

Frequently Asked Questions: Health Care Reform

Congress passed the Patient Protection and Affordable Care Act (PPACA) on March 23, 2010. Provisions in the new law become effective at varying dates over the next several years, through 2020. The following is a very brief summary of some key provisions, but many details remain uncertain until *U.S. Department of Health and Human Services* (HHS) adopts various federal regulations in the coming months. We will update this FAQ as new information becomes available.

Q1: Will I be required to give up my current coverage?

A: No. Health plans in effect as of 3/23/10, will be grandfathered under the law and considered “qualified coverage” that meets the individual mandate to have health insurance coverage as of 1/1/14.

Q2: How do I apply for the federal high-risk health insurance pool?

A: Arizona residents can now apply for the federal high-risk health insurance pool, also called the Pre-Existing Condition Insurance Plan (PCIP) at www.healthcare.gov. To be eligible, applicants must meet the federal criteria specified on the website.

Q3: When can I enroll my child who has a pre-existing condition on my health insurance policy?

A: The law prohibits insurers from excluding coverage of children’s pre-existing conditions for plan years beginning after 9/23/10, requiring insurers to provide coverage without pre-existing condition exclusions to children if they cover the parents. HHS will soon provide more detailed guidance.

Q4: When can my “adult child” be added to my policy?

A: 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, unless your adult child has an offer of coverage through his or her employer.* Both married and unmarried dependents qualify for this dependent coverage. This requirement becomes effective for “plan years” beginning 9/23/10, 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, HHS will have to clarify when this requirement will become effective for individual plans.

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

Q5: When will the law prohibit cost-sharing for preventive care?

A: Beginning 9/23/10, group and individual plans that became effective after 3/23/10, must, upon renewal, eliminate deductibles and copayments for designated vaccination and preventive services. Medicare beneficiaries will also no longer have to pay for some preventive services.

Q6: When will the law restrict lifetime and/or annual limits on insurance policies?

A: Beginning 9/23/10, the law will prohibit all new and existing individual and group plans from placing *lifetime limits* on what they will pay for your medical care. Beginning January 2014, there will also be restrictions on *annual limits* in new and existing group health plans.

Q7: Can my health care plan drop or rescind my coverage?

A: Beginning 9/23/10, insurance companies can not rescind your insurance coverage unless you commit fraud or make an intentional misrepresentation of a material fact.

Q8: What are the “exchanges” and will I have to buy insurance from them?

A: Exchanges are the mechanisms to help individuals and small businesses to comparison shop and purchase health insurance coverage. Beginning in 2014, each State will establish an Exchange to help individuals and small businesses compare and purchase health insurance. Nobody will be required to purchase health insurance through the Exchange, although 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.

Q9: What is the reinsurance program for early retirees that is available to employers?

A: Effective 90 days after enactment, the new law creates a reinsurance program to provide financial assistance *to employers* who provide health insurance coverage to retirees from age 55 to 65 that are not otherwise eligible for Medicare. Employers must apply to HHS to participate in the program.

Q10: When does the federal law require that I buy insurance and what happens if I don't?

A: Effective January 1, 2014, the law requires all U.S. citizens and legal residents to obtain qualifying coverage. Those who do not obtain coverage will pay a tax penalty.

MEDICARE BENEFICIARIES

Q1: Will the new law reduce my Medicare benefits?

A: No, the new federal law does not eliminate or reduce benefits provided under Medicare.

Q2: Will the healthcare reform help cover my Medicare prescription drug costs that are not covered in the Medicare Part D "donut hole"?

A: Medicare beneficiaries who reach the gap in prescription drug coverage known as the “donut hole” will receive a \$250 rebate in 2010. Beginning in 2011, those in the “donut hole” will receive a 50% discount on prescription drugs; thereafter, phasing out the gap until elimination in 2020.

Q3: I currently have a Medicare Advantage plan. Will I be able to keep it?

Yes. The federal law does not require individuals to drop their Medicare Advantage coverage; however, Medicare Advantage plans are not guaranteed renewable. Carriers may choose not to offer

a Medicare Advantage Plan at the end of the year, at which time enrollees can change insurers or return to original Medicare.

Q4: When will the law prohibit cost sharing on preventive care?

All Medicare beneficiaries will receive preventive services without cost-sharing (co-pays and deductibles) beginning 1/1//2011. In addition, Medicare will now provide an annual wellness visit to create a personalized prevention plan.

Q5: I have a Medicare Supplement (Medigap) plan. Must I make any changes to my plan under the new law?

No, the law does not require Medicare beneficiaries to change their Medigap coverage.