http://www.counterpunch.org/2013/02/05/obamacare-a-deception/

Obamacare: A Deception

The Devil is in the Details

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The article below is the most comprehensive analysis available of "Obamacare" – the Patient Protection and Affordable Care Act. The author, a knowledgeable person who wishes to remain anonymous, explains how Obamacare works for the insurance companies but not for you.

Obamacare was formulated on the concept of health care as a commercial commodity and was cloaked in ideological slogans such as "shared responsibility," "no free riders" and "ownership society." These slogans dress the insurance industry's raid on public resources in the cloak of a "free market" health care system.

You will learn how to purchase a subsidized plan at the Exchange, what will happen when income and family circumstances change during the year or from one year to the next, and other perils brought to you by Obamacare. It is one of the most important articles that will be posted on my website this year. Americans will be shocked to learn the extent to which they have been deceived. The legislation neither protects the patient nor are the plans affordable.

The author shows that for those Americans whose income places them between 138% and 400% of the Federal Poverty Level, the out-of-pocket cost for one of the least expensive (lower coverage) subsidized policies ranges from 2% to 9.5% of Modified Adjusted Gross Income (MAGI), a tax base larger than the Adjusted Gross Income used for calculating federal income tax.

What this means is that those Americans with the least or no disposable income are faced in effect with a substantial pay cut. The author provides an example of a 35 year-old with a MAGI of $27,925. The out-

of- pocket cost to this person of a Silver level plan (second least expensive) is $187.33 per month. This cost is based on pre-tax income, that is, before income is reduced by payroll and income taxes. There goes the car payment or utility bill. The lives of millions of Americans will change drastically as they struggle with a new, large expense – particularly in an era of no jobs, low-paying jobs and rising cost of living.

The author also points out that the cost of using the mandated policies will be prohibitive because of the large deductibles and co-pays. Many Americans will find themselves not only with a policy they can't afford, but also with one they cannot afford to use. Those who cannot afford the insurance, even with a subsidy, will be faced with a costly penalty, and in many cases, this, too, will be difficult, if not impossible, to pay. As each year's subsidy is based on last year's income, there will be a substantial year-end tax liability for those who must repay the subsidy in whole or part because their income increased during the year. The stress alone from such a regressive scheme is, without a doubt, not conducive to good health and well-being.

Diets will worsen for millions of Americans as they struggle with a new large expense. Thus, the effect of Obamacare will be to worsen the health of millions. Indeed, a "glitch" in the legislation allows millions to be priced out of coverage. http://www.huffingtonpost.com/2013/01/30/obamacare-glitch-priced-out-of-health-care_n_2585695.html?view=print&comm_ref=false

Alternatively, Americans might be able to acquire health insurance coverage but have no doctors willing to treat them. http://www.californiahealthline.org/road-to-reform/2013/access-denied-implications-of-medi-cal-pay-cut.aspx#

The demand that Obamacare places on household budgets in which there is no slack makes me wonder where the president's economists were while the insurance lobby crafted the product that serves the profits of insurance companies. Two well-known economic facts are that real family income has been stagnant or declining for a number of years and Americans are over their heads in debt.

How does Obama preside over a recovery when consumer purchasing power is redirected to insurance company profits?

Obamacare not only rations health care by what a person or family can afford, but also has implications for Medicare patients. Hundreds of billions of dollars are siphoned from Medicare to help pay the cost of Obamacare. The health care provided to Medicare patients will decline with the reduced payments to care providers. Health care seems destined to be rationed according to the age and illnesses of Medicare patients. Those judged too old and too ill could be denied expensive treatments or procedures that would prolong their lives.

Obama will rue the day that his name was put on this special interest legislation, and most Americans, once they realize what has been done to them, will be angry that special interests again prevailed over the health of the nation.

OBAMACARE: THE DEVIL IS IN THE DETAILS

The Patient Protection and Affordable Care Act of 2010, commonly referred to as the ACA or Obamacare, will go into full effect in 2014. This decree mandates that all Americans must purchase and maintain government-approved health insurance or pay a penalty to the IRS. Touted as a plan to provide all Americans with access to medical care, in reality, this compulsory shakedown commands everyone to purchase insurance that for many will be too expensive, even with government subsidies – or unaffordable to use – or both.

The ACA was not selflessly designed with the intent of providing affordable and equitable medical services to those in need, but rather to acquire taxpayer money for the private insurance companies under the seemingly helpful guise of health care and the ideological excuse of personal responsibility. It takes money from ordinary people and gives it to a medical insurance industry that profits handsomely from this legally-enforced corporate welfare – all while keeping Americans locked in the same broken system that puts profit before patients. The law was essentially written by business executives from the industry so that special interests would not be upset and profits assured.

There's a lot to digest about how the ACA works and much is buried in a complex, convoluted maze of regulations and procedures. A few websites contain explanations, but very important details have either been left out or glossed over. These details are well worth understanding so you will know what's at stake for you and your family. This lesson is not meant to convey a political opinion. This is how the ACA works and under this law, there are no sacred cows.

In today's lesson, you will learn why 2013 is an important year for many of you with regard to your income and the ACA. We will discuss 1) use of Modified Adjusted Gross Income, 2) tax credits (help paying for insurance), 3) your share of the premium, 4) paying back the tax credits to the IRS, 5) expansion of Medicaid and estate recovery which could affect you if you are put into that plan, 6) inadequate coverage in most subsidized plans, 7) penalties, 8) exemptions and 9) a few tidbits. We'll also take a look at the agenda of Enroll America and the Health Insurance Exchanges, and what you can expect to hear in the very near future.

Here we go. Fasten your seat belts.

1. HEALTH INSURANCE EXCHANGE BASICS

In 2014, each state will have an Affordable Insurance Exchange where qualified individuals and families with incomes between 138 and 400 percent of the Federal Poverty Level (FPL) can shop for commercial insurance policies. Most individuals and families with incomes at or below 138 percent FPL will be put into Medicaid. You may be eligible for help paying for your insurance in the form of a tax credit. In most states, the Children's Health Insurance Program (CHIP) will continue to cover children in families with incomes up to at least 200 percent FPL. Some states may offer a Basic Health Plan for those who earn up to 200 percent FPL and are not eligible for Medicaid. Under limited circumstances, you may also be eligible for a cost-sharing credit.

Eligibility to receive a tax credit, the amount of your tax credit and your out-of-pocket share for the insurance will be determined by your income and where you fall in the Federal Poverty Level Guidelines (FPL). This is easy to understand.

Your annual gross income determines which FPL you're in. For example, based on 2012 FPL Guidelines, an individual with an annual income of $33,510 is at 300 percent FPL; a family of 4 with an annual income of $69,150 is at 300 percent FPL. To see where you're at, try the handy calculator at this link. FPL Guidelines are revised every January, so the 2013 edition should be up soon. http://www.safetyweb.org/fpl.php

The ACA requires use of MODIFIED ADJUSTED GROSS INCOME (MAGI) instead of Adjusted Gross Income for all determinations made by an Exchange including eligibility for Medicaid except in certain cases. So, in this lesson, we'll refer to annual income as MAGI.

