FEDERAL HEALTH CARE REFORM

***Important Note**: The National Association of Insurance Commissioners (NAIC), an organization of insurance regulators from the 50 states, the District of Columbia and the five U.S. territories, has posted "Heath Care Reform Frequently Asked Questions" at its website at:* **http://www.naic.org/index health reform section.htm**

The information provided below is a reproduction of the frequently asked questions posted on the NAIC's website as of December 17, 2010, except as noted below for additional Medicare information and changes to Medicare to become effective January 1, 2011. Please refer to the website address above for updates to these questions and responses.

This information is not intended to be an opinion, legal or otherwise, on the federal health care reform legislation, nor should it be construed as a position of the Bureau of Insurance or Virginia State Corporation Commission on the federal health care reform legislation or any of its provisions.

Frequently Asked Questions (FAQ)
Consumers/Employers/Seniors

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 the next 5 years. Most provisions will not take effect until Jan. 1, 2014. However, some new protections must be implemented when plans renew after Sept. 23, 2010. In addition, new federal high risk pool programs and transparency measures were adopted during the summer of 2010.

For more information on when certain provisions become effective, see the three PPACA Charts: (Immediate Implementation, Market Reforms and American Health Benefit Exchanges) at:
http://www.naic.org/index_health_reform_section.htm#consumers.

(Updated 8/4/10) The U.S. Department of Health and Human Services (HHS) along with the Office of Consumer Information and Insurance Oversight frequently issues regulations that implement many of the provisions of the legislation that address private health insurance. Find the most current information on the HHS Regulations and Guidance Web page.

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.

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

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

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

The federal health care reform law requires that insurers and employers providing dependent coverage to children make that coverage available to adult children of enrollees up to their 26th birthday. This requirement becomes effective for "plan years" beginning Sept. 23, 2010, so you will be able to enroll your child in group coverage at the first open enrollment period following this date. For more information on companies that have agreed to implement this requirement before the Sept. 23 deadline go to the U.S. Department of Health & Human Services at: http://www.hhs.gov/ociio/regulations/adult_child_fact_sheet.html. If the child is 19 or older, the health plan may exclude coverage of pre-existing conditions for a period of time, as allowed by existing state and federal law until the prohibition on pre-existing condition exclusions takes effect in 2014.

(Updated 08/04/10) The U.S. Department of Health and Human Services (HHS) has published updated Regulations and Guidance on this subject. See their FAQ providing details on this issue at: http://www.hhs.gov/ociio/regulations/adult_child_faq.html.

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

The federal health care reform law prohibits insurers from excluding coverage of children's pre-existing conditions for plan years beginning after Sept. 23, 2010. The Obama administration has indicated that it will interpret this provision to require that insurers provide coverage without pre-existing condition exclusions to children if they cover the parents, and the health insurance industry has signaled its intention to comply with this interpretation. More detailed guidance will be forthcoming from the U.S. Department of Health and Human Services.

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

Exchanges are the central mechanisms created by the federal health care reform bill to help individuals and small businesses purchase health insurance coverage. Beginning in 2014, an Exchange will be established in each state to help consumers make valid comparisons between plans that are certified to have met benchmarks for quality and affordability.

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). Nobody will be required to purchase health insurance through the Exchange, though subsidies will only be available for plans sold through the Exchange. If you would rather buy your insurance through an insurance agent or broker, you will be free to do so. However, the law's intent is to make purchasing insurance on the Exchange's website easy to do in a matter of minutes.

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

Beginning as early as July 1, 2010, the Pre-existing Condition Insurance Plan will begin enrollment. This program will be operated by the federal government in states that chose not to establish a high risk pool under the federal program. Coverage will be available to individuals with pre-existing conditions who have been uninsured for at least six months through high risk pool programs in every state. These programs will provide coverage that immediately covers pre-existing conditions at premiums that are capped at the average cost of private coverage in your state's individual market. In 2014, when the Exchanges open for business, 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.

I am single, have no children and earn less than $10,000 per year. What coverage choices will be available to me?

