Health Reform FAQs

SMALL BUSINESSES

Q: ***My sister has a BBQ restaurant in Texas. She only has 6 employees. Does this new health care reform bill require her to provide insurance? She currently doesn't because she is in a very small business market and needs to know for the future. (Source: Healthreform.gov)***

A: The new law will not require your sister to provide insurance. However, it will provide your sister with tax credits if she chooses to provide insurance to her employees. Starting this year – starting retroactively to January 1, 2010 – a new small business health care tax credit will be in effect that will provide a 35% tax credit on health premiums, with the credit increasing to 50% in 2014. Your sister's restaurant is one of about 4 million small businesses that will be eligible for this tax credit, and small business owners can now find information on the tax credit online.

Q: ***What is the small business tax credit and how do I know if I am eligible? (Source: Whitehouse.gov)***

A: Effective January 1, 2010, tax credits are available to qualifying small businesses that offer health insurance to their employees. So if your business qualifies for a tax credit, you are eligible right now.

About 4 million small businesses will be eligible to receive tax credits if they provide insurance. The tax credit is worth up to 35 percent of the premiums your business pays to cover its workers – 25 percent for registered non-profit firms. In 2014, the value of the credit will increase to 50 percent – 35 percent for non-profits.

Your business qualifies for the credit if you cover at least 50 percent of the cost of health care coverage for your workers, pay average annual wages below $50,000, and have less than the equivalent of 25 full-time workers (for example, a firm with fewer than 50 half-time workers would be eligible).

The size of the credit depends on your average wages and the number of employees you have. The full credit is available to firms with average wages below $25,000 and less than 10 full-time equivalent workers. It phases out gradually for firms with average wages between $25,000 and $50,000 and for firms with the equivalent of between 10 and 25 full-time workers. To learn more about the small business tax credit, you can also visit IRS.gov

Q: ***Am I required to offer insurance to my employees? (Source: Healthreform.gov)***

A: No. There is not a so-called "employer mandate" in the legislation.

Q: ***Are there small business tax increases in this new law? (Source: Healthreform.gov)***

A: No. In fact, small businesses get tax breaks for health insurance rather than tax increases under the law.

Q: ***What if my small business doesn't offer insurance today, but I choose to start offering insurance this year. Will I be eligible for these tax credits? (Source: Healthreform.gov)***

A: Yes. The tax credit is designed to both support those small businesses that provide coverage today as well as those that newly offer such coverage.

Q: ***Can I join a pool now to lower my costs? (Source: Healthreform.gov)***

A: Beginning in 2014, reform will create state-based health insurance exchanges that pool small businesses and their employees, which will spark competition and give you the kind of purchasing power that big businesses enjoy today. The exchange will offer the same types of private insurance choices that the President and Members of Congress will have. Increased purchasing power and competition will make premiums more affordable. The exchange will also reduce administrative costs for your businesses and your employees, enabling them to easily and simply compare the prices, benefits, and quality of health plans.

PARENTS

Q: ***How do I get my 23 year old onto my plan? (Source: Healthreform.gov)***

A: Six months from now, insurers will be required to permit children to stay on family policies until age 26. This applies to all plans in the individual market, new employer plans, and existing employer plans, unless your adult child has an offer of coverage through his or her employer. This requirement will take effect the next time your plan comes up for renewal. Adult children who are on their parents' plan now but who lose that coverage when they graduate from college will have the option of rejoining their parents' policy in the new plan year beginning 6 months from now. Those whose parents work at self-insured companies will also be eligible if they do not have an offer of employer-sponsored insurance.

Both married and unmarried dependents qualify for this dependent coverage.

Beginning in 2014, children up to age 26 can stay on their parent's employer plan even if they have an offer of coverage through their employer.

Q: ***Will I be fined if I do not insure all of my children younger than 26?***

A: Patents are not required to cover children over the age of 18. This rule applies to all plans in the individual market and to new employer plans. It also applies to existing employer plans unless the adult child has another offer of employer-based coverage (such as through his or her job). Beginning in 2014, children up to age 26 can stay on their parent's employer plan even if they have another offer of coverage through an employer.

Q: ***Can I now get coverage for my 6-year-old who has a pre-existing condition? (Source: Healthreform.gov)***
A: Yes. Effective 9/23/10 it will be illegal for health insurance companies that cover children to deny coverage to your child based on a pre-existing condition. This applies to all new employer plans, new plans in the individual market, and existing employer plans.