Modified Adjusted Gross Income (MAGI) is defined as Adjusted Gross Income PLUS
a) all tax exempt interest accrued or received in the taxable year;
b) the non-taxable portion of Social Security benefits provided under Title II of the Social Security Act which includes old-age benefits, disability benefits, spousal benefits, child benefits, survivor benefits and parental benefits;
c) tier 1 Railroad Retirement benefits that are not includible in gross income; and
d) the exclusion from gross income for citizens or residents living abroad.

The adoption of MAGI, created by the ACA, is defined in a new section of the IRS code.

2. DETERMINING ELIGIBILITY FOR A TAX CREDIT

The tax credit is to help you pay for insurance. The ACA says it must be based on annual income for the tax year it's received, but since you will need help paying for your plan during that year, the ACA allows for advance payment of the tax credit.

Here's an example of what that means: Let's say you apply for insurance at an Exchange in 2014. Therefore, 2014 is the tax year you will receive your tax credit, and per the ACA, the amount you receive must be based on that year's MAGI. But, that year's MAGI won't be available until 2015 when you file your 2014 tax return and you need help paying for your insurance plan when you buy it in 2014. So, the amount of your tax credit has to be determined on information that is available such as your prior-year (2013) tax return. Thus, the tax credit morphs into an 'advance payment of the tax credit' (also referred to as an advance premium assistance credit). Now you see why 2013 is an important year for many of you.

The ACA allows for limited disclosure of tax return info in order for an Exchange employee to verify your citizenship status and MAGI, and, not only to let you know how much your advance tax credit will be, but also to see if you are eligible to receive this in the first place. An Exchange can also consider using your real-time income by looking at your state's most current quarterly wage database, or it may agree to accept paper verification (pay stubs, etc.) as a last resort or an attestation of your income with no verification. Creation of a federal 'data services hub' is in the works so your income information will be more readily accessible. But, no matter how this plays out, you'll still receive an advance payment of the tax credit because your actual MAGI for 2014 will not be known by you nor can it be verified by an Exchange until you file your 2014 tax return in 2015.

Ultimately, no matter which method is used – prior year or partial current year – this advance payment of the tax credit carries with it some heavy-duty consequences which are discussed in topic 4 of this lesson.

3. TAX CREDITS AND YOUR SHARE OF THE PREMIUM

The amount of your tax credit will be based on the second lowest-cost Silver plan in the area where you live and your MAGI. Here's how this works – it's quite simple:

a) First, the amount you will pay out of your pocket for that Silver plan – copays and deductibles not included – will be a specific percentage of your MAGI, and you will pay this to the insurer on a monthly basis. The way this percentage will be calculated is described a few lines down.

b) Next, your share will be deducted from the cost of that Silver plan and the difference will be your tax credit which the government will pay directly to the insurer on a monthly basis when you purchase a plan.

The specific percentage you will have to pay for the second lowest-cost Silver plan will be based on your FPL using a well-greased sliding scale. As your FPL increases little by little, the percentage you will pay increases. The same percentage applies to an individual or a family. Here's how much of your MAGI you will pay for that Silver plan:

— up to 138 % FPL: 2% for people legally present less than 5 full years and residents of states that do not expand Medicaid
— 138-150% FPL: 3 to 4%
— 150-200% FPL: 4 to 6.3%
— 200-250% FPL: 6.3 to 8.05%
— 250-300% FPL: 8.05 to 9.5%
— 300-400% FPL: 9.5% – there's no range, but the dollar amount of your share will change because 9.5% of a lower MAGI is less than 9.5% of a higher MAGI.

Here are two examples in dollars using 2012 FPL Guidelines and an estimate for a second lowest-cost Silver plan which will vary depending where you live – actual costs are not yet available:

a) You are 35 years old and the price of the second lowest-cost Silver plan for an individual in the area where you live is $4,750 with no tax credit. If your MAGI is $33,510 ($2,792.50 per month) putting you at 300 percent FPL, your share for that Silver plan, per the chart above, would be 9.5 percent of your MAGI which comes to $3,183 ($265.25 per month). Your tax credit would be $1,567 which is the difference between the unsubsidized cost of that Silver plan and your share.

b) You are 35 years old and your MAGI is $27,925 ($2,327 per month) putting you at 250 percent FPL, so, your share of that Silver plan would be 8.05 percent of your MAGI which comes to $2,247.96 ($187.33 per month) and your tax credit would be $2,502.

If the second lowest-cost Silver plan is too expensive, you can apply your tax credit to a Bronze plan which will be cheaper but less comprehensive. If you want a better plan than the Silver, you will have to pay the full difference in the premium.

Don't forget that your share of the monthly premium will be figured on your MAGI which is pre-tax income. So, after you deduct your income taxes and your share of an insurance plan, will you be able to cover your monthly basic living costs including paying off debt you may owe and still have some cash left to pay for medical care if you have to use your insurance? Check out topic 6 in this lesson for a rundown of plans and coverage you can expect to find at an Exchange. Hope you don't faint.

Once you purchase a plan, your share and your tax credit won't change until the next enrollment period unless, before that time, your income goes up or down enough to bump you into a different FPL or you get a job with insurance. You can let your Exchange know by phone or via your online account, or, your Exchange might notice while cruising the data services hub you learned about in topic 2 and notify you that you must 'up' your coverage or that you've been tossed into Medicaid if your MAGI has decreased enough to make you eligible for that plan. Exchanges will be encouraged to use as many different avenues as possible including private databases to keep tabs on your income.

Thus, you could end up bouncing from Medicaid to a subsidized plan or vice versa. By the same token, you could take some extra work to help pay the bills or to save for a vacation, and, oops, you went over 400 percent FPL and are no longer eligible for a tax credit. The Exchange may not find out about this unless you spill the beans, but, no matter how it all plays out, income changes will catch up with you when you file your tax return.

To be eligible for a tax credit you must file your tax return no later than April 15. Married taxpayers must file a joint return. Individuals who are listed as dependents on a return are ineligible for a tax credit.

If you are eligible for Medicaid, you will not be allowed to receive a tax credit or a cost-sharing credit although some states impose premium and cost-sharing charges on certain Medicaid enrollees per the Deficit Reduction Act of 2005 (DRA) and clarified in the Tax Relief and Health Care Act of 2006.

