Questions and Answers on Health Reform

This "Q&A" is designed to answer basic questions on the 2010 landmark federal health care law, called the Affordable Care Act (ACA). (We've also discussed a few relevant state laws that address similar topics.)

This Q&A is not a full description of the law; it supplements two PowerPoint presentations produced by Health Care for All New York (HCFANY): one aimed at general audiences and one aimed at advocates who need greater detail. Both presentations can be found here:

Insurance Reforms/People With Employer-Sponsored Insurance

(Also see question 21 for a discussion of the restrictions in the ACA on "lifetime limits" and "annual limits.")

Q1. My 8 year old son was treated for cancer last year. He's fine now, but I've had trouble getting him covered before. Does the new law help me?

A. Yes it does. It is now against the law for health insurance companies that cover children to deny them coverage based on a previous illness or disease, known as a "pre-existing condition." This protection applies to all new plans for employers and individuals as well as existing plans.

Q2. I'm an adult, and I was treated for cancer several years ago. How can I get coverage this year?

A. Adults will not be protected by the pre-existing protections in the new law until 2014. As of that year, insurers will no longer be able to deny you coverage based on a previous illness or disease. However, a new program has been established under the ACA to address the needs of people with pre-existing conditions until 2014. This program, called the NY Bridge Plan, will provide low-cost insurance for those who are uninsured. To qualify for this special program, commonly called a "high-risk pool," the federal law requires that any enrollee: 1) be a citizen or lawful immigrant, 2) have a pre-existing condition, and 3) not have had coverage for the previous 6 months before applying for coverage. (The NY Bridge plan uses the same immigration status rules as New York's Medicaid program.) To find out more information about the NY Bridge Plan or to apply, visit: http://www.ghi.com/nybridgeplan/index.html.

Q3. My employer offers its employees coverage, but my share of the premiums is taking a huge bite out of our family budget. Can I get alternative coverage under the new law?

A. Starting in 2014, employees who pay more than 9.5% of their income on their share of their employer-provided health insurance coverage will be eligible to buy health insurance through the new exchanges created by the new law. And these employees may be eligible for subsidies to purchase insurance, if they meet the income and other guidelines for subsidies (see question 14).

Q4. My employer offers its employees coverage. I heard something about a tax that will be charged on my health insurance premiums. Is that true?

A. Starting in 2018, an "excise tax" will be imposed under the new law on insurers of employer-sponsored health plans that cost more than $10,200 for individuals and $27,500 for family coverage. The tax applies to self-insured and group plans, but generally not to individual plans. The tax is 40% of the premium amounts above the $10,200 and $27,500 thresholds. Beginning in 2020, these amounts will be adjusted upwards for inflation.

Employers will also report the value of employer-provided coverage on employee W-2s starting with employees' 2011 earnings (i.e. the form furnished to most employees in January of 2012); this requirement is optional, at least in 2012. The value of the employer-provided coverage will be disclosed to employees, but it will not increase their taxable income.

Q5. I am currently ensured, but I'm worried about high expenses for co-pays and deductibles. Does the law help me in any way?

A. Yes. The ACA prohibits health insurers that provide group and individual health insurance coverage (other than so called "grandfathered plans") from charging for certain preventative services, including most immunizations for routine use in children, adolescents and adults as well as health screenings. Also see questions 31 and 32 for how this law affects women's health services, including contraception. The law also places monetary limits on co-payments and deductibles (see question 15 for details).

Small Businesses and Non-Profits

Q6. I own a small business with only 5 employees in Buffalo, New York. I'd like to provide my employees with health insurance but I simply can't afford it. Am I obligated to provide my employees with health insurance?

A. Small businesses are not required to provide insurance. However, we encourage you to take this step. It's the right thing to do and will help you to retain your employees. And, if you do choose to provide health insurance,

you'll become eligible for the small business tax credit that's described in question 7. Your business is one of roughly 4 million businesses nationally that will be eligible for this credit.

Q7. What is this small business tax credit that I've heard about and how do I know if my business is eligible?

A. Tax credits are now available to small businesses that offer health insurance to their employees, provided that the business covers at least 50% of the cost of health insurance for its workers, pays average annual wages below $50,000, and has less than the equivalent of 25 full-time workers. If your business qualifies for the tax credit, you can apply right now. The tax credit is up to 35% of the amount your business pays to cover its workers. The full credit of 35% is for employers with 10 or fewer employees and average annual wages of less than $25,000. The credit gets lower as firm size and average wages get higher than these figures.

