Healthcare Reform FAQ

The following information is generously provided by Kaiser Health News (KHN)

Now that President Barack Obama has won a second term, the Affordable Care Act is back on a fast track. The law will have sweeping ramifications for consumers, state officials, employers and health care providers, including hospitals and doctors.

While some of the key features don't kick in until 2014, the law has already altered the health care industry and established a number of consumer benefits.

Here's a primer on parts of the law already up and running, what's to come and ways that provisions could still be altered.

I don't have health insurance. Under the law, will I have to buy it and what happens if I don't?

Today, you are not required to have health insurance. But beginning in 2014, most people will have to have it or pay a fine. For individuals, the penalty would start at $95 a year, or up to 1 percent of income, whichever is greater, and rise to $695, or 2.5 percent of income, by 2016.

For families the penalty would be $2,085 or 2.5 percent of household income, whichever is greater. The requirement to have coverage can be waived for several reasons, including financial hardship or religious beliefs.

Millions of additional people will qualify for Medicaid or federal subsidies to buy insurance under the law.

While some states, including most recently Alabama, Wyoming and Montana, have passed laws to block the requirement to carry health insurance, those provisions do not override federal law.

I get my health coverage at work and want to keep my current plan. Will I be able to do that? How will my plan be affected by the health law?

If you get insurance through your job, it is likely to stay that way. But, just as before the law was passed, your employer is not obligated to keep the current plan and may change premiums, deductibles, co-pays and network coverage.

You may have seen some law-related changes already. For example, most plans now ban lifetime coverage limits and include a guarantee that an adult child up to age 26 who can't get health insurance at a job can stay on her parents' health plan.

What other parts of the law are now in place?

You are likely to be eligible for preventive services with no out-of-pocket costs, such as breast cancer screenings and cholesterol tests.

Health plans can't cancel your coverage once you get sick – a practice known as "rescission" – unless you committed fraud when you applied for coverage.

Children with pre-existing conditions cannot be denied coverage. This will apply to adults in 2014.

Insurers will have to provide rebates to consumers if they spend less than 80 to 85 percent of premium dollars on medical care.

Some existing plans, if they haven't changed significantly since passage of the law, do not have to abide by certain parts of the law. For example, these "grandfathered" plans can still charge beneficiaries part of the cost of preventive services.

If you're currently in one of these plans, and your employer makes significant changes, such as raising your out-of-pocket costs, the plan would then have to abide by all aspects of the health law.

I want health insurance but I can't afford it. What will I do?

Depending on your income, you might be eligible for Medicaid. Currently, in most states nonelderly adults without minor children don't qualify for Medicaid. But beginning in 2014, the federal government is offering to pay the cost of an expansion in the programs so that anyone with an income at or lower than 133 percent of the federal poverty level, (which based on current guidelines would be $14,856 for an individual or $30,656 for a family of four) will be eligible for Medicaid.

The Supreme Court, however, ruled in June that states cannot be forced to make that change. Republican governors in several states have said that they will refuse the expansion, though that may change now that Obama has been re-elected.

What if I make too much money for Medicaid but still can't afford to buy insurance?

You might be eligible for government subsidies to help you pay for private insurance sold in the state-based insurance marketplaces, called exchanges, slated to begin operation in 2014. Exchanges will sell insurance plans to individuals and small businesses.

These premium subsidies will be available for individuals and families with incomes between 133 percent and 400 percent of the poverty level, or $14,856 to $44,680 for individuals and $30,656 to $92,200 for a family of four (based on current guidelines).

Will it be easier for me to get coverage even if I have health problems?

Insurers will be barred from rejecting applicants based on health status once the exchanges are operating in 2014.

I own a small business. Will I have to buy health insurance for my workers?

No employer is required to provide insurance. But starting in 2014, businesses with 50 or more employees that don't provide health care coverage and have at least one full-time worker who receives subsidized coverage in the health insurance exchange will have to pay a fee of $2,000 per full-time employee. The firm's first 30 workers would be excluded from the fee.

However, firms with 50 or fewer people won't face any penalties.

In addition, if you own a small business, the health law offers a tax credit to help cover the cost. Employers with 25 or fewer full-time workers who earn an average yearly salary of $50,000 or less today can get tax credits of up 35 percent of the cost of premiums. The credit increases to 50 percent in 2014.

I'm over 65. How does the legislation affect seniors?