On January 22, 2013, the Centers for Medicare & Medicaid Services (CMS) proposed allowing states to further increase Medicaid premiums and out-of-pocket costs by 5 percent. The most egregious part of this proposed rule says that states may allow providers to deny services for failure to pay the required cost-sharing in certain circumstances. The Obama administration is behind this proposed rule hoping to persuade states to expand Medicaid since many have refused and others are still undecided – the expansion of Medicaid is an integral part of the ACA. Allowing states to further increase premiums and cost-sharing for the poorest segment of the population underscores the existing political bias toward low-income Americans despite rhetoric which claims otherwise.
https://www.federalregister.gov/articles/2013/01/22/2013-00659/medicaid-childrens-health-insurance-programs-and-exchanges-essen- tial-health-benefits-in-alternative#h-186
http://www.nytimes.com/2013/01/23/health/medicaid-patients-could-face-higher-fees-under-a-proposed-federal-policy.html

Affordability rates (the percentage of your MAGI the government has decided you can afford to pay for insurance) are based on boardroom formulas which don't take particular individual needs into account such as housing costs, property taxes, debt, education, transportation, retirement savings, etc. Also, FPL Guidelines are standard across the country and do not take into consideration those who reside in a more expensive region or vice versa. They are one-size-fits-all with the exception of Alaska and Hawaii. See topic 8 in this lesson to learn about exemptions.

Check out what self-proclaimed health care expert Jonathan Gruber says about affordability and get a load of all the "formulas." According to Mr. Gruber, you may be having too much fun in life and need to get serious, buy health insurance and live under a rock in order to pay for it. He was involved with Romneycare in Massachusetts and was also Mr. Obama's go to man under a no-bid contract. Per a bar graph on page 6 of a report prepared by Stan Dom for the Urban Institute, subsidized plans under the ACA are estimated to cost 2 to 3 times more (give or take) than the subsidized plans under Romneycare. Per several surveys during the years that Romneycare has been in effect, many low and modest income MA residents have had difficulty paying for those plans and the out-of-pocket costs to use the insurance, particularly chronically-ill residents.
http://ebookbrowse.com/1493-gruber-will-affordable-care-act-make-hlt-ins-affordable-reform-brief-v2-pdf-d124754327
http://www.statecoverage.org/files/TheBasicHealthProgramOptionUnderHealthReform.pdf

4. PAYBACK OF TAX CREDITS TO THE IRS

Perhaps you recall hearing politicians including Mr. Obama say if you can't afford to pay for health insurance, the government will help you. That was one of the key talking points repeated non stop. We just went over the help part – the tax credits. Now we'll look at what Mr. Obama et al didn't tell you which is important to understand because it could cause you some serious financial distress.

Remember the "advance payment of the tax credit" in topic 2 of this lesson? Well, essentially, that was a loan from the government which was paid in advance to the insurer on your behalf when you purchased your plan, and, as you know, loans have to be paid back. So, when you file your tax return for the year

you received your "advance tax credit" (your loan), if your income has changed, you have to settle this with the IRS. Here's the deal:

a) If your MAGI is higher and the increase puts you into a higher FPL, you may have to pay back a portion or all of the tax credit because it was based on a lower MAGI. In other words, you could have an additional tax liability on top of the income taxes you already paid (or still owe) because you received a higher tax credit than you were entitled to.

b) If your MAGI is lower and the decrease puts you into a lower FPL, a refund could be coming to you because you were eligible for a larger tax credit than the government paid to the insurer. In other words, you overpaid for your portion of the insurance premium.

c) If you earned a bit more or less, but your extra earnings or loss didn't bump you into another FPL, you're home free.

To figure out your payback, you will have to enter the relevant figures on the reconciliation page of the tax return. Changes in filing status such as the number of people in your household will also have an impact. For those of you who marry or divorce, the rules for the payback amount as well as the amount of the tax credit you are eligible to receive will make your head spin – the computation includes pre- and post-marriage FPL and uses the highest FPL of the two people involved. Ditto for divorce.

Here is one of the reconciliation explanations in IRS-speak: Your liability for an excess tax credit you received must be reflected on your current year income tax return subject to a limitation on the amount of such liability.

Oh! Limitation on the amount of such liability. That sounds good.

Let's take a peek at the payback limitations on record at the time of this writing. "At the time of this writing" are the operative words because the cap has been increased twice since the ACA was signed into law. The original payback was capped at $400 for families under 400 percent FPL and $200 for individuals. We'll skip over the first increase. The story behind the second one is that a particular revenue stream was removed from the original law, so something had to be done to compensate for this lost money. Thus, an amendment was passed that increased the cap using a sliding scale, thereby putting a huge financial burden on the backs of the very people the ACA claims to help. In other words, tag, you're it. You are the cash cow.

Here are the current sliding-scale caps:

If the household income (expressed as a percent of poverty line) is:
less than 200 percent, the applicable dollar amount is $600
at least 200 percent but less than 300 percent, the applicable dollar amount is $1,500
at least 300 percent but less than 400 percent, the applicable dollar amount is $2,500

Effective date: the amendment made by this topic shall apply to taxable years ending after December 31, 2013. Very truly yours, House Ways and Means Committee

The name of this bloodsucker is The Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011. http://www.gpo.gov/fdsys/pkg/PLAW-112publ9/html/PLAW-112publ9.htm

But wait, there's more!

a) Update: Today (Feb. 17) (2011) the House Ways and Means Committee approved the 1099 repeal bill which requires consumers earning more than 400 percent of the poverty line to pay back the [entire] subsidy. http://thehill.com/blogs/healthwatch/health-reform-implementation/144847-1099-repeal-gets-trickier-with-house-bill

b) Also, per IRS final regulations: for taxable years beginning after December 31, 2014, the payback caps may be adjusted to reflect changes in the consumer price index.

Payback amounts are reduced to one-half for unmarried individuals who are not surviving spouses or filing as heads of households. There is no help if you get hit with a payback and many of you will have difficulty paying this liability.

Chances that you may have received an incorrect tax credit are not exactly slim because this poorly thought-out scheme does not take into account the unpredictable and complex financial situations that confront the low and modest income population.

Keep in mind that by ending up in a higher FPL, you may also have to pay more out of your pocket for an insurance premium. You learned how that works in topic 3. If you can't afford a higher premium and drop your insurance, you may still owe a payback plus a penalty for being uninsured which is also MAGI-based. Penalties are discussed in topic 7. If your MAGI puts you over 400 percent FPL, you just knocked yourself into left field and are on your own paying for an insurance plan on the open market. And, you may also be required to payback the entire tax credit.

If you get a job during the current year that offers health insurance which is not more than 9.5 percent of your total salary and the coverage is not less than 60 percent, you must take that insurance or pay a penalty for being uninsured. But, you may owe a payback for the months you received a tax credit before you landed the job. How large that payback is will depend on your MAGI for the entire tax year, not just on your income during the months you received the tax credit. Or, you may lose a job during the year and have a significantly reduced income even though the amount reported on your tax return is high because you had a job for part of the year. In this case as well, your payback will be based on your MAGI for the entire tax year.

More interest income from taxable and tax-exempt savings or a year-end bonus could also contribute to an increased MAGI and the possibility of a payback as well as taking extra work to help pay the monthly bills, house and car repairs, educational aspirations or a vacation. So, whether or not you end up in payback land will depend on how close you are teetering on the edge of an FPL. Ditto for your share of the premium and the amount of your tax credit.

