CPPP CENTER for PUBLIC POLICY PRIORITIES
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Health Care Coverage TODAY Versus 2014
NOT FAIR TO COMPARE

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On October 1, 2013, Texans will have the opportunity to sign up for new, affordable health care coverage options in the Health Insurance Marketplace. Chances are that you've heard a lot in recent weeks about what will happen to Texas health insurance premiums with the implementation of the Affordable Care Act (ACA) and the launch of the new Marketplace. In fact, the U.S. Department of Health and Human Services recently unveiled preliminary Marketplace rates for a number of states, including Texas. In states across the country, numerous attempts have been made to compare today's premiums with tomorrow's coverage options, but the truth is that health care coverage tomorrow will look very different from many of the insurance policies available today. Many attempts at premium comparison pit today's cheapest and least-protective coverage against the new-and-improved policies available in the Marketplace, resulting in uneven and misleading comparisons. See the chart below to learn more about the difference between coverage today and coverage starting January 1, 2014, and why the two are "apples and oranges" when it comes to comparing premiums.

Coverage in the Individual Market TODAY	Coverage in the Health Insurance Marketplace JANUARY 2014
Comprehensive coverage is not guaranteed. Today, insurers are not required to cover a number of important health care services. In Texas today there are no individual market plans that include maternity coverage, for example, and in several of Texas' most populous counties none of the cheapest plans available cover pediatric oral and dental care. In addition, mental health services are often limited and not required to meet mental health parity standards. Consumers may be paying premiums for a policy that gives them a very limited benefit package.	**All policies must cover Essential Health Benefits.** Policies are required to cover maternity care and pediatric oral and vision care, as well as other critical health care services such as hospitalization, emergency services, mental health services (subject to federal mental health parity standards), and preventive and wellness services. Consumers will be paying for a more comprehensive benefit package.

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TODAY	JANUARY 2014
Policies don't have to cover pre-existing conditions. Today, insurers routinely deny coverage for health care costs associated with conditions that enrollees had prior to applying for coverage. Because of this, some individuals may find themselves paying an insurance premium but still lacking coverage for the health care services they need the most.	**Pre-existing condition exclusions are prohibited.** Insurers are no longer allowed to exclude coverage for pre-existing conditions as part of their policies. Consumers will have access to important medical benefits and services beginning their first day of coverage.
Policies may have very high out-of-pocket costs. Today, there is no limit on the amount of out-of-pocket costs that insurers can push onto the consumer. Some of the least expensive policies on the market today have a $10,000 annual deductible for a single individual ($30,000 for a family), and individual out-of-pocket spending limits of up to $13,000. These limits rarely include what consumers pay out-of-pocket in the form of co-payments. Many of today's policies do not meet the cost-sharing standards that new plans in the Health Insurance Marketplace must meet.	**Out-of-pocket costs are capped for the consumer.** The maximum that an individual consumer will be responsible for paying out-of-pocket will be $6,350 ($12,700 for a family). This maximum includes copayments, coinsurance, and deductibles, meaning the deductibles in the Marketplace won't top $6,350, and many deductibles will be far lower.
Insurers can charge more, or deny coverage, based on health status. In several of Texas' most populous counties, the cheapest policies deny, on average, 12% of applicants outright and approve policies at higher than standard rates for nearly another 10% of applicants. Today, not everyone can get a policy at the cheapest rate available.	**Policies are guaranteed issue, and insurers can't charge more based on health status.** Everyone who meets the basic eligibility criteria can purchase a policy in the Marketplace, regardless of health status. Insurers cannot charge consumers a higher premium because of health status or gender, and can only charge older consumers three times the base rate based on their age.
No assistance is available when coverage becomes unaffordable. In today's individual market, when insurance becomes unaffordable, many individuals and families must choose to go uninsured.	**Premium tax credits and cost-sharing reductions help make higher quality plans more affordable.** The federal government will provide tax credits to help reduce premiums for individuals and families with incomes between 100% and 400% of the Federal Poverty Line (FPL). This means an individual making between roughly $11,500 and $46,000 a year will get a break on premiums. Moreover, low-income individuals and families with incomes between 100% and 250% FPL ($11,500 to $28,700 a year for an individual) may be eligible for cost-sharing reductions which help reduce out-of-pocket costs like deductibles and co-payments, enabling them to get more value for their premium contribution.