Beginning in 2014, single adults earning between $10,830 and $14,400 will be able to choose whether to enroll in Medicaid or to purchase coverage through the Exchange with a generous federal subsidy. Those earning less than $10,830 will be eligible for their state’s Medicaid program, but not for subsidies in 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, co-payments and coinsurance, will depend upon the size of your family and your household income.

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

If your insurance company “rescinds,” or retroactively cancels, your health insurance coverage, it will be required, in plan years beginning Sept. 23, 2010, 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 on your application. 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 insurance department to file a complaint. You can find contact details on your state's insurance department website at:www.scc.virginia.gov/boi

How will the bill improve access to preventive care?

Beginning Sept. 23, 2010, plans that became effective after March 23, 2010, must, upon renewal, eliminate any cost-sharing for preventive services covered under the contract.

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 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.

How much will this new law cost?

The total cost over 10 years is projected to be $940 billion. This is more than offset by cuts in spending and increased fees and taxes, resulting in a reduction in total spending of $138 billion over 10 years, according to the Congressional Budget Office. Time will tell if these estimates are accurate and whether the offsets materialize.

Employers

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

The Small Business Tax Credit is available beginning with 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 at 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 federal health care reform law 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.

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 x (75-30) = $90,000. If an employee's share of the premium for coverage provided by an employer exceeds 9.5% of his or her household income, employers that do offer minimum essential coverage will be assessed a penalty of $3,000 per employee that receives a subsidy through the Exchange. This penalty may not exceed $2,000 times the number of employees beyond the first 30.

I am self-employed. Will the new law impact my health insurance choices?

Yes. Beginning Jan. 1, 2014, self-employed individuals and their families must be included in the small group market in all states and will have the option of purchasing coverage through the Exchange. This will increase plan choices and include the self-employed in a more stable pool.

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.

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

The federal law (PPACA) 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 or discourage these options.

SENIORS

Will my Medicare benefits be cut under the new law?

No, the Patient Protection and Affordable Care Act (PPACA) does not eliminate or reduce benefits provided under Medicare.

I currently have a Medicare Advantage plan. Will I be able to keep it?

Yes. The PPACA does not require individuals to drop their Medicare Advantage coverage. It should be noted, however, that Medicare Advantage plans are not guaranteed renewable. Carriers may pull out of a market at the end of the year, forcing enrollees to change carriers or return to Medicare. The PPACA does cut payments to Medicare Advantage plans, which could result in carriers pulling out of more areas.

My prescription drug costs push me into the "doughnut hole" every year. Will I receive any relief under the new law?

Seniors who reach the gap in prescription drug coverage known as the "doughnut hole" will only pay 50% of the price of covered outpatient brand-name prescription drugs in 2011. Also in 2011, those in the coverage gap will pay 93% of the price for covered generic drugs, and Medicare will pay the remaining 7%. The amount you pay for covered brand-name and generic drugs in the gap will gradually decrease over the next 10 years to 25% by 2020.

This answer has been revised from the NAIC's posted FAQ on its website, using the NAIC Consumer Alert regarding Medicare enrollment dated November 2010, also posted on its website.

When will the new preventive care improvements begin?

Under the PPACA, beneficiaries of Original Medicare will receive preventive services without cost-sharing beginning January 1, 2011. In addition, an annual wellness visit to create a personalized prevention plan will now be provided under Medicare. Currently, Medicare Advantage plans are not required to provide preventive care without cost sharing, but usually offer this as a benefit with no cost sharing. If you are enrolled in a Medicare Advantage plan, be sure to check your preventive care benefits.

This answer has been revised from the NAIC's posted FAQ on its website, using the NAIC Consumer Alert regarding Medicare enrollment dated November 2010, also posted on its website.

I have a Medicare Supplement (Medigap) plan. Must I make any changes to my plan under the new law?

No, the PPACA does not require seniors to change their Medigap coverage. However, the law will be adding cost-sharing requirements to plans C and F that are sold after Jan. 1, 2015.

More Information:

For more information about your Medicare options, the new required coverages under the PPACA or to use Medicare's online Prescription Drug Plan Finder, go to www.medicare.gov.

This information is a reproduction of information from the NAIC Consumer Alert regarding Medicare enrollment dated November 2010, posted on the NAIC's website.