The payback may stop many of you from purchasing insurance at the Exchange because you know in advance you will not have the money to pay it. If this is the case, you may be allowed to negotiate a lesser tax credit by paying more out of your pocket for your monthly insurance premium in order to avoid or decrease the payback. It's a crap shoot. Considering what you've learned so far in today's lesson, many of you will find yourselves between a rock and a hard place under the ACA, and you will be forced to make untenable choices. Given the skyrocketing costs of food, heat and other basics, how will you even tread water under this set-up, nevermind get ahead?

Being told you will receive help from the government if you can't afford to purchase insurance and finding out at tax time this was really a loan and you owe the IRS a substantial debt on top of your

income taxes is outright shameful. But most politicians have no shame – which brings us to the next topic.

5. MEDICAID EXPANSION AND ESTATE RECOVERY

In order to expand Medicaid, several Medicaid regulations were changed:

a) the income limit for eligibility was increased to 133 percent FPL, but since states must apply a 5 percent disregard, this effectively raises the eligibility to 138 percent FPL
b) Modified Adjusted Gross Income will be used in most cases to determine eligibility (also applies to certain CHIP applicants)
c) the age limit was increased to 64, childless adults will be eligible; and
d) the asset test was dropped except for certain groups such as the elderly and people on Social Security Disability – BINGO!

The fact that the asset test was dropped is very important, but before we look at why, you must first understand that if an Exchange determines you are eligible for Medicaid, you have no other choice. Code for Exchanges specifies, "an applicant is not eligible for advance payment of the premium tax credit (a subsidized plan) or cost-sharing reductions to the extent that he or she is eligible for other minimum essential coverage, including coverage under Medicaid and CHIP." Therefore, you will be tossed into Medicaid unless there are specific rules as to why you would not be eligible. If you are enrolled in a private plan through an Exchange and have been receiving a tax credit, and your income decreases making you eligible for Medicaid, in you go. If you are allowed to opt out because you don't want Medicaid, you will have to pay a penalty for being uninsured unless you can afford to purchase insurance in the open market.

Just so you're clear on this: the ACA stipulates that the system will ensure that if any individual applying to an Exchange is found to be eligible for Medicaid or a state children's health insurance program (CHIP), the individual will be enrolled in such a plan.

Furthermore, to increase enrollment in health coverage without requiring people to complete an application on their own, states are advised to automate enrollment whenever possible by using existing databases for social services programs such as SNAP (food stamps) to enroll people who appear eligible for Medicaid but are not currently enrolled. Therefore, you could find yourself auto-enrolled in Medicaid against your will if your state acts on this advice.

Many times over Mr. Obama et al told you that all Americans would have choice. Choice was another big talking point. Are poor and low-income Americans undeserving of choice? Is the ACA a class-based system? Maybe they meant that for this segment of the population, the choice would be between Medicaid or a penalty for remaining uninsured. This is blatant discrimination.

Here's why dropping the asset test got the BINGO – Estate Recovery! You won't find the following info in the ACA. It's in the Omnibus Reconciliation Act of 1993 (OBRA 1993) – a federal statute which applies to Medicaid, and, if you are enrolled in Medicaid, it will apply to you depending on your age.

a) OBRA 1993 requires all states that receive Medicaid funding to seek recovery from the estates of deceased individuals who used Medicaid benefits at age 55 or older. It allows recovery for any items or services under the state Medicaid plan going beyond nursing homes and other long-term care institutions. In fact, The Centers for Medicare & Medicaid Services (CMS) site says that states have the option of

recovering payments for all Medicaid services provided. The Department of Health and Human Services (HHS) site says at state option, recovery can be pursued for any items covered by the Medicaid state plan.

b) The HHS site has an overview of the Medicaid estate recovery mandate which also says that at a minimum, states must pursue recoveries from the "probate estate," which includes property that passes to the heirs under state probate law, but states can expand the definition of estate to allow recovery from property that bypasses probate. This means states can use procedures for direct recovery from bank accounts and other funds.

c) Some states use recovery for RX and hospital only as required by OBRA 1993; some recover for a few additional benefits and some recover for all benefits under the state plan. Recovery provides revenue for cash-strapped states and it's a big business.

Your estate is what you own when you die – your home and what's in it, other real estate you may own, your bank account, annuities and so on. And even if you have a will, your heirs are chopped liver. Low-income people often have only one major asset – the home in which they live and, in some cases, this has been the family home through several generations.

So what this boils down to is: if you are put into Medicaid – congratulations – you just got a mandated collateral loan if you use Medicaid benefits at age 55 or older! States keep a running tally.

Estate recovery can be exempted or deferred in certain situations after your death, but the regulations for this are limited and complicated with multitudes of conditions. You may not have an attorney on speed dial, but with regard to this hundred pound gorilla, it sure would be handy.

Should you decide to ask your congresscritter about estate recovery, be prepared for responses such as:

— "Estate recovery doesn't apply to you." (Great news. Please overnight a copy of the amendment to OBRA 1993 that stipulates estate recovery is no longer required and no longer allowed. Here's my address.)
— "Oh, estate recovery is state, I'm federal." (Wrong – estate recovery is federally mandated although the estate recovery program itself is administered by each state.)
— "I don't know anything about this." (Highly unlikely because the expansion of Medicaid is an integral part of the ACA and estate recovery is not a secret.)
— "The ACA wasn't about revamping Medicaid." (As explained above, Medicaid regs were revised in order to expand Medicaid.)
— "I'll look into that and get back to you." (Don't hold your breath – they don't want to go there.)

If you ask about estate recovery when you contact an Exchange or speak with an outreach agency, you'll probably run into a brick wall or be told it doesn't apply to you – whatever. But, it doesn't matter because what you are told is not legally binding. What is legally binding is your signature on the Medicaid application which indicates that you agree to the terms of the contract – which brings us to another item in OBRA 1993. Read on.

OBRA 1993 also contains procedural rules intended to ensure that individuals are informed about Medicaid program requirements including disclosure of estate recovery before they complete the application process and also during the annual re-determination process. Notification of estate recovery should be on the signature page of your state's Medicaid application and is usually a one-liner: I understand that if I am aged 55 or older, (name of your state's Medicaid plan) may be able to get back money from my estate after I die. (Use of the word 'may' doesn't mean if the state feels like it – it means

recovery will take place unless there are specific circumstances for exemption or deferment as mentioned above.) There are also strict recovery/repayment clauses for injury-related settlements disclosed on the signature page and a few other ditties that apply to you or a family member who is enrolled in Medicaid. All of these items must also be disclosed in your state's Medicaid handbook.

Under the ACA and proposed federal rules for implementation, states will be required to provide a single, simple application to apply for and enroll in Exchange plans, Medicaid and CHIP, and consumers must be able to apply by phone, in person or online. The Secretary (HHS) is charged with this task and it's in the works. This begs an answer to the following questions:

— Will Medicaid applicants be diligently informed about estate recovery and other rules that apply to Medicaid enrollees on this single application? Failure to do so would be in non compliance with OBRA 1993 and would also be deceptive.
— Will applicants be provided with a signature page that contains appropriate disclosure of these rules so they can be reviewed before signing on the dotted line?
— How will appropriate disclosure and obtaining a signature work for those who are bumped into Medicaid due to a decrease in income or who might be auto-enrolled because they were presumed eligible through a database.

