

<http://healthreform.gov/about/answers.html>

Answers For Families And Small Business

Q: What is the small business tax credit and how do I know if I am eligible?

A: Effective January 1, 2010, tax credits are available to qualifying small businesses that offer health insurance to their employees. So if your business qualifies for a tax credit, you are eligible right now.

About 4 million small businesses will be eligible to receive tax credits if they provide insurance.

The tax credit is worth up to 35 percent of the premiums your business pays to cover its workers – 25 percent for nonprofit firms. In 2014, the value of the credit will increase to 50 percent – 35 percent for nonprofits.

Your business qualifies for the credit if you cover at least 50 percent of the cost of health care coverage for your workers, pay average annual wages below \$50,000, and have less than the equivalent of 25 full-time workers (for example, a firm with fewer than 50 half-time workers would be eligible).

The size of the credit depends on your average wages and the number of employees you have. The full credit is available to firms with average wages below \$25,000 and less than 10 full-time equivalent workers. It phases out gradually for firms with average wages between \$25,000 and \$50,000 and for firms with the equivalent of between 10 and 25 full-time workers. To learn more about the small business tax credit, you can also visit IRS.gov

Q: Am I required to offer insurance to my employees?

A: No. There is not a so-called “employer mandate” in the legislation.

Q: Are there small business tax increases in this new law?

A: No. In fact, small businesses get tax breaks for health insurance rather than tax increases under the law.

Q: What if my small business doesn't offer insurance today, but I choose to start offering insurance this year. Will I be eligible for these tax credits?

A: Yes. The tax credit is designed to both support those small businesses that provide coverage today as well as those that newly offer such coverage.

Q: Can I join a pool now to lower my costs?

A: Beginning in 2014, reform will create state-based health insurance exchanges that pool small businesses and their employees, which will spark competition and give you the kind of purchasing power that big businesses enjoy today. The exchange will offer the same types of private insurance choices that the President and Members of Congress will have. Increased purchasing power and competition will make premiums more affordable. The exchange will also reduce administrative costs for your businesses and your employees, enabling them to easily and simply compare the prices, benefits, and quality of health plans.

PARENTS

Q: How do I get my 21 year old onto my plan?

A: Six months from now, insurers will be required to permit children to stay on family policies until age 26. This applies to all plans in the individual market, new employer plans, and existing employer plans, unless your adult child has an offer of coverage through his or her employer. This requirement will take effect the next time your plan comes up for renewal. Adult children who are on their parents' plan now but who lose that coverage when they graduate from college will have the option of rejoining their parents' policy in the new plan year beginning 6 months from now. Those whose parents work at self-insured companies will also be eligible if they do not have an offer of employer-sponsored insurance.

Both married and unmarried dependents qualify for this dependent coverage.

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

Q: Can I now get coverage for my 6-year-old who has a pre-existing condition?

A: Yes. Effective 6 months from now it will be illegal for health insurance companies that cover children to deny coverage to your child based on a pre-existing condition. This applies to all new employer plans, new plans in the individual market, and existing employer plans.

[Back to Top](#)

CONSUMERS

Q: What consumer protections will I get this year if I get insurance at work?

A: In 6 months, insurers will be prohibited from placing lifetime limits on what they will pay for your medical care and they can only apply restricted annual benefit limits. Insurers will no longer be able to arbitrarily cancel your insurance policy when you get sick, except in cases of fraud.

Insurance companies will be prohibited from denying coverage to children with pre-existing conditions. This applies to all new and existing employer plans.

In 6 months, all new group health plans must provide coverage for preventive services. Recommended prevention and vaccination services will be covered without any deductibles or copayments. Plans must also have a straightforward and independent appeals process so you can appeal decisions by your health insurance plan.

Beginning on January 1, 2011, insurance companies will be required to spend most of your premium dollars on your care, not on profits and overhead—85% in the large group market and 80% in the small group and individual market - and rebate any excessive overhead to enrollees.

Similarly, starting in plan year 2011, insurance companies that jack up rates will have to disclose requested premium increases publicly. If that rate increase is found to be unreasonable, the insurer may be prohibited competing for your business in the new state-based exchange that will begin operating in 2014.

Q: What consumer protections will I get this year if I buy coverage in the individual market?

A: In 6 months, insurers will be prohibited from placing lifetime limits on what they will pay for your medical care, and they can only apply restricted annual benefit limits. Insurers will no longer be able to arbitrarily cancel your insurance policy when you get sick, except in cases of fraud.

Insurance companies will be prohibited from denying coverage to children with pre-existing conditions. This applies to all new plans in the individual market.

In 6 months, all new individual market health plans must provide coverage for preventive services. Recommended prevention and vaccination services will be covered without any deductibles or copayments. They must also have a straightforward and independent appeals process so you can appeal decisions by your health insurance plan.

Beginning on January 1, 2011, insurance companies will be required to spend most of your premium dollars on your care, not on profits and overhead—75% in the individual market – and rebate any excessive overhead to enrollees.

Similarly, starting in plan year 2011, companies that sell insurance in the individual market that jack up rates will have to disclose requested premium increases publicly. If that rate increase is found to be unreasonable, the insurer may be prohibited competing for your business in the new state-based exchange that will begin operating in 2014.

Q: I have a pre-existing condition. How can I get coverage this year?

A: This year, if you have been uninsured for 6 months and have a pre-existing condition, you will gain access to health insurance that was not previously available to you. ..

A new program – known as a high-risk pool – will provide affordable insurance for Americans who are uninsured and have a pre-existing condition. This program will provide temporary protection for people with pre-existing conditions until 2014, when insurance companies can no longer deny you coverage based on your health.

