
# Health Care Reform: General Q&A for Individuals

**I've heard a lot about the health care reform law. When did the reforms go into effect?**
The health care reform law, the Affordable Care Act (ACA), was signed into law by President Obama in March 2010. The changes made by the ACA take effect over a period of years. Some of the law's changes are already in effect, such as the individual mandate. Other changes will become effective in the future.

**Are individuals required to have health insurance?**
Most individuals are required to obtain acceptable health insurance coverage for themselves and their family members or pay a penalty. This provision of the health care reform law is often called the "individual mandate" because it requires individuals to have health coverage.

**Who is exempt from the individual mandate?**
Certain individuals are exempt from the individual mandate. For example, you may be exempt from the penalty for not maintaining acceptable health coverage if you:

- Cannot afford coverage (that is, the required contribution for coverage would cost more than 8 percent of your household income)
- Have income below the federal income tax filing threshold
- Are not a citizen, national or lawfully present in the United States

**What are the penalties for individuals who don't have health coverage?**
In 2016, the penalty for not obtaining acceptable health coverage is $695 per person or up to 2.5 percent of income, whichever is higher.

Under the ACA, U.S. citizens must obtain health insurance coverage or they will be subject to penalties, with exceptions for low-income individuals and those unable to obtain affordable coverage.

The penalty for a child is half of that for an adult. The annual penalty is calculated on a monthly basis, and it will be assessed for each month in which an individual goes without coverage. For example, if the flat dollar amount applies and a person goes without coverage for the entire year in 2016, the annual penalty amount will be $695 for that individual. However, if the individual has coverage for part of the year in 2016, the flat dollar amount penalty will be 1/12 of $695 for each month without coverage.

There is no penalty for a single lapse in coverage lasting less than three months in a year.

**Does the law affect health flexible spending accounts (FSAs), health reimbursement arrangements (HRAs) and health savings accounts (HSAs)?**
The costs of over-the-counter medications can be reimbursed under a health FSA, HRA or HSA **only** if the medications are purchased with a doctor's prescription. This restriction does not apply to the purchase of insulin.

In 2016, there is an annual cap of $2,550 on employee pre-tax contributions to health FSAs. (The health care reform law does not change the limit on dependent care accounts, which remains capped at $5,000.) Also, if you are under age 65 and you



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withdraw money from your HSA for a purpose other than a qualified medical expense, you will be subject to an additional excise tax of 20 percent (up from 10 percent).

**How long can my adult child remain covered under my health plan?**
Health plans are required to permit children to stay on family coverage until they turn 26. This rule applies to all plans in the individual market.

**Is the coverage for my adult dependent taxable?**
No, the value of the coverage is not subject to federal tax for yourself or the dependent. The health care reform law revised the Internal Revenue Code to clarify that the cost of coverage for a taxpayer's child is excluded from income through the end of the year in which the child turns 26.

**Can I get coverage for my pre-existing condition?**
Health plans cannot deny benefits or limit coverage for a child under the age of 19 because the child has a pre-existing condition (that is, a health problem that developed before the child applied to join the plan). Health plans cannot impose pre-existing condition exclusions on any enrollees.

**Are my health benefits subject to lifetime or annual limits?**
The health care reform law prohibits health plans from placing lifetime limits on most benefits. A lifetime limit is the dollar amount on what the plan would spend for your covered benefits during the entire time you were enrolled in the plan.

**Can my health plan or insurance company terminate my coverage if I get sick?**
Health plans and insurance companies are prohibited from retroactively dropping, or rescinding, your coverage when you get sick. Also, your coverage cannot be retroactively canceled solely because you made an honest mistake on your insurance application. Rescissions of coverage are allowed only in cases of fraud or material misrepresentation.

**Is my plan required to provide free preventive care?**
All non-grandfathered plans in the individual market must provide coverage for recommended preventive health services. If your plan is subject to this requirement, you should not have to pay a copayment, coinsurance or deductible to receive recommended preventive health services, such as screenings, vaccinations and counseling.

For example, depending on your age, you may have access (at no cost) to preventive services such as:

- Blood pressure, diabetes and cholesterol tests
- Many cancer screenings, including mammograms and colonoscopies
- Regular well-baby and well-child visits, from birth to age 21
- Routine vaccinations against diseases such as measles, polio or meningitis

Non-grandfathered health plans must provide additional preventive services for women without cost sharing, such as coverage for well-woman visits, breastfeeding support and contraception. Exceptions to the contraceptive coverage requirement apply to certain religious employers.