If an applicant or someone who has been bumped or auto-enrolled in Medicaid is not satisfied with the terms of the Medicaid contract, lack of another health insurance option that is in the best interest of low-income earners represents undue and unconscionable advantage being taken of this segment of the population under a law that mandates health insurance or a penalty.

Do the health insurance policies enjoyed by lawmakers on Capitol Hill and paid for by taxpayers include an estate recovery program?

Medicaid is poor, underfunded, overstretched and constantly bombarded by state budget cuts – even before an ACA expansion. It offers a low quality of care in many states, and, in general, represents inequities in care. Office-based doctors typically refuse to accept Medicaid patients, thus, millions thrust into this plan will have difficulty finding a primary-care doctor or a specialist.

A perfect example is the December 2012 federal appeals court decision that allowed California to cut reimbursements by 10 percent to doctors, pharmacies and others who serve low-income residents under the state's Medi-Cal plan (a version of Medicaid) due to state budget issues. California was already at the bottom of the rate-reimbursement heap which made finding doctors difficult for residents in Medi-Cal. This decision will further reduce the number of health care providers willing to take new Medi-Cal patients, thus jeopardizing their access to primary and specialized care. Under the ACA's expansion of Medicaid, state budget crises across the nation will exacerbate the ongoing problems regarding access to care for Medicaid patients, particularly in states that have a high low-income population. http://www.sfgate.com/health/article/Medi-Cal-cuts-upheld-by-appellate-court-4116971.php

6. INSURANCE PLANS AT THE EXCHANGES

Below are the 4 plan levels that will be offered at Exchanges for people between 138 and 400 percent FPL. Each one has government- approved benefits including prescription coverage. You will be entitled to one free preventive visit each year. Per the most recent study commissioned by the Kaiser Family Foundation, several cost-sharing options were estimated for non-group (individual and family) Bronze and Silver plans. Cost-sharing is the amount you must pay to use your insurance. Your share of the premium is not part of cost-sharing. http://www.kff.org/healthreform/upload/8303.pdf

The way this works is you will pay for all your medical care until you reach the annual deductible. Then you'll pay the applicable percentage of coinsurance until you reach the annual out-of-pocket spending cap which will be set on a sliding scale. Annual means these amounts start again the following year, and if they change, you will find out when you re-apply for insurance. There will also be copays – an amount you will pay to the doctor for an office visit.
Here are the current estimates:

Bronze: cheapest and dry as dust with 60/40 coverage – a win-win for insurers
a) annual deductible of $4,375 for an individual (double for a family) with 20 percent coinsurance, b) annual deductible of $3,475 for an individual (double for a family) with 40 percent coinsurance

Silver: next cheapest – offers an illusion of coverage at 70/30
a) annual deductible of $2,050 for an individual (double for a family) with 20 percent coinsurance, b) annual deductible of $650 for an individual (double for a family) with 40 percent coinsurance

Gold: expensive – 80/20 – better coverage
Platinum: most expensive – 90/10 – most comprehensive coverage

A fifth plan will be available for the under-30 crowd and people who have been granted a hardship exemption. See topic 8 in this lesson. Coverage in this plan will be less comprehensive than the Bronze – it is primarily for major-medical expenses except that it has a free preventive visit. Cost-sharing for people at 138 to 200 percent FPL is estimated to be a bit less than the Bronze and Silver estimates mentioned above.
OBJ

The high deductibles in all but the two most expensive plans could saddle you with mounting bills for routine care and may stop you from seeking necessary treatment for illness or injuries. Many of you will find that the promise of access to affordable health care really means access to inadequate coverage at a price the government has decided you can afford to pay.

The number of drugs in each plan at an Exchange will vary from state to state. In some states, plans will offer up to 99 percent of available drugs and others only 45 percent which means you may not have access to the specific drugs you need. Perhaps Big Pharma will change its stance on this before 2014.

The cost of plans at an Exchange will vary from state to state based on where you live and your age. The ACA allows insurers to charge older customers up to three times more for a plan, even if they are in good health, as long as the state in which an Exchange is located doesn't have a law that caps age-rating. Some Exchanges will tuck an administrative fee of 2 to 4 percent into premiums to help cover operating expenses.

Cost-sharing tax credits will be available if you are below 250 percent FPL to protect you from high deductibles and copays – but only if you purchase a Silver plan. If you buy the cheaper Bronze plan, you won't be eligible for these credits, which are, by the way, direct federal payouts to private health insurance companies.

Obamacare has no cost controls. There is nothing stopping the insurance companies from increasing their rates, and Washington has already estimated higher premium costs at the Exchange for 2016 which doesn't mean that 2015 won't have an increase. Sounds like 2014 prices will be an Introductory Offer. Get 'em while their hot!

7. PENALTY FOR BEING UNINSURED

The ACA requires that people who have been deemed able to purchase health insurance but decide not to buy it starting in 2014 will owe a penalty (a tax) to the IRS. Here's what this looks like:

a) In 2014, the annual penalty will be $95 per adult and $47.50 per child, up to a family maximum of $285 or 1 percent of family income, whichever is greater.
b) In 2015, the penalty will be $325 per adult and $162.50 per child, up to a family maximum of $975 or 2 percent of family income, whichever is greater.
c) In 2016, the penalty will be $695 per adult and $347.50 per child, up to a family maximum of $2,085 or 2.5 percent of family income, whichever is greater.

The IRS collects the penalty, but the ACA stipulates that taxpayers shall not be subject to any criminal prosecution or penalty, tax liens, seizure of bank accounts or garnishment of wages for failure to pay it and no accumulation of interest on the unpaid balance. So, it appears that all the IRS can do is deduct the penalty from a refund it owes you, and if you're not due a refund, then you'll have an outstanding tax obligation.

Keep in mind that the penalty is described in annual amounts but is really monthly. So, if you are uninsured for only part of the year, you will accrue only 1/12 of the total for each month you are uninsured unless you qualify for an exemption.

8. EXEMPTIONS FROM THE PENALTY

You may be eligible for official permission that excuses you from having to pay the penalty for being uninsured. The requirements are:

a) If the cheapest health care plan available costs more than 8 percent of your MAGI after subtracting the tax credit or employer contribution, whichever is applicable.
b) Your income is so low that you aren't required to file federal income taxes.
c) You are between jobs and without insurance for up to three months.
d) You have a sincerely-held religious belief that prevents you from seeking and obtaining medical care.
e) You are in jail.
f) You are an undocumented immigrant.
g) You are a member of an Indian tribe or a religious group currently exempt from paying Social Security tax.

