the Medicaid expansion.

"If she could just not worry about the politics and do what's right for the people of Oklahoma — that's what her job is," Gatliff said. "That's what politicians forget sometimes."

Smoker

(Continued from page F-3)

yearly smoking penalty in the least expensive plan, equaling 7 percent of his income. Michigan is not among the few states that have banned tobacco surcharges on their insurance marketplaces.

At least in the interim, Jones may get some relief.

A glitch will limit penalties that insurers can charge smokers until it's fixed next year. The government's computer system has been unable to accommodate a provision that prevents companies from charging older customers more than three times what they charge younger adults and the provision letting smokers be charged higher premiums.

In addition, Jones and other smokers newly insured through exchanges or Medicaid will benefit from requirements that tobacco cessation treatments be covered.

Experts say with the prevalence of high tobacco taxes and workplace smoking bans, those able to quit more easily already have done so. Long-time smokers such as Jones — who wants to quit but has found an inexpensive way to keep the habit — usually need nicotine replacement therapy and classes.

Jones spends under $10 a month to roll his own cigarettes with a machine. But he's taking notice of the penalty that could keep him without insurance.

"I guess it's an incentive to quit," he said.

Applying for coverage: Navigating the new health insurance marketplaces

Beginning Jan. 1, most Americans will be required to carry some form of health insurance. Getting that coverage under the Affordable Care Act might feel a little like filing your taxes and researching a big purchase at the same time. Here is what you will need, based on preliminary forms released by the government:

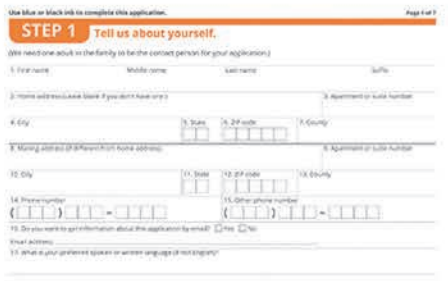
1. Starting the process

Marketplaces open for business Oct. 1, beginning an "open enrollment" period that runs through March 31, 2014.

ONLINE: Go to **www.healthcare.gov** and click "Get Insurance," then choose your state of residence to be connected to a marketplace (more than half of states have left it to the federal government to run their marketplaces). You will create an account with a user name, password and security questions.

TIP: Treat your account as you would a banking, credit card or other site you want to keep secure — create a hard-to-guess password for security.

BY MAIL/IN PERSON: Call **1-800-318-2596** to apply by phone or for a list of locations near you where applications are available. In-person assistance is available in many areas from helpers known as navigators. Call the number above or get a list of community-based organizations from **localhelp.healthcare.gov**.



2. Applying for tax credits

Be sure to have:

- Social Security numbers for everyone on your tax return
- Employer and income information for everyone in your family (W-2s, tax statements, pay stubs)
- Policy numbers for any current health insurance plans

Fill out the online form, providing personal and financial information on yourself and everyone for whom you are seeking coverage. **If you are not seeking a subsidy to defray premium costs, you do not have to share your financial information.**

Based on the information provided, low-income applicants will be steered toward Medicaid in states that are expanding the program; otherwise, subsidies in the form of tax credits are calculated after an electronic verification process. Generally, households earning up to four times the federal poverty level ($94,200 for a family of four) are eligible for tax credits.

TIP: Read the privacy page — It will tell you how your information is being used and where it is being sent.

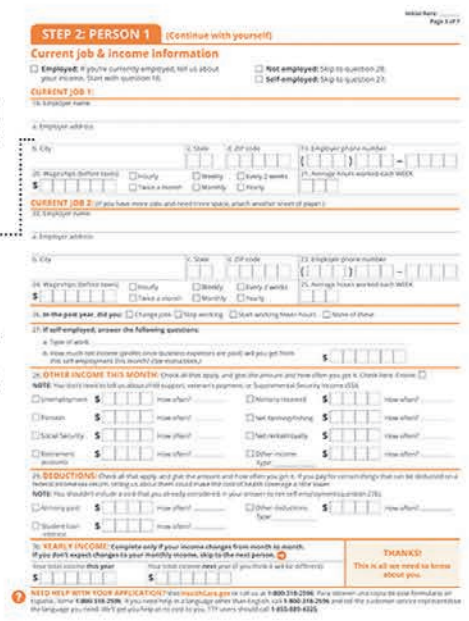
TIP: Provide an accurate estimate of your 2014 income. If the number is too low, you might see a smaller tax refund next year. If it is too high, you won't get as big a tax credit now.

TIP: You do not have to plow through the entire process in one sitting; you can save your work and come back later.

Enter detailed information about yourself and each member of your household, including citizenship status (only U.S. citizens and legal residents can get subsidies) and whether anyone is pregnant or disabled.

Financial information to enter includes employer's address, wages, extra income and deductions claimed on your income tax.

TIP: A shorter form skipping the financial disclosure is available for those who are not applying for tax credits.



3. Picking a plan

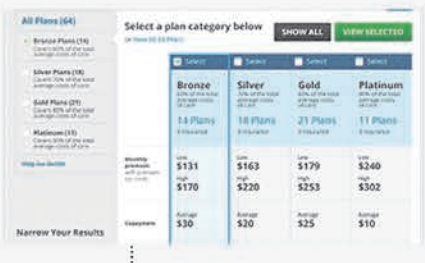
All plans are required to offer the same basic benefits. Consumers can pay more up front in premiums and face lower out-of-pocket expenses, or pay a cheaper premium but shell out more in medical costs. Levels to consider:

- **Bronze:** Covers 60 percent of medical costs on average (lowest premium)
- **Silver:** Covers 70 percent of medical costs
- **Gold:** Covers 80 percent of medical costs
- **Platinum:** Covers 90 percent of medical costs (highest premium)
- Low-priced "catastrophic" plans are available to people under 30 but tax credits cannot be applied

If you are eligible for a tax credit, you can determine how much to apply to premiums – all, some or none. Credits not applied will go to next year's tax refund. The amount is keyed to the cost of a midlevel "silver" policy.

You will be shown a number of plans available based on the level of coverage you select. You may narrow the selection by criteria such as price, copayments or benefits and compare plans side by side. Detailed information will be available. The government is not allowed to make recommendations, only display choices.

Once you have settled on a plan, you can pay online or contact the plan's customer service representative for payment. Coverage will begin Jan. 1.



TIP: Make sure your doctors and hospitals are in the plan you pick to avoid "out of network" costs. You may have to check the plan's website or call your medical provider.

TIP: While the tax credit amount is geared toward a benchmark silver plan, you can apply it to any level, including cheaper "bronze" plans for further premium savings.

TIP: Premiums will be significantly higher for tobacco users and tax credits cannot be applied toward reducing them.

After receiving your application, the government will determine your eligibility and may get in touch with you if more information is needed. The form promises a follow-up in one to two weeks.

A packet will be mailed that will include information on your eligibility for public programs, such as Medicaid or the Children's Health Insurance Program (CHIP), the amount of any tax credit and the plans from which you may choose. You may also be eligible for additional subsidies to reduce your out-of-pocket medical costs, but only if you choose a silver plan.

TIP: Using an online marketplace or working through a navigator with Internet access will be faster.

Mail your completed application to:

Health Insurance Marketplace
Dept. of Health and Human Services
465 Industrial Blvd.
London, KY 40750-0001

SOURCE: Department of Health and Human Services AP

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