

HEALTH CARE REFORM FREQUENTLY ASKED QUESTIONS

Consumers

When will the health care reform law take effect?

The health insurance reforms adopted as part of the Patient Protection and Affordable Care Act (PPACA), and the subsequent reconciliation bill, are phased-in over 5 years. Most provisions will not take effect until January 1, 2014. However, there are some new protections that have already been implemented:

- Lifetime limits are prohibited and annual limits are restricted
- Enhanced appeal procedures are available to consumers
- Children under 19 years of age cannot be denied coverage
- Children up to age 26 may remain on a parent's policy
- Preventive services must be covered and cannot have cost-sharing
- New rate review transparency requirements are in place
- Medical loss ratio standards limit insurers' overhead
- A standardized summary of benefits must be used by all insurers, allowing for easier comparison of plans

In addition, subsidized coverage for people with pre-existing conditions that cannot find coverage in the private market is now available in every state through January 1, 2014.

Will I be required to give up my current coverage?

No. Health plans in effect as of March 23, 2010, are grandfathered under the law and will be considered "qualified coverage" that meets the mandate to have health insurance that begins January 2014 as long as the issuer continues to offer it without substantial changes.

Why does the law require me to purchase health insurance coverage?

The key goal of the health care reform law is to ensure that nobody can be denied coverage or be priced out of coverage due to a health problem. However, if you allow people to wait until they have a health problem to purchase insurance, then the market simply will not work. There would be few choices available to consumers, and those choices would be expensive for everyone. So, the law requires everyone to have minimum coverage, thus creating a pool of both sick and healthy individuals.

How will my benefits be impacted by the law?

Every plan sold or renewed in the individual and small group market after January 1, 2014, must include all the benefits in a "benchmark" plan – a plan chosen for the state based on coverage currently available in the state – and will cover services in the following categories:

- Ambulatory patient services
- Emergency services

- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

How will my out-of-pocket costs be impacted?

All plans sold or renewed in 2014, must limit the out-of-pocket exposure of consumers to approximately \$6,000 for individual and \$12,000 for families. These limits will be indexed to average premium growth in future years. In addition, the deductible for plans in the small group market will be limited to \$2,000 for individuals and \$4,000 for families in 2014, also indexed to average premium growth in future years.

Also, all plans must design their cost-sharing (deductibles, copays, coinsurance) to fit into specific levels of coverage. The levels of coverage are defined as follows:

- **Bronze Level** – The plan must cover 60% of expected costs for the average individual
- **Silver Level** – The plan must cover 70% of expected costs for the average individual
- **Gold Level** – The plan must cover 80% of expected costs for the average individual
- **Platinum Level** – The plan must cover 90% of expected costs for the average individual

The exchange will group coverage by these “metal” levels, allowing consumers to easily compare comparable options.

Will insurers be able to charge me more because of my age?

Yes, though they may not charge older individuals a premium that is more than 300% of the premium charged a younger individual. Currently, rates can vary based on age as much as 700% in some cases. In addition, insurers may not vary rates based on health, claims, genetic information, or any other health-related factors. Insurers may only vary rates in a state by age (within limits), tobacco use, geography, and the number of family members covered.

When can my 21 year old be added to my plan?

The health reform law requires that insurers and employers that provide dependent coverage to children make that coverage available to adult children of enrollees up to their 26th birthday. This requirement became effective for “plan years” beginning September 23, 2010, so parents will be able to enroll a child in group coverage during the next open enrollment period. Children can be added to an individual policy when it is renewed.

Of course, adding an adult child to the plan will likely increase your premiums. If the child is 19 or older, the insurer may exclude coverage of pre-existing conditions for a period of time, as allowed by existing state and federal law, until the prohibition on preexisting condition exclusions takes effect in 2014.

When can I enroll my 10-year-old who has a pre-existing condition?

The law and subsequent regulations prohibit insurers from denying coverage for children based on health status or excluding coverage of their pre-existing conditions if otherwise covered under the policy. This protection became effective after September 23, 2010. A child can be added to an existing policy under the enrollment rules of the policy. If you are seeking a child-only policy, you will need to inquire whether child-only coverage is available in your state. If you are covered under a group plan, you may add your child to your policy at the next open enrollment period.

I have been denied coverage because I have a pre-existing condition. What will this law do for me?

Subsidized coverage is now available in every state to individuals with pre-existing conditions who have been uninsured for at least six months through the Preexisting Condition Insurance Program. This program, either run by the federal government or the state, provides coverage that immediately covers preexisting conditions at premiums that are capped at the average cost of private coverage in your state's individual market.

Beginning January 1, 2014, insurers will be prohibited from discriminating against individuals with pre-existing conditions in offering or pricing health insurance policies. In addition, for those with qualifying incomes, subsidies will be available to reduce premiums and cost-sharing for plans purchased through the Exchange.

My family income is about \$45,000, but my employer does not subsidize our health insurance and we cannot afford it on our own. What will the new law do to make coverage more affordable?