If item d) is the case, you must file a sworn statement as part of your tax return, and should you obtain care during the tax year, the exemption will no longer apply and you will have to pay a penalty for being uninsured. Per H.R. 6597, medical care is defined as acute care at a hospital emergency room, walk-in clinic or similar facilities. Medical care excludes treatment not administered or supervised by a medical doctor such as chiropractic, dental, midwifery, personal care assistance, optometry, physical exams or treatment where required by law or third parties such as an employer, and vaccinations.

If you think you can't afford the amount the government has decided you can afford to pay for your insurance plan, and you don't fit into any of the categories described above, you can apply for a Hardship Waiver. Details have not yet been provided regarding hardship eligibility requirements under the ACA, but, for an idea of what they might look like, let's check out what the deal is in Massachusetts which already has a mandated health insurance law – Romneycare! In fact, Romneycare was the model for Obamacare. That's why some people call Obamacare, Obamneycare.

To qualify for a Certificate of Exemption under Romneycare, a Massachusetts resident must demonstrate that health insurance is not affordable due to one of the following: 1) homelessness; 2) eviction or foreclosure notice; 3) domestic violence-related medical trauma; 4) major long-term illness of a child; 5) death of your spouse; 6) your house burned down; or 7) "you can establish that the expense of purchasing health insurance would cause you to experience serious deprivation of food, shelter, clothing or other necessities."

Ya gotta luv number 7. And in Massachusetts, exemptions come with an expiration date, so you have to clean up your act in short order. Under the ACA, the Secretary of Health and Human Services will determine if, indeed, you have suffered a hardship that keeps you from being able to pay for coverage.

9. OTHER TIDBITS

There is much more in the ACA including all kinds of rules and penalties for employers, employees and the self employed as well as the Accountable Care Organization (ACO) model which will be mandated starting in 2014. The latter works as follows: under the simplest option available, a small group of doctors and hospitals – an ACO – will manage your care and be graded and paid based on the outcome of all patients who seek treatment with that ACO. The ACO will also be rewarded with a share of the savings in health costs it achieves by following best treatment practices and reaching specific benchmarks set by CMS. The second option, "shared savings plus risk," is for larger ACOs. Providers will receive a lump-sum payment to treat their patients and assume a portion of the risk for above target spending but are eligible to keep a greater portion of the savings.

Either of these options reduce patient care to numbers and paperwork because doctors are essentially controlled and incentivized by an administrator in some far-flung office. The ACO model is the insurance industry's version of "budgeting" the cost of health care which ultimately benefits insurers at the expense of doctors and their patients.

Doctors say that basing their pay on treatment outcomes creates an incentive for them to avoid tough cases whose outcomes could "kill my numbers." "Paradoxically," writes Dr. G. Keith Smith, "doctors who are doing sham surgery will be the ones with the best outcomes, as their patients, many of whom don't need surgery in the first place, will exhibit great, basically perfect outcomes. Physicians who don't do unnecessary surgery will be pushed to do so to improve their 'scores.' 'Pay for performance' trends in medicine are not a good idea in my opinion. Paying based on patient outcomes will have perverse effects, not the least of which will be the complete denial of care to the very sick." http://www.medibid.com/blog/2012/10/your-disease-can-kill-you-in-more-than-one-way/?utm_source=Registered+Physicians&utm_campaign=8f9028ddaf-October_Physician_Newsletter11_17_2012&utm_medium=email

The ACA also requires Health Insurance Exchanges to establish a navigator program to inform the uninsured about the availability of government-approved subsidized plans at an Exchange and to facilitate enrollment in these plans, but it leaves the design of the program up to each Exchange.

Depending how an Exchange sets up its program, some Navigators will sell plans offered by an Exchange while others will be responsible for maintaining the existing market but may also be allowed to sell Exchange plans. All seller Navigators will be compensated either by Exchanges or insurance carriers for the plans they sell. Many options are being considered by Exchanges including using insurance agents. Hopefully, Navigators and insurance agents will not be knocking on your door or contacting you by phone. That would be over the top. Here's a link to read what the California Exchange is pondering with regard to its Navigation program.

http://www.healthexchange.ca.gov/StakeHolders/Documents/CHBE,DHCS,MRMIB_StatewideAssistersProgramDesignOptionsRecommendationsandWorkPlan_6-26-12.pdf

10. ENROLL AMERICA, HERNDON ALLIANCE & THE EXCHANGES – MASTERS OF SPIN

Since many Americans don't know about the ACA, somehow the word has to get out and people must be encouraged to purchase health insurance either in the open market or at an Exchange. And who better to do this?

Enter "Enroll America" – a nonprofit 501(c)3, financially backed by Aetna, Blue Cross Blue Shield, UnitedHealth, America's Health Insurance Plans, hospitals, associations that represent drug manufacturers and nonprofits with vested interests. For insurers and pharma, the ACA is manna from heaven – scratch that – manna from Capitol Hill – and the dollar signs in their eyes are on fire! These profit seekers and connected nonprofits will be using every avenue possible to maximize their bottom lines.

The mission of Enroll America per its website is to "ensure that all Americans are enrolled in and retain health coverage." It's Board of Directors and Avisory Council reads like a Who's Who in the Medical Industry Cartel – CEOs, presidents, vice presidents and directors of such entities as the American Hospital Association, Express Scripts, Medicaid Health Plans of America, Kaiser Permanente and many others – the list is long. If you would like to donate to these mega-profit vultures, you can do so on the Enroll America home- page. The goal is $100 million by 2014. http://www.enrollamerica.org

In its publication, "Ten Ways to Make Health Coverage Enrollment and Renewal Easy," Enroll America has recommended availability of web-based applications to increase the places where people can enroll in coverage: at home, at grocery stores, community health centers, state fairs, sporting events, places of worship, and more. Gee, you can apply for insurance while you pray. How thoughtful. http://www.enrollamerica.org/best-practices-institute

The strategy for insurers and state Exchanges to persuade you to purchase insurance and warn you about the penalties includes using ads, social media, blogs, YouTube, Flickr, Twitter, hospitals, health centers, McDonald's, in-store radio announcements, ballparks, county fairs, libraries, laundromats, community events, libraries, county fairs and drugstores – you name it. Blue Cross Blue Shield has partnered with H & R Block. Health insurers are already setting up shop inside some supermarkets so they can answer your questions and sign you up for coverage while you do your grocery shopping. They will likely be showing up in shopping malls – maybe even in parking lots, on street corners and at church fairs. And, their aim is to recreate themselves from the bloodsucking leeches that they are to your new, cool-dude friends.

We'll be living in Occupied Territory.

Let's connect some dots. The executive director of Enroll America is Ron Pollack, also president of Families USA – a nonprofit and friend of the industry. On its website, Families USA bills itself as "a national non-partisan organization dedicated to the achievement of high quality, affordable health care for all Americans." Philippe Villers and Robert Crittenden, M.D. are on Families USA Board of Directors. Mr. Villers is also on the BOD of Herndon Alliance, Bob Crittenden is a Herndon staff member and Ron Pollack is a Herndon founder. http://www.familiesusa.org

Herndon Alliance is an influential health care spinmeister creating messaging to change public opinion and tweaking each message to reach particular groups.