CONSUMERS

Q: ***When do the main reform changes kick in?***

A: In 2014. That's when insurance marketplaces, known as exchanges, will be set up in states to offer competitive pricing on health policies for individuals and small businesses that don't have coverage. People with a pre-existing condition will no longer be denied coverage, and all lifetime and annual limits on coverage would be eliminated. Medicaid would be expanded to cover more low-income Americans. But there are a lot of changes to the way insurers will have to do business that happen before 2014. For example, insurance companies will not be able to rescind coverage because someone gets sick. Adult children up to the age of 26 will be allowed to stay on their parents' policies starting in the plan year following September 23, 2010. Also, insurers will not be able to exclude coverage for pre-existing conditions in children.

Q: ***What consumer protections will I get this year if I get insurance at work? (Source: Healthreform.gov)***

A: On 9/23/10, insurers will be prohibited from placing lifetime limits on what they will pay for your medical care and they can only apply restricted annual benefit limits. This provision applies to both new and current insurance policies. Insurers will no longer be able to arbitrarily cancel your insurance policy when you get sick, except in cases of fraud.

Insurance companies will be prohibited from denying coverage to children with pre-existing conditions. This applies to all new and existing employer plans.

On 9/23/10, all new group health plans must provide coverage for preventive services. Recommended prevention and vaccination services will be covered without any deductibles or copayments. Plans must also have a straightforward and independent appeals process so you can appeal decisions by your health insurance plan.

Beginning on January 1, 2011, insurance companies will be required to spend most of your premium dollars on your care, not on profits and overhead-85% in the large group market and 80% in the small group and individual market - and rebate any excessive overhead to enrollees. Similarly, starting in plan year 2011, insurance companies that jack up rates will have to disclose requested premium increases publicly. If that rate increase is found to be unreasonable, the insurer may be prohibited from competing for your business in the new state-based exchange that will begin operating in 2014.

Q: ***What consumer protections will I get this year if I buy coverage in the individual market? (Source: Healthreform.gov)***
A: Starting 9/23/10, insurers will be prohibited from placing lifetime limits on what they will pay for your medical care, and they can only apply restricted annual benefit limits. Insurers will no longer be able to arbitrarily cancel your insurance policy when you get sick, except in cases of fraud.

Insurance companies will be prohibited from denying coverage to children with pre-existing conditions. This applies to all new plans in the individual market.

All new individual market health plans must provide coverage for preventive services. Recommended prevention and vaccination services will be covered without any deductibles or copayments. They must also have a straightforward and independent appeals process so you can appeal decisions by your health insurance plan.

Beginning on January 1, 2011, insurance companies will be required to spend most of your premium dollars on your care, not on profits and overhead—80% in the individual market – and rebate any excessive overhead to enrollees. Per Title X Sec 2718

Similarly, starting in plan year 2011, companies that sell insurance in the individual market that jack up rates will have to disclose requested premium increases publicly. If that rate increase is found to be unreasonable, the insurer may be prohibited competing for your business in the new state-based exchange that will begin operating in 2014.

Q: ***I have a pre-existing condition. How can I get coverage this year? (Source: Healthreform.gov)***

A: This year, if you have been uninsured for 6 months and have a pre-existing condition, you will gain access to health insurance that was not previously available to you.
A new program – known as a high-risk pool – will provide affordable insurance for Americans who are uninsured and have a pre-existing condition. This program will provide temporary protection for people with pre-existing conditions. It caps out of pocket expenses, limiting them to $5,959 for an individual or $11,900 for a family. This program continues until 2014, when insurance companies can no longer deny you coverage based on your health.

Q: My insurance company wants to raise my rates. What recourse do I have? (Source: Healthreform.gov)

A: For most consumers today, it is hard to figure out how to challenge a rate increase. The new health insurance reform law will create a clear pathway for consumers to hold insurance companies accountable.