In 2014, the maximum value of the credit will increase to 50%. Here too, the maximum credit applies to businesses with 10 or fewer employees and wages of less than $25,000 and phases out as firm size and average wages increase.

The tax credit may be claimed for a total of 6 years, and starting in 2014, businesses may only claim it for 2 years.

If you represent a non-profit organization, somewhat different rules apply: see question 10.

Q8. My business has part-time workers. Are we eligible for the small business tax credit?

A. As we previously stated, you small business qualifies for the tax credit if you cover at least 50% of the cost of health insurance for your workers, pay average annual wages below $50,000, and have less than the equivalent of 25 full-time workers. Part time workers are pro-rated for purposes of determining eligibility for the credit. For example, a firm with fewer than 50 half-time workers is eligible.

Q9. My small business doesn't offer insurance today, but I want to start offering it. Does the law help me?

A. Yes. Both small businesses that already provide coverage as well as those that newly offer such coverage are eligible for the tax credit.

Q10. I run a non-profit organization. Does the law help us in any way?

A. Yes, credits are available for non-profits who want to provide health insurance to their employees too, but the subsidies are at different levels than for small businesses. Non-profits meeting the general eligibility requirements

(see questions 7 and 8) are eligible for tax credits of up to 25% of their contributions to their employees' health insurance and beginning in 2014, up to 35%. The credit will be in the form of a reduction in the income and Medicare taxes withheld from employee wages and the employer share of the Medicare tax on employee wages.

Large Employers

Q11. I work for a business with just over 100 employees that doesn't provide health insurance. What are my alternatives to obtain coverage?

Unfortunately, your employer is not required by the law to provide coverage to its employees. Your major options are Family Health Plus and Child Health Plus (two New York State programs), Medicaid (if you qualify based on your income), and (beginning in 2014) buying health insurance individually or through your family through the new health insurance exchange. If your income is less than 400% of the Federal Poverty Level (FPL), you will also qualify for the premium credits provided under the new law. (Premium credits are discussed in question 14.)

While your employer is not *required* to offer coverage, there is an incentive for your employer to take this step. Starting in 2014, any employer who has at least one employee who receives a premium credit through an exchange will have to pay a penalty of $2000 per employee per year for every employee they have over 30. (For example, if they have 130 employees, the penalty will be 100 times $2000, or $200,000.)

Exchanges

Q12. Who will run the exchange in New York once it is established, and how will it operate?

Some of the structure and operation of the new exchanges is mandated in the new law, and other issues will have to be determined by each state. The ACA states, for example, that businesses of up to 100 employees will be able to buy coverage through exchanges. In order to sell insurance through an exchange, health insurers will have to meet certain federal standards to make sure the plans offered through exchanges are adequate. For example, all plans must have certain essential benefits, including coverage of doctor's visits, hospitalizations, maternity care, mental health prescription drugs and rehabilitation services. (HHS has not determined yet the full list of benefits that will be required.) Exchanges will have to maintain a customer call center and web page to help consumers figure out what to buy, and insurers will be subject to certain rules on how to conduct business; for example, marketing rules will govern claims made by insurers about their insurance products offered for sale through the exchange.

The ACA requires that each state exchange include a Small Business Health Options Program (SHOP) to provide health insurance for businesses up to 100 employees or create a separate SHOP exchange. State exchanges can be administered by a government agency or non-profit organization. States can also form regional exchanges or even allow more than one exchange to operate in the state, as long as each serves a distinct geographic area.

The new federal law also gives leaves a number of decisions about the structure of the exchanges to the states. As of November of 2011, New York State has not passed legislation to establish an exchange or to define its functions, so we don't know yet what functions our state exchange will perform beyond those that are mandated by the ACA (like providing a call center). It's not 100% certain that New York State will operate an exchange at all. The law provides that the Department of Health and Human Services (HHS) will operate the exchange in any state if it determines in 2013 that the state will not have an exchange in operation by 2014, or will not implement the federal standards. However, most assume New York will decide to operate its own exchange. We hope the state takes this step.