Herndon has close ties to Capitol Hill and helped market the ACA providing words politicians and supporters should use to promote the bill. For example, during the national health care debacle a few years ago, you heard Mr. Obama et al continually talk about 'choice,' 'we need a uniquely American solution,' 'fair rules,' 'investing in America's future' and 'high-quality, affordable healthcare.' That last one is used in Families USA mission statement. The Council for Affordable Health Insurance, a frontgroup for the industry, gets right to the point – its name. Ron Pollack worked with the Obama administration to help reshape public opinion of Mr. Obama's unpopular health care bill. Leading up to 2014 when the Exchanges are scheduled to open, there will most likely be a blitz of TV ads in which you will hear many of these same nebulous, feel-good words. And, you'll undoubtedly read or hear plenty of Herndon spin from your Exchange and throughout your state in the immediate future.

In the interest of coming up with messaging, Enroll America held a few focus groups and commissioned a nationwide survey in fall 2012. Research was provided by Celinda Lake from Lake Research Partners, a national public opinion and political strategy research firm. One takeaway was when a monthly premium cost was given, the majority of people polled thought that it was too expensive and the ACA would not provide affordable and comprehensive coverage even with the government tax credits (subsidies). So, Lake Research Partners advised Enroll America not to mention specific costs but to use the phrase 'free or low-cost plans.' http://www.nytimes.com/2012/12/20/us/officials-confront-skepticism-over-health-law.html?ref=us&_r=0&pagewanted=all

Herndon has been working on messaging various parts of the ACA that will be used by outreach partners, insurers and state Exchanges. Its messaging is not based on truth or evidence – Herndon actually stays away from any mention of facts as you read above regarding the cost of plans. Instead, its messaging is designed to mislead an uninformed public.

A few of Herndon's target populations include voters, people of color, red states, skeptical audiences, and you'll love this one – Elevator Language with a list of succinct scripts to use based on the person you're speaking to during the ride. You must check out Herndon's website and read the many instructions of what to say and what not to say. You'll either get very annoyed or laugh yourself silly. http://herndonalliance.org/resources/research/communications-tips-exchange-talking-with-voters.html http://herndonalliance.org/resources/implementation-basics/communications-tips-to-use-with-skeptical-audiences.html

Here are some examples of Herndon spin regarding the ACA:

— Use "family values" when talking to the public about the expansion of Medicaid. Is estate recovery a family value? http://herndonalliance.org/resources/what-s-new/talking-about-medicaid-connecting-with-the-public.html

— When talking about the ACA's required Accountable Care Organization (ACO) model that will pay doctors according to patient outcomes and reward them for savings they achieve, Herndon says to call this "Coordinated Patient Care" and "do not connect pricing with rewards or incentives for doctors" or "with lump-sum payments for medical care" and do not mention "payment based on positive patient outcomes." Why not? The three do-nots are how ACOs work. (ACOs are described in topic 9.) http://herndonalliance.org/resources/system-change/payment-reform-quality-care-pricing.html http://herndonalliance.org/resources/system-change/coordinated-patient-care.html

— Here's an award winner: "Members of Congress will purchase their insurance at the Exchange. If members of Congress are part of the marketplace then it's got to offer quality plans and protections." http://herndonalliance.org/resources/research/communications-tips-exchange-talking-with-voters.html

— Stressing that under the ACA insurers won't be able to deny coverage for pre-existing diseases is a Herndon biggie. In fact, you heard this many times over from Mr. Obama and other politicians. But a loophole in the law allows insurers to rescind (cancel) your policy if you intentionally put false or incomplete information on your application. The ACA says you must be given at least 30 days' notice before your coverage can be rescinded, giving you time to appeal the decision or find new coverage. So, if your care becomes costly for the insurer and you didn't mention you had a rash on your arm when you were 15, that'll work. How can you prove if leaving this out was intentional or not? It's them against you.

Enroll America's Best Practices Institute is publishing a series of briefs on the best way to write and design websites and marketing materials, no doubt, using Herndon messaging. PR and marketing firms are helping various state Exchanges come up with appealing branding such as using a name everyone will like and spiffy logos with cool type styles in colors that will appeal to all audiences. Branding lessons include advising Exchanges which words to 'embrace' such as emphasizing choice, control, transparency and competition. Other messaging includes, "the Exchange should be viewed as an educator, not an enforcer" and using the word 'marketplace' instead of Exchange is a must. Tennessee Health Care Campaign will be telling potential customers ". . . the exchange offers us more choices, greater control over our health care, and more competition to control costs." It's all Herndon's handywork in one form or another. http://dhmh.maryland.gov/exchange/pdf/Brand_Recommd_may182012_final.pdf http://www.thcc2.org/PDFs/rtm_exchange_talking_point.pdf

More choice means choice of insurance companies, not choice of doctors and hospitals. In rural areas, there may be only one insurer offering plans which means one network and doctors may not be taking new patients. This happened in MA under Romneycare, and on top of that, many doctors would not accept people in the subsidized plans because of time-consuming red tape and low reimbursement rates. Under the ACA, insurers are planning to limit networks in the cheaper plans at the Exchanges. Having too few doctors in a network is a means of suppressing the use of health care which increases an insurer's profits. Further on in this lesson, you'll learn that the Maryland Exchange has been advised to ignore negative problems such as not enough doctors to serve the newly insured. http://www.kaiserhealthnews.org/Stories/2013/January/23/HMO-limited-networks-comeback-in-exchanges.aspx

Choice is definitely a non starter for people found eligible for Medicaid – the ACA allows no other choice for this segment of the population and many doctors do not accept Medicaid. As for giving you greater control, considering all the rules about income and FPL, not to mention the data-mining to monitor your income during the year and those nasty tax credit paybacks, it's you who is being controlled. And competition? Read this stunning op-ed by Nomi Prins: "Real Danger of "Obamacare" Insurance Company Takeover of Health Care." http://www.nationofchange.org/real-danger-obamacare-insurance-company-takeover-health-care-1352648027

In Enroll America's January 15, 2013 press release, Executive Director Rachel Klein says the ACA offers the promise of "access to comprehensive, affordable health coverage." That is a false promise. As you learned in this lesson, coverage in the plans that will be offered at the Exchanges, with the exception of the two most expensive, is anything but comprehensive – the cheaper plans are unaffordable to use. Furthermore, how can she claim that the cost of the plans are affordable? Ms. Klein should be well aware of the nationwide survey Enroll America commissioned in which the majority of people polled said that the plans are too expensive.

http://files.www.enrollamerica.org/news-room/press-releases/Enroll_America_Plans_Major_Affordable_Care_Act_Enrollment_Campaign_1-15-13.pdf

http://www.nytimes.com/2012/12/20/us/officials-confront-skepticism-over-health-law.html?ref=us&_r=0&pagewanted=all