In 6 months, all new health plans will be required to have implemented a clear and effective process under which policy holders can appeal coverage determinations and claims. States

must also have an external appeals process to ensure a fair and objective review of coverage disputes.
Additionally, millions of dollars in grants will be made available this year to states to help create a health insurance consumer assistance office where consumers can learn how to enroll in a plan or file a complaint. There will also be a new website that will begin operating this year, which will help consumers identify and compare health coverage options. Information will be presented in a standardized, easy-to-understand format to ensure that individuals and families understand their options and purchase the right coverage for their needs.

Finally, new standards for the amount an insurance company must pay out in benefits as opposed to profits and administrative expenses will go into effect in 2011. Insurance companies will be required to give money back to consumers if they do not meet those standards. In addition, requested premium increases will be made publicly available, and in 2014, plans that have arbitrarily raised rates previously may not be able to participate in the new health insurance exchanges.

Q: ***Can you explain whether the elimination of lifetime caps under the new health care bill applies to existing policy-holders as well as new insurance sign-ups?***

A: Yes, within six months, the private insurance plans will have to stop some practices, such as setting lifetime limits on coverage and canceling policy-holders who get sick, on all new policies and current policies.

Q: ***My insurance company just withdrew my coverage, claiming I had a previous illness. Can I fight back? (Source: Healthreform.gov)***

A: Effective six months from now, insurance companies will be prohibited from dropping your coverage when you get sick. This will apply to all new and existing insurance plans.

Q: ***I have heard many people worry that health care will be "rationed" under health reform. I won't be able to get certain tests or procedures. What if I want those tests and what if they detect something that could save my life? (Source: aarp.com)***

A: First, there is already widespread rationing in today's system. Right now, decisions about what doctor you can see and what treatment you can receive are made by insurance companies, which routinely deny coverage because of cost or the insurance company rules. Health reform will do away with many of those rules that result in rationing today. Health insurance reform will also put treatment decisions back into the hands of doctors in consultation with their patients.

Q: ***When does free preventive care start and will it affect my plan? (Source: Healthreform.gov)***

A: In 6 months, all new group health plans and new plans in the individual market must provide coverage for preventive services. Recommended prevention and vaccination services will be covered without any deductibles or copayments. Seniors enrolled in Medicare will also no longer have to pay for proven preventive services.

Q: ***What happens when there aren't enough doctors to oblige all the patient population?***

A: The new law addresses the primary care doctor shortage in 3 basic ways.

First, primary care doctors who treat Medicare patients will receive a 10% bonus from 2011-2016 for caring for those patients. Medicaid providers also receive an increase in payments. Physicians will also receive an additional bonus if they file health care quality reports with Medicare. Adjustments in Medicare payments based on geographical regions to reflect the cost of providing care will also be made.

Second, the new law provides incentives to encourage doctors to go into primary care. Examples include- expanding loan forgiveness programs to defray the cost of medical school, providing money for primary care training programs at teaching hospitals, providing grants to medical schools to recruit and train students who will practice in rural communities. There are also similar incentives for training nurses and other medical providers to help ease the demand on the primary care doctor.

Finally, the law creates "accountable care organizations", consisting of physicians and other medical groups, which will be based on how well their patients fare, rather than the number of services/tests provided to them.

Q: ***What information about insurance companies is going to be posted on the web?***

A: Consumers will immediately have more opportunities to take control of their health insurance choices. Effective July 1, 2010, a website will provide information to help consumers choose the plan that is best for them. The Secretary of HHS will establish an Internet website through which residents of any State may identify affordable health insurance coverage options in that State. The website will include information on coverage options for small businesses as well.

Effective January 1, 2011, health plans, including existing plans, must annually report on what percentage of premium dollars they spend on medical care, as opposed to profits, marketing, and administrative expenses. You will be able to see that information online and may be entitled to a rebate if your plan spent too much on overhead and profits. Health insurers must also post unreasonable rate increases along with a justification for them.

Q: ***Will this bill place any limits on what kind of tests or procedures I can have?***
(Source: wbztv.com)

A: This law places no limits on what your doctor can do for you or what your doctor can authorize for you.

Q: ***If I become unemployed or disabled will my entire family be covered by health insurance paid for by the government?***
A: Individuals and families with incomes up to 133% of the federal poverty level (below $29,327 for a family of four) will gain coverage under health reform

GENERAL

Q: ***How will the new law impact plans like Kaiser Permanente, Blue Cross, ODS, etc?***

A: These companies will no longer be able to deny coverage based on preexisting conditions, rescissions and annual/lifetime limits are also eliminated. These insurance providers are now required to cover dependents up to age 26, must accept all who apply and must guarantee renewability of coverage regardless of health status. These companies are required to spend at least 85% of premium revenues from large group plans (80% from small group and individual markets) on clinical services, and activities to improve quality. If less than these specified amounts are spent on clinical services and quality improvements, a rebate must be provided to enrollees.