The law is narrowing a gap in the Medicare Part D prescription drug plan known as the "doughnut hole." That's when seniors who have paid a certain initial amount in prescription costs have to pay for all of their drug costs until they spend a total of $4,700 for the year. Then the plan coverage begins again.

That coverage gap will be closed entirely by 2020. Seniors will still be responsible for 25 percent of their prescription drug costs. So far, 5.6 million seniors have saved $4.8 billion on prescription drugs, according to the Department of Health and Human Services.

The law also expanded Medicare's coverage of preventive services, such as screenings for colon, prostate and breast cancer, which are now free to beneficiaries. Medicare will also pay for an annual wellness visit to the doctor. HHS reports that during the first nine months of 2012, more than 20.7 million Medicare beneficiaries have received preventive services at no cost.

The health law reduced the federal government's payments to Medicare Advantage plans, run by private insurers as an alternative to the traditional Medicare. Medicare Advantage costs more per beneficiary than traditional Medicare. Critics of those payment cuts say that could mean the private plans may not offer many extra benefits, such as free eyeglasses, hearing aids and gym memberships, that they now provide.

Will I have to pay more for my health care because of the law?

No one knows for sure. Even supporters of the law acknowledge its steps to control health costs, such as incentives to coordinate care better, may take a while to show significant savings. Opponents say the law's additional coverage requirements will make health insurance more expensive for individuals and for the government.

That said, there are some new taxes and fees. For example, starting in 2013, individuals with earnings above $200,000 and married couples making more than $250,000 will pay a Medicare payroll tax of 2.35 percent, up from the current 1.45 percent, on income over those thresholds. In addition, higher-income people will face a 3.8 percent tax on unearned income, such as dividends and interest.

Starting in 2018, the law also will impose a 40 percent excise tax on the portion of most employer-sponsored health coverage (excluding dental and vision) that exceeds $10,200 a year and $27,500 for families. The tax has been dubbed a "Cadillac" tax because it hits the most generous plans.

In addition, the law also imposes taxes and fees on several major health industries. Beginning in 2013, medical device manufacturers and importers must pay a 2.3 percent

tax on the sale of any taxable medical device to raise $29 billion over 10 years. An annual fee for health insurers is expected to raise more than $100 billion over 10 years, while a fee for brand name drugs will bring in another $34 billion.

Those fees will likely be passed onto consumers in the form of higher premiums.

Has the law hit some bumps in the road?

Yes. For example, the law created high-risk insurance pools to help people purchase health insurance. But enrollment in the pools has been less than expected. As of Aug. 31, 86,072 people had signed up for the high-risk pools, but the program, which began in June 2010, was initially expected to enroll between 200,000 and 400,000 people. The cost and the requirements have been difficult for some to meet.

Applicants must be uninsured for six months because of a pre-existing medical condition before they can join a pool. And because participants are sicker than the general population, the premiums are higher.

Enrollment has increased since the summer, after the premiums were lowered in some states by as much as 40 percent and some states stepped up advertising.

A long-term care provision of the law is dead for now. The Community Living Assistance Services and Supports program (CLASS Act) was designed for people to buy federally guaranteed insurance that would have helped consumers eventually cover some long-term-care costs. But last fall, federal officials effectively suspended the program even before it was to begin, saying they could not find a way to make it work financially.

Are there more changes ahead for the law?

Some observers think there could be pressure in Congress to make some changes to the law as a larger package to reduce the deficit. Among those options is scaling back the subsidies that help low-income Americans buy health insurance coverage. The amount of the subsidies, and possibly the Medicaid expansion as well, could be reduced.

It's also possible that some of the taxes on the health care industry, which help pay for the new benefits in the health law, could be rolled back. For example, legislation to repeal the tax on medical device manufacturers passed the House with support from 37 Democrats (it is not expected to receive Senate consideration this year). Nine House Democrats are co-sponsoring legislation to repeal the law's annual fee on health insurers.

Meanwhile, the Independent Payment Advisory Board (IPAB), one of the most contentious provisions of the health law, is also under continued attack by lawmakers. IPAB is a 15-member panel charged with making recommendations to reduce Medicare

spending if the amount the government spends grows beyond a target rate. If Congress chooses not to accept the recommendations, lawmakers must pass alternative cuts of the same size.

Some Republicans argue that the board amounts to health care rationing and some Democrats have said that they think the panel would transfer power that belongs on Capitol Hill to the executive branch. In March, the House voted to repeal IPAB.