Currently PR firms are working with some state Exchanges to develop effective communications plans and advertising campaigns. Names include Mintz & Hoke, Hill & Company Communications and Weber Shandwick just to name a few. Ask the Massachusetts Health Insurance Connector – the prototype of an Exchange in the land of Romneycare – how much it spent on PR contracts over the years. In 2007, board members signed off on a two-year contract with Weber Shandwick for $1.85 million the first year with nearly $3 million for advertising – commission on media buys not included. And, by the way, the MA Connector upper management boasts six-figure salaries. Former MA Connector Executive Director Jon Kingsdale's salary in 2007 was $225,000 and increased in 2008 to $231,750. In 2007, Deputy Director Rosemary Day alternated between a four-day and five-day work week to the tune of $175,000. These are only two examples of the many high-flying salaries at the MA Connector, an operation run by politicians and unelected political appointees and influenced by executives from the private insurance industry, http://www.wickedlocal.com/cambridge/news/x497793387/Connector-re-ups-contract-with-Cambridge-based-Weber-Shandwick
http://www.boston.com/yourlife/health/other/articles/2007/01/27/6_figure_pay_for_care_plan_overseers/?page=full http://www.highbeam.com/doc/1G1-166773095.html

Add up pay scales like that for every Exchange in the country, throw in some bennies, a PR contract for each Exchange, campaign costs and compensation paid by Exchanges to Navigators for plans they sell – a grand and costly effort to push more people into America's for-profit health care system. Your tax dollars at work and mega bucks that could be used for actual hands-on medical care.

The Maryland Exchange has three campaign funding levels – Basic, Plus and Full-Scale – with a total for year one, two and three. Basic funding for year one is $2,450,000, Plus is $4,000,000 and Full-Scale is $6,300,000. See p.137 at this link for years two and three. http://www.dhmh.maryland.gov/exchange/pdf/FinalAdvertisingReportWeber.pdf

The following, from the maryland link above, gives you an idea of some of the strategies that will be in play, most likely in all states. The Maryland Exchange has been advised by Weber Shandwick to "establish a system to monitor newspaper, radio, TV and online conversations about the Exchange and the program and to establish procedures and priorities for responding to negative media stories, op-eds, blogs and reports." You can find this in the Risk Management and Responses section of Maryland's strategic marketing plan.

In the Earned Media/Public Relations section, advice includes " . . . putting out stories on the first effective enrollees, enrollment number milestones, and enrollee testimonials. Each of these becomes the focus for positive, brand-reinforcing stories. There will also be the risk of negative stories, including potential topics such as enrollment snafus, delays in issuing insurance cards, the cost of Qualified Health Plans [government-approved plans], claims of 'shoddy' Bronze coverage, incidents of physicians refusing to accept enough new patients to serve the uninsured and other negative topics." "While coverage is bound to include some level of criticism it can be success- fully countered by putting a human face on heatlh reform."

The Social and Digital Media section advises an invasion of the Internet including social media to market health insurance by "delivering the right messages to the right audience at the right time," (probably using Herndon spin) to "help drive enrollment in the Exchange," and also flooding newspapers with op-eds to contradict reported adverse effects of the ACA.

More details can be found at the Maryland pdf link below. It's worth looking at this presentation to grasp the big business approach of Exchanges which is clearly profit-driven. The Maryland Exchange strategy is just one example. The goal of Exchanges is sell, sell, sell.

http://www.dhmh.maryland.gov/exchange/pdf/FinalAdvertisingReportWeber.pdf

Exchanges certainly have a lofty goal – promote success stories only and be ready to contradict and cover up the bad stuff as quickly as possible. Massachusetts residents have been there. The Connector and state politicians including the governor made sure that anyone being harmed by Romneycare would not be heard in spite of statewide survey reports put together by outreach agencies advising state legislators and powerplayers that low-income people were not faring well under this law. Various issues were spelled out and testimonials were included, but residents' concerns about the adverse effects of Romneycare were ignored. MA national legislators also went along with this agenda as did the mainstream media.

When $130 million was needed in 2009 to balance the Massachusetts state budget, the Connector – with the blessing of MA Gov. Deval Patrick and the MA legislature – removed about 28,000 legal immigrants – working people paying taxes – from their insurance plans. Another 8,000 or so were barred from enrolling in insurance plans because the MA legislature voted to cap enrollment in the subsidized plans. This took place at the same time Mr. Obama was trying to sell the ACA to the nation, so, under pressure from Washington, the MA legislature restored some of the money, and the Connector dumped these people, without their consent, into an out-of-state plan with higher copays, less comprehensive coverage and next to no doctors or safety net hospitals in its network. http://www.huffingtonpost.com/iyah-romm/lessons-from-massachusett_b_380718.html

This has huge implications for the ACA. If legal immigrants can be removed from their plans and others denied enrollment when a state budget is squeezed, which vulnerable segment of the population is next in line? The good news is these legal immigrants in MA sued the Connector and its then-Executive Director, Jon Kingsdale, and the Massachusetts Supreme Judicial Court ruled unanimously that the state could not violate their right to equal protection under the state and federal constitutions and fiscal considerations alone can not justify a state's invidious discrimination against them. As a result of this decision, the state had to come up with some bucks, and the Connector was forced to put the plaintiffs back into their original plans.

http://www.healthlawadvocates.org/priority-areas?id=0015

Getting back to Enroll America, Herndon Alliance and some of the less-than-honorable Exchange strategies – it's one thing to inform Americans about the ACA and Exchanges that offer the possibility of either purchasing high-deductible or catastrophic coverage with a loan from the government to help pay for it or being tossed into expanded Medicaid – but, mounting a costly, massive campaign to purposely deceive and manipulate the public with the unstated goal of more profit for the already extremely lucrative health insurance industry is disgraceful.

Is the ACA a fair law if it helps only one small segment of the population but hurts and exploits a larger number to do so? The way this law works is fundamentally unfair and will not bring medical care to the many, but, instead will progress to greater personal debt for individuals and families who can't afford the "affordable" insurance as well as those who must keep an eye on their income to avoid the many traps and false ends this law creates. At their expense, the forced purchase of health insurance will bring

increased revenue to the industry, not to mention more kickbacks to Congress, and in the very near future, the health insurance industry will be "too big to fail."

The ACA is most definitely a "uniquely American solution" which has little to do with reforming this country's barbaric health care system. It merely controls peoples' finances and choices while leaving insurance companies in charge and does virtually nothing to end their abuses. It will leave many millions of Americans uninsured and millions more underinsured at a staggering cost to taxpayers.

Politicians, health care policy wonks and vested interests will brush aside the ACA's adverse effects. You'll hear that some have fallen through the cracks of health care reform but the problems can be easily tweaked. You will also witness the usual dog-and-pony show on Capitol Hill in which the two parties play the blame game. The bought-and-paid-for mainstream media will regurgitate whatever Washington feeds it, and TV talking heads will chime in, inviting their "experts" to analyze the situation while real people in the real world struggle to get by under this law or fall by the wayside.

Good luck everyone and watch out for the folding chairs.