Q: ***Some people tell me that I should get health insurance directly from the government because it won't cost as much. When will this coverage be available and how much will it cost?***

A: Exchanges, which offer private plans subsidized by the federal government, should be up and running in each state by January 1, 2014. There is no information available on cost for plans purchased through the exchanges as of yet. However, families who do not have access to affordable employer-based insurance, Medicaid, or Medicare, who have incomes less than 400% of the Federal Poverty Level will be eligible for premium credits on a sliding scale basis.

Q: ***It is my understanding that Senators and Congressmen will not be covered by the same Patient Protection and Affordable Care Act that they say all Americans are entitled to. Is that true?***

A: No, Members of Congress are entitled to the same protection and affordability offered to all citizens under the Patient Protection and Affordable Care Act. Members of Congress and their personal staffs will, by law, enter the newly created health care exchanges to purchase coverage along with roughly 30 million other Americans.

Q: ***As we all know, obesity is causing billions in health care costs. If the government can force people to buy health insurance "for the good of all" can't the government also force people to lose weight "for the good of all?"***

A: No, the constitution does not allow the government to force individuals to lose weight. However, there are several initiatives available for those who want to lose weight.

SENIORS

Q: ***How much will the reduction in Medicare and Medicaid be, and when will these reductions go into effect? (Source: aarp.com)***

A: Spending reductions were targeted to areas of Medicare and Medicaid with high levels of waste, fraud and abuse. Health reform strengthens and improves Medicaid by providing new coverage to vulnerable Americans, improving access to preventative services, providing home and community based services that otherwise would require institutionalization, makes enrollment simpler , and improves and modernizes delivery systems. Medicare recipients will receive a $250 rebate if they enter the "doughnut hole" in 2010 and a 50% discount on all brand name drugs and biologics purchased during the coverage gap beginning January 1, 2011. Medicare Advantage providers in Oregon will be rewarded for providing high quality services. Beneficiaries may see a nominal increase in premiums and will be notified of any proposed increase in advance.

Q: ***Does the government intend to notify those affected in sufficient time to adjust budgets, find new doctors, etc?***

A: In the event there are changes to premiums, beneficiaries will be notified in a timely manner.

Q: ***My prescription drug spending will push me into the donut hole this year. What relief will I get? (Source: Healthreform.gov)***

A: Seniors who hit the gap in Medicare prescription drug coverage known as the donut hole will be provided with a $250 rebate in 2010.

Beginning in 2011, seniors in the donut hole will receive a 50 percent discount on prescription drugs. In addition, the Medicare share of costs will increase so that the donut hole will be completely closed in 2020.

Q: When does my free preventive care start and what does it cover?
(Source: Whitehouse.gov)

A: Effective January 1, 2011, proven preventive services will be free. In addition, a new annual wellness visit that provides a personalized prevention plan services, including a health risk assessment, will be provided under Medicare.

Q: Can you define the doughnut hole? (Source: Healthreform.gov)

A: Medicare Part D provides prescription drug benefits to Americans on Medicare. This benefit comes with a $310 deductible. After you've spent $310, you pay 25 percent of the cost of your prescriptions until the total cost of all the medicine you have received in a year hits $2,830. Then, you are stuck with 100 percent of the bill until the total cost of your medicines hits $6,440. The gap when Medicare does not cover the cost of your prescription drugs is known as the doughnut hole.
Health reform will close the donut hole. Reform also offers immediate relief by providing a $250 rebate this year to seniors who hit the doughnut hole.

Q: How will the $250 benefit toward coverage gap cost be received by beneficiaries? What's the Eligibility? (Source: Healthreform.gov)

A: Once you have hit the prescription drug doughnut hole, you will eligible for a $250 rebate. That check will be sent directly to you from Medicare. There's no application process and no private company will be involved in getting your rebate check to you.

Q: What effect will the $250 rebate have on my taxes? Will I have to pay it back?

