Health Reform Frequently Asked Questions

Please note: We will be adding questions/answers to this document so check back often. You may submit questions at DOI.Info@ky.gov. Any personal information will be removed prior to posting.

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 five 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, a new federal high risk pool program will begin this summer and greater transparency will be required of health care plans in the coming months.

Additional information on implementation is available on the Kentucky Department of Insurance Web site (http://insurance.ky.gov) under Health Reform Information.

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," meeting the mandate to have health insurance beginning January 2014.

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. 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 health 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. Because the individual market coverage does not use plan years, the U.S. Department of Health and Human Services (HHS) will have to clarify when this requirement will become effective for individual plans.

However, some insurers have notified HHS of their intent to implement this change sooner than the law requires. States are waiting for guidance on whether this is will be continuation for those currently on a parent's plan or if it also will apply to those who have dropped off a parent's plan and want to be covered again.

The health reform law does not indicate whether or not an insurer may charge an additional premium for coverage of adult children, which will have to be determined in the near future. 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.

When can I enroll my 10-year-old who has a pre-existing condition?
The health 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 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 health 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, but 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. If not, you will be able to purchase insurance in a matter of minutes on the exchange's Web site.

I have been denied coverage because I have a pre-existing condition. What will this law do for me?
Beginning July 1, 2010, information on coverage will be available (through high risk pools in every state) to individuals with pre-existing conditions who have been uninsured for at least six months. At this time, it is anticipated that the plan will begin offering coverage on Aug. 1. These programs will provide immediate coverage for pre-existing conditions.

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?
Beginning in 2014, 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 the Kentucky Department of Insurance to file a complaint. A complaint form and online submission are available at http://insurance.ky.gov.

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, 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.

I am currently covered under COBRA and have a high-risk condition that makes me ineligible for coverage in the regular health insurance market. Will I be able to obtain coverage through the temporary federal high-risk pool or will I have to go to Kentucky Access?
To be eligible for the temporary federal high-risk pool, a person must be uninsured for six months. If you are unable to obtain coverage in the regular market, you will need to contact Kentucky Access for coverage once your COBRA ends since you do not meet that eligibility requirement.

I am interested in the new federal high-risk pool. Where do I go for information?
The federal government will contract with a third party to run Kentucky’s high-risk pool. When the information on plan design, cost, etc. becomes available on July 1, 2010, it is anticipated that the Department of Health and Human Services (HHS) Web portal will be the source of this information. This FAQ will be updated when more details become available.

I am currently a member of Kentucky Access and am considering dropping out and going uninsured for six months so I can get the cheaper coverage in the federal high-risk pool. Will the benefits be comparable and will I be eligible?
We would never advise anyone, particularly those with a high-cost condition, to go uninsured. At this point, we have not seen the new pool’s plan design but all indications are that the benefits will be substantially less than those offered by Kentucky Access. In addition, we do not know if eligibility requirements would allow someone who has been insured but dropped coverage for that specific reason to be accepted into the new pool. You also would need to consider the consequences of going uninsured in light of possible capping of enrollment in the new pool.

It is worth noting that premiums from Kentucky Access members pay for only 48 percent of the actual cost of the plan's expenditures. Once more information is available on the new high-risk pool, you will want to discuss these issues with someone from HHS.

Are there plans to lower the cost of Kentucky Access premiums once the new pool begins offering coverage?
No.

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 percent 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 percent of the employer's contributions (25 percent for nonprofit employers). Beginning tax year 2014, the maximum credit is 50 percent of the employer's contribution (35 percent for nonprofit employers). The full 35 percent tax credit (50 percent 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 five employees. Will I be required to provide insurance for my employees?
No. The employer responsibilities under the health 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. Beginning in 2014, an employer that fails to offer minimum essential coverage to its employees will be subject to a penalty of $2,000 for each of the 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 percent 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," meeting the mandate to have health insurance beginning 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. In addition, those under 65 and on Medicare will not lose any benefits. Coverage will remain the same and some in this group also will receive additional benefits included under Part B.

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 receive a $250 rebate in 2010. Beginning in 2011, those in the "doughnut hole" will receive a 50 percent discount on prescription drugs and the gap will be phased out until it is eliminated in 2020.

When will the new preventive care improvements begin?
Under the PPACA, all Medicare beneficiaries will receive preventive services without cost-sharing beginning Jan. 1, 2011. In addition, an annual wellness visit to create a personalized prevention plan will now be provided under Medicare.

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.

Agents

I am an insurance agent. Will I be able to sell and collect commissions on policies in the exchange and high risk pool?
We do not know at this time exactly how agents will operate under the exchange or high-risk pool. Although no one will be required to purchase insurance through the exchange, subsidies will be available only for plans sold to individuals through the exchange. The degree of agent involvement, if any, in the temporary high-risk pool has not been decided at this time.