Q: My insurance company wants to raise my rates. What recourse do I have?

A: For most consumers today, it is hard to figure out how to challenge a rate increase. The new health insurance reform law will create a clear pathway for consumers to hold insurance companies accountable.

In 6 months, all new health plans will be required to have implemented a clear and effective process under which policy holders can appeal coverage determinations and claims. States must also have an external appeals process to ensure a fair and objective review of coverage disputes.

Additionally, millions of dollars in grants will be made available this year to states to help create a health insurance consumer assistance office where consumers can learn how to enroll in a plan or file a complaint. There will also be a new website that will begin operating this year, which will help consumers identify and compare health coverage options. Information will be presented in a standardized, easy-to-understand format to ensure that individuals and families understand their options and purchase the right coverage for their needs.

Finally, new standards for the amount an insurance company must pay out in benefits as opposed to profits and administrative expenses will go into effect in 2011. Insurance companies will be required to give money back to consumers if they do not meet those standards. In addition, requested premium increases will be made publicly available, and in 2014, plans that have arbitrarily raised rates previously may not be able to participate in the new health insurance exchanges.

Q: My insurance company just withdrew my coverage, claiming I had a previous illness. Can I fight back?

A: Effective six months from now, insurance companies will be prohibited from dropping your coverage when you get sick. This will apply to all new and existing insurance plans.

Q: When does free preventive care start and will it affect my plan?

A: In 6 months, all new group health plans and new plans in the individual market must provide coverage for preventive services. Recommended prevention and vaccination services will be covered without any deductibles or copayments. Seniors enrolled in Medicare will also no longer have to pay for proven preventive services.

Q: What information about insurance companies is going to be posted on the web?

A: Consumers will immediately have more opportunities to take control of their health insurance choices. Effective July 1, 2010, a website will provide information to help consumers choose the plan that is best for them. The Secretary of HHS will establish an Internet website through which residents of any State may identify affordable health insurance coverage options in that State. The website will include information on coverage options for small businesses as well.

Effective January 1, 2011, health plans, including existing plans, must annually report on what percentage of premium dollars they spend on medical care, as opposed to profits, marketing, and administrative expenses. You will be able to 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 unreasonable rate increases along with a justification for them.

[Back to Top](#)

SENIORS

Q: My prescription drug spending will push me into the donut hole this year. What relief will I get?

A: Seniors who hit the gap in Medicare prescription drug coverage known as the donut hole will be provided with a \$250 rebate in 2010.

Beginning in 2011, seniors in the donut hole will receive a 50 percent discount on prescription drugs. In addition, the Medicare share of costs will increase so that the donut hole will be completely closed in 2020.

Q: When does my free preventive care start and what does it cover?

A: Effective January 1, 2011, proven preventive services will be free. In addition, a new annual wellness visit that provides a personalized prevention plan services, including a health risk assessment, will be provided under Medicare.

Q: Can you define the doughnut hole?

A: Medicare Part D provides prescription drug benefits to Americans on Medicare. This benefit comes with a \$310 deductible. After you've spent \$310, you pay 25 percent of the cost of your prescriptions until the total cost of all the medicine you have received in a year hits \$2,830. Then, you are stuck with 100 percent of the bill until the total cost of your medicines hits \$6,440. The gap when Medicare does not cover the cost of your prescription drugs is known as the doughnut hole.

Health reform will close the donut hole. Reform also offers immediate relief by providing a \$250 rebate this year to seniors who hit the doughnut hole.

Q: How will the \$250 benefit toward coverage gap cost be received by beneficiaries? What's the Eligibility?

A: Once you have hit the prescription drug doughnut hole, you will be eligible for a \$250 rebate. That check will be sent directly to you from Medicare. There's no application process and no private company will be involved in getting your rebate check to you.

Q: I'm covered by a Medicare HMO which served my health very well. Will I be able to maintain the same coverage I have after health insurance reform is implemented?

A: Unfortunately there has been a lot of misinformation about Medicare Advantage plans. Seniors have a choice when they turn 65 and beyond, enroll in the traditional Medicare plan or enroll in a Medicare HMO or Medicare Advantage Plan. Medicare Advantage plans will continue to offer services to beneficiaries. Companies right now choose whether to offer Medicare Advantage plans. Some may make the business decision to exit the market, but nothing in health reform forces these plans to stop offering benefits and services.

Q: I cannot get Medicare until I am 62. I do not have health coverage. I cannot get health coverage because I have a pre-existing condition. Do I get a piece of this new health care plan?

A: Absolutely. Beginning this year, you will be eligible to receive coverage through the new high-risk pools. Today, too many insurance companies reject Americans with pre-existing conditions or charge exorbitant rates. High-risk pools will offer these individuals access to affordable insurance and in 2014 there will be a new market that will prevent insurance companies from eliminating anyone with preexisting conditions. We will have more details regarding the high-risk pools in the weeks ahead. You can read about the first step we have taken here:

<http://www.hhs.gov/news/press/2010pres/04/20100402b.html>

Q: Leonard from CA asks: How will the new health care law affect those of us who are under age 65 but still disabled and on Medicare? Is there anything that is different for us than those on Medicare due to age? For people who are disabled, how does the new law impact them?

A: If you're on Medicare, nothing will change for you. You will continue to receive your Medicare benefits and reform makes Medicare stronger. Today, Medicare beneficiaries must pay 20 percent of the cost of many preventive services and office visits. Reform eliminates deductibles, copayments, and other cost-sharing for recommended preventive care, and provides free annual wellness check-ups starting in 2011. Reform will also improve the quality of care you receive, fight Medicare fraud and extend the financial health of Medicare by 9 years.

[Back to Top](#)