



Top 10 questions about health care reform

1. When can I cover my young adult child on my plan?

The federal health care reform law allows children to stay on their parent's or guardian's health plan until their 26th birthday. In some states, dependents can stay on the plan even longer. To be eligible for this coverage, children do not need to be financially dependent on you for support, claimed as dependents on your tax return, residents of your household, enrolled as students or unmarried. However, if you have a grandfathered group health plan and your child has access to group coverage elsewhere, your employer's plan doesn't have to cover your child.

If you have children who are newly eligible for coverage because of this change, you can add them to your plan during the next open enrollment after September 23, 2010, (for group plans) or during a 30-day special enrollment period (for individual plans and some group plans). If you have coverage at work, check with your employer for details about eligible dependents and enrollment periods. If you have individual coverage, call the customer service number on your member ID card for details.

2. What does "grandfathered" mean?

This word describes a health plan that was in effect on March 23, 2010, and hasn't had certain changes since then. The health care reform law has special rules for grandfathered plans. For example, they're not required to make some of the changes mandated in the law. In general, buying a new plan or making a change that reduces your benefits— for example, raising your deductible or lowering the percentage your plan pays — would cause a loss of grandfathered status.

3. Does the law require health plans to cover my child?

Yes and no. Here's the deal: The health care reform law that passed in March 2010 said health plans couldn't have "pre-existing condition limitations" for kids under 19. But it didn't spell out exactly what that meant. Did it mean that all children should be eligible for coverage even if they're sick — also known as "guaranteed issue"? Or did it mean that plans can't exclude certain conditions from a child's coverage? In June 2010, the government chose option No. 1: All children are eligible for coverage. However, health plans may limit guaranteed issue for kids to certain periods. For example, the state of California passed a law that created an enrollment period in January and February 2011. After that, kids in California will be guaranteed issue only during their birth month. And other rules may still apply, such as a requirement to apply for coverage with a parent.

4. What are my options if I lose the health coverage I get at work?

From now until the end of 2013, if you're under the age of 65 you'll have these options:

- COBRA or state continuation coverage — These arrangements allow you to stay on the same plan you had with your employer. But you pay the entire premium, so your monthly premium will increase.
- Individual coverage — You and other individuals like you are grouped together to help share the risk, much like a group health plan. Usually, you have to qualify for individual plans by meeting certain enrollment guidelines and/or health criteria.
- High risk pool — States must offer high risk pools for people who aren't able to get health coverage because of pre-existing conditions.
- Medicaid — Medicaid provides health coverage for low-income people.

Starting in 2014, some of these options will change. The high-risk pools will go away. Individual coverage will be guaranteed-issue (meaning you can't be turned down just because of your health) and will be sold through insurance exchanges. Also, more people will be eligible for Medicaid.



5. How will the health insurance exchanges work?

Beginning in 2014, these state-run programs will allow individuals and small employers to comparison-shop for health insurance online. Plans in the exchange will have standard levels of benefits – for example, a “gold” plan will have certain features and a “silver” plan will have certain features. Subsidies will be available to low-income people and small businesses that buy insurance through an exchange.

6. Is it true that I won’t be able to use my flexible spending account for allergy medicine anymore?

Not unless you have a prescription. That’s one of a few changes for flexible spending accounts (FSAs), health reimbursement arrangements (HRA) and health savings accounts (HSAs) in the next few years:

- For FSAs, HRAs and HSAs – Starting January 1, 2011, you can use your spending account for an over-the-counter drug only if you have a prescription. You won’t need a prescription to use your account for insulin or for over-the-counter items that aren’t drugs (such as bandages).
- If you have an HSA – Starting January 1, 2011, the penalty for using HSA funds for unapproved expenses went up from 10% to 20%. Plus, the money you spent on unapproved items will be taxed. The rules are different for people 65 and older.
- If you have an FSA – Starting January 1, 2013, you’ll be able to contribute up to \$2,500 a year for medical expenses. In the past, the federal government didn’t set a limit. The limit will be adjusted for the cost of living every year.

7. Is it true that I’ll have to pay taxes on the premiums my employer pays?

No. There’s a lot of confusion about this because the health care reform law requires employers to report the cost of employer-sponsored group health coverage. You’ll start seeing this on the W-2 form you receive at the beginning of 2013. Depending on your employer, you could see it a year earlier. But this is a reporting requirement only. It doesn’t change your taxable earnings.

8. Is it true that I’ll have to get health insurance coverage or pay a penalty?

Yes. Starting in 2014, all Americans (including people from other countries who are in the U.S. legally) will need to have coverage through some type of plan. If they don’t, they’ll pay a tax penalty. The penalty starts out small in 2014, but it will get bigger over time. To avoid the penalty, you’ll need to show on your tax return that you have some type of health coverage – be it an employer’s plan, an exchange plan or something else.

9. Why does the law require people to get coverage?

Starting in 2014, you can’t be turned down for health insurance just because you have health problems. That means people could wait until they’re sick or injured to get coverage. Why pay for something you don’t need, right? But here’s the problem: An insurance plan must have people with low costs to balance out people with high costs. If things get out of balance, the plan premiums won’t be enough to cover everyone’s claims. That makes premiums go up. When premiums go up, healthy people have even less of a reason to get insurance. That makes the balance shift even more. See the cycle? The so-called “individual mandate” helps to prevent this cycle, which helps to keep coverage affordable for everyone.

10. Is anything changing for retirees?

Yes. The health care reform law gradually closes the Medicare Part D prescription drug “coverage gap” starting in 2011. It also makes preventive care services free for people with Medicare starting in 2011. And many new programs designed to make health care more efficient and more affordable will be tested with Medicare first. These programs may extend beyond Medicare if they’re successful.