If your plan is grandfathered, these benefits may not be available to you. Also, if your health plan uses a network of providers, these benefits may only be available through a network provider. Your plan may allow you to receive these services from an out-of-network provider but may charge you a fee.

**How does the health care reform law make insurance companies more accountable for how they spend premium dollars?**
Health insurers, including insurers of grandfathered plans, must annually report on what percentage of premium dollars they spend on medical care, as opposed to

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profits, marketing and administrative expenses. You can see that information online and may be entitled to a rebate if your plan spent too much on overhead and profits. Health insurers must also post information about some rate increases along with a justification for them. This information is available at www.healthcare.gov.

**How does the health care reform law help me learn more about my health plan coverage?**
Under the health care reform law, your health insurance company or group health plan is required to provide you with an easy-to-understand summary about benefits and coverage. This requirement is designed to help you better understand and evaluate your health coverage choices. This summary is called a Summary of Benefits and Coverage, or SBC. You may also request a glossary of terms from your health plan or health insurer. The glossary includes definitions for commonly used terms in health insurance coverage, such as "deductible" and "copayment."

**What is the health insurance exchange, or Marketplace?**
The health insurance Marketplace is an online marketplace that was designed to help make buying health coverage easier and more affordable. The Marketplace allows individuals to compare health plans, get answers to questions and find out if they are eligible for tax credits for private insurance or health programs like the Children's Health Insurance Program (CHIP) and enroll in a health plan that meets their needs.

**When will I be able to enroll in a health plan through the Marketplace?**
You can enroll in a health plan during the annual open enrollment period. The open enrollment period for the Marketplace for coverage in 2016 begins on Nov. 1, 2015, and ends Jan. 31, 2016. After open enrollment, you can enroll in a private health plan through an Exchange only if you have a qualifying life event. You can apply for Medicaid and the Children's Health Insurance Program (CHIP) at any time during the year. If you qualify, you can enroll immediately.

Here are some examples of qualifying life events:

- Marriage or divorce
- Having a baby, adopting a child or placing a child for adoption or foster care
- Moving your residence, gaining citizenship or leaving incarceration
- Losing other health coverage due to losing job-based coverage, the end of an individual policy plan year in 2016, COBRA expiration, aging off a parent's plan, losing eligibility for Medicaid or CHIP, and similar circumstances. Important: Voluntarily ending coverage doesn't qualify you for a special enrollment period. Neither does losing coverage that doesn't qualify as minimum essential coverage.
- For people already enrolled in Exchange coverage, having a change in income or household status that affects eligibility for premium tax credits or cost-sharing reductions
- Gaining status as a member of an Indian tribe. Members of federally recognized Indian tribes can sign up for or change plans once per month throughout the year.

If none of the options for getting covered outside open enrollment works for you, your next chance to enroll in health coverage through the Exchange is the next open enrollment period.

**Where can I find out more information about the Marketplace?**
For more information about individual insurance and health care reform contact The Wladis Companies, Inc. today.

**What types of health plans are available through the Marketplace?**
All health plans offered through the Marketplace have limits on cost-sharing and cover a comprehensive package of items and services, which is known as the "essential health benefits" package. In general, the Marketplace offers four levels of

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coverage for consumers. The levels are based on an actuarial value (AV) standard that measures the percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an AV value of 70 percent, a consumer would be responsible for 30 percent of the costs for covered benefits. The Exchange's coverage levels are bronze (AV – 60 percent), silver (AV – 70 percent), gold (AV- 80 percent) and platinum (AV – 90 percent).

**How much will a health plan cost through the Marketplace?**
The premiums for health plans offered on the Marketplace vary by type of plan and location. Different financial assistance programs are linked to the Exchange, such as Medicaid and the Children's Health Insurance Program. Also, some individuals who enroll through the Exchange will be eligible for a new kind of tax credit they can use right away to lower their monthly health plan premiums. The tax credit is sent directly to the insurance company and applied to the premium, so eligible individuals pay less out of their own pockets.

**Who will be eligible for the Marketplace's premium tax credit?**
Eligibility for the tax credit depends on your income and family size and your eligibility for minimum essential coverage (such as coverage under your employer's plan). The amount of the credit also depends on how much income your family expects to earn. To be eligible for the tax credit, you must enroll in a health plan through the Marketplace and you:

- Must have household income for the year between 100 percent and 400 percent of the federal poverty line for your family size
- May not be claimed as a tax dependent of another taxpayer
- Must file a joint return, if married
- Cannot be eligible for minimum essential coverage

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