A: The $250 rebate is not taxable income and will not have to be repaid.

Q: I'm covered by a Medicare HMO which served my health very well. Will I be able to maintain the same coverage I have after health insurance reform is implemented? (Source: hhs.gov)

A: Unfortunately there has been a lot of misinformation about Medicare Advantage plans. Seniors have a choice when they turn 65 and beyond, enroll in the traditional Medicare plan or enroll in a Medicare HMO or Medicare Advantage Plan. Medicare Advantage plans will continue to offer services to beneficiaries. Companies right now choose whether to offer Medicare Advantage plans. Some may make the business decision to exit the market, but nothing in health reform forces these plans to stop offering benefits and services.

Q: I cannot get Medicare until I am 62. I do not have health coverage. I cannot get health coverage because I have a pre-existing condition. Do I get a piece of this new health care plan? (Source: Healthreform.gov)

A: Absolutely. Beginning this year, you will be eligible to receive coverage through the new high-risk pools. Today, too many insurance companies reject Americans with pre-existing conditions or charge exorbitant rates. High-risk pools will offer these individuals access to affordable insurance and in 2014 there will be a new market that will prevent insurance companies from denying coverage to anyone with preexisting conditions. The Federal government will have more details regarding the high-risk pools in the weeks ahead. You can read about the first step being taken here.

Q: How will the new health care law affect those of us who are under age 65 but still disabled and on Medicare? Is there anything that is different for us than those on Medicare due to age? For people who are disabled, how does the new law impact them? (Source: Healthreform.gov)

A: If you're on Medicare, nothing will change for you. You will continue to receive your Medicare benefits and reform makes Medicare stronger. Today, Medicare beneficiaries must pay 20 percent of the cost of many preventive services and office visits. Reform eliminates deductibles, copayments, and other cost-sharing for recommended preventive care, and provides free annual wellness check-ups starting in 2011. Reform will also improve the quality of care you receive, fight Medicare fraud and extend the financial health of Medicare by 9 years.

Q: What will happen when there aren't enough doctors to oblige all the new patients? (Source: cnn.com)

A: There was a physician shortage predicted before the passage of healthcare reform. Patients could see increased wait times, as in Massachusetts where residents wait an extra 10 days to see a provider. However there are provisions in the legislation that call for more community health centers- allowing care to happen in these centers as opposed to more expensive areas such as emergency rooms.

Taxes

Q: Is it true that the IRS will fine me if I cannot prove my health care insurance is in compliance with standards established by the government?

A: Proof of insurance will be required when filing annual tax returns. Failure to provide such proof will result in a penalty being assessed.

Q: Will I have to pay more taxes?

A: Most people will not pay any more taxes. Under the new law, starting in 2013, individuals with earned income above $200,000 or above $250,000 for married couples they will pay an extra 0.9 percent (for a total of 2.3 percent) in their Medicare payroll tax. They will also a pay a new tax on unearned income, including money from investments, dividends, annuities, royalties and rent. Social security, pensions or IRA income are excluded.

Starting in 2013, you can deduct from your taxes medical expenses that exceed 10 percent of your income—up from 7.5 percent now. This change is postponed until 2017 for taxpayers age 65 and older.

Q: Will I have to pay new taxes on my blood pressure monitor?

A: No. The tax on medical devices does not affect devices to monitor blood pressure, glucose levels, eye glasses, contacts, hearing aids or any other medical device generally purchased by the public at retail stores. The medical device tax imposes an excise tax on the sale of medical devices by the manufacturer or importer equal to 2.3 % of the sales price. The tax is deductible for federal income tax purposes.

Q: If the fine for not having insurance is less than the first month's premium, what will happen to me if I wait until I'm sick before I get insurance?

A: You will have to pay a penalty for not securing insurance. The penalty will be the greater of $95 or 1% if your annual income in 2014, $325 or 2% of your annual income in 2015, $695 or 2.5% of your annual income in 2016 up to a cap of the national average bronze plan premium. After 2016, dollar amounts will increase by the annual cost of living adjustments.

Q: What will happen to me if I can't afford to pay the fine?

A: Exemptions will be made for those who cannot afford coverage, taxpayers with income below the annual tax filing threshold, members of Indian tribes, and those who receive a hardship waiver, as well as those not covered for less than 3 months per year.