Low- and moderate-income individuals and families whose employers do not subsidize health insurance coverage will be eligible for subsidies that enable them to purchase coverage through the Exchange in their state. The amount of these subsidies, which will reduce premiums and out-of-pocket costs for deductibles, copayments and coinsurance, will depend upon the size of your family and your household income.

What are "Exchanges"? Can I still purchase coverage through my agent?

Exchanges are the central mechanisms created by the health reform bill to help individuals and small businesses purchase health insurance coverage. On October 1, 2013, an Exchange in every state will begin enrolling individuals and small businesses into qualified health plans. The Exchange, operated by the federal government or by the state, will provide information to consumers about their coverage options and what assistance is available to them. The Exchanges will also administer the new health insurance subsidies and facilitate enrollment in private health insurance, Medicaid, and the Children's Health Insurance Program (CHIP). The federal law does not require anyone to purchase health insurance through the Exchange, though subsidies will only be available for plans sold through the Exchange. You will be able to purchase this coverage right on the Exchange's website or through your agent if he or she is approved to sell Exchange plans. If you would rather buy other health insurance through an insurance agent or broker, you will be free to do so.

What should I do if my insurance company rescinds my coverage?

If your insurance company “rescinds,” or retroactively cancels, your health insurance coverage, it is now required to provide advance notice of its intention to do so, and may only do so if you committed fraud or made an intentional misrepresentation of an important fact. If your insurer notifies you that it wants to rescind your policy, and you have not done either of these things, request more information from the company. If you are not satisfied with their explanation, immediately contact your state Department of Insurance to file a complaint.

Can I still have a Health Savings Account (HSA)?

Yes, nothing in the legislation would infringe upon the ability of an individual to contribute to a Health Savings Account (HSA), or discourage an individual from doing so. The minimum level of coverage required to meet the individual mandate was specifically designed to allow for the purchase of a qualified high deductible health plan that would complement the HSA.

Will my health insurance premiums continue to go up?

Unfortunately, the grim fact is that health care spending is likely to continue rising faster than general inflation well into the future, resulting in higher premiums. While some individuals and families with health problems may see their premiums decrease significantly under the new rating rules, for most Americans premiums will continue to increase from year to year. However, the new regulations are designed to prevent unreasonable and unexpected spikes in premiums and, over time, to slow the growth in health care spending.

[Employers](#)

What is the new small business tax credit and how do I know if I am eligible?

The Small Business Tax Credit has been available since the 2010 Tax Year. Businesses with fewer than 25 full-time equivalent employees (FTE) and average annual wages less than \$50,000 per employee may qualify. To receive the tax credit, an employer must have a group health plan and must pay at least 50% of the premium.

The tax credit is equal to a percentage of what the employer pays and is based on the average premium in the small group market in the State. For Tax Years 2010 through 2013, the maximum credit in each year is 35% of the employer’s contributions (25% for nonprofit employers). Beginning Tax Year 2014, the maximum credit is 50% of the employer’s contribution (35% for nonprofit employers). The full 35% tax credit (50% in future years) is available for a business with 10 or fewer full time equivalent workers and average annual wages of \$25,000 or less. The tax credit phases out completely for employers with 25 workers (FTEs) or average wages of \$50,000.

I have 5 employees. Will I be required to provide insurance for my employees?

No. The employer responsibilities under the health reform bill do not apply to employers with fewer than 50 employees. However, you will be able to enroll your employees in coverage through the Exchanges beginning in 2014, if you choose to do so.

I have 75 employees. Will I be required to provide insurance for my employees?

Yes. An employer that fails to offer “minimum essential coverage” to its employees will be subject to a penalty of \$2,000 for each of their employees beyond the first 30. In your case, this penalty would be $\$2,000 \times (75-30) = \$90,000$. Employers that do offer minimum essential coverage will be assessed a penalty of \$3,000 per employee that is eligible for, and receives, a subsidy through the Exchange because their share of the premium for the employer’s group health plan exceeds 9.5% of their household income. This penalty may not exceed \$2,000 times the number of employees, disregarding the first 30 employees.

What new options will be available to me as a small employer?

Through the small business (SHOP) exchange, small employers will have the option of choosing a level of coverage and then allowing each employee to select their own insurer and plan. The exchange can also collect the employer and employee contributions and direct those payments to the chosen insurers.

Will I be required to drop my current coverage?

No. Group health plans in effect as of March 23, 2010, are grandfathered under the law and will be considered “qualified coverage” that meets the mandate to have health insurance that begins January 2014. Employees and dependents can be added to the policy without losing grandfather status, though other substantial changes, such as an increase in the percentage of premium an employee must contribute, may cause your plan to lose its grandfathered status.

Must I go to the Exchange to purchase insurance, or can I continue to purchase coverage through my insurance agent?

The federal law specifically states that businesses are not required to purchase through the small business Exchange.

Can I continue to provide assistance to my employees through flexible spending accounts?

Yes, nothing in the PPACA would eliminate these options, nor discourage them.