In addition, the law provides an option for states to apply for a federal waiver of the normal requirements for exchanges and other requirements, like tax credits, if it can demonstrate to HHS that its plan will provide coverage as comprehensive and affordable, and to at least a comparable number of residents, as if it implemented the general provisions of the law (for example, providing small business tax credit and premium credits; this apparently gives the state the option of experimenting with, for example, a government run plan.

Exchanges must be in operation in 2014 under the ACA. But it is urgent that the New York State Legislature passes exchange legislation in 2012 to give the state enough time to take the preliminary steps to establish an effective exchange. Given the number of options New York State has and its importance to consumers, health care advocates should carefully monitor the state's implementation of health care reform to make sure the final state plan serves the best interests of consumers.

Requirement of Individuals to Obtain Coverage and Subsidies

Q13. I have heard that people will be required by the ACA to obtain health insurance and you'll face a tax penalty if you don't get insurance. On the other hand, I've also heard that this requirement was thrown out in court. I'm confused: what's the truth?

A. The wording of ACA as passed by the Congress requires all U.S. citizens and legal residents to have coverage starting in 2014; this section of the law is sometimes called the "individual responsibility" or "minimum coverage" provision. While we encourage people to comply with the law in 2014 and to buy health insurance because it's in your interests to protect yourself against

the risk of catastrophic medical bills, in fact, the penalty is much lower than many people believe. This penalty will be phased in, year by year: it will start at the greater of $95 or 1% of your income in 2014, when state exchanges will be established, and rise to the greater of $695 or 2.5% of your income by 2016.

There are some exceptions in the ACA to the requirement to buy health insurance including a waiver for financial hardship. If you can prove you simply can't afford insurance under the standards in the law, you don't have to pay this penalty. Some other exceptions to either the requirement to obtain insurance or to pay a penalty are as follows:

- taxpayers whose income is too low to have to file an income tax return;
- individuals with religious objections;
- immigrants who are undocumented or not "lawfully present";
- incarcerated individuals;
- members of Indian tribes; and
- individuals who were not covered for a period of less than three continuous months during the year.

Opponents of the law have challenged the individual responsibility provision in court, claiming it violates the U.S. Constitution. Some federal courts examining the question have said the mandate is constitutional and others have said it isn't. The U.S. Supreme Court has agreed to hear the case, and will probably answer the question by June of 2012.

Q14. Please explain the subsidies ("premium credits") that are available for people to buy insurance through the new health insurance exchanges.

A. Starting January 1, 2014, individuals and families who purchase health insurance through the new exchanges are eligible for subsidies to buy insurance if their income is between 133% and 400% of the FPL. As of 2011, 133% of the FPL (for all states and the District of Columbia, except Hawaii and Alaska) is roughly $24,645 for a family of 3 and $29,726 for a family of 4; 400% of the FPL is roughly $74,120 for a family of 3 and $89,400 for a family of 4. The amount of your tax credit will depend on your income, with lower income people receiving a larger credit. The subsidy will be limited to the following percentages of income for these income levels:

- up to 133% FPL: 2% of income
- 133-150% FPL: 3% – 4% of income
- 150-200% FPL: 4% – 6.3% of income
- 200-250% FPL: 6.3% – 8.05% of income
- 250-300% FPL: 8.05% – 9.5% of income
- 300-400% FPL: 9.5% of income

People will receive the premium credit either via their tax return (called a "refundable" credit) if they have already paid the health insurance premium or

via a payment made to their health insurer (called an "advanceable" credit) if the health insurance premium payment has not yet been made. Advanceable tax credits allow you to receive the credit at the time you enroll, rather than paying the full amount of the premium out of your own pocket and waiting to be reimbursed later when you file your tax return.

(It is possible that New York will decide to establish a low-cost "basic health plan" under the ACA for families or individuals making at or below 200% of FPL for people who are not eligible for Medicaid; if this alternative, which provides significant benefits to low-income people, is selected, people with income under 200% of FPL will then not be eligible for premium credits.)

Cost Sharing Limits

Q15. The provisions of the new law that subsidize health insurance premiums through the exchange sound great, but are there any limits to the co-payments and deductibles I would otherwise pay?

A. Yes, for people who purchase their health insurance through the exchange, the new law sets maximums on the amounts you can pay out of pocket for such items as copayments for office visits and other services, as well as deductibles. The current maximums anyone can pay, based on the cost of living in 2010, are $5,950 for single coverage and $11,900 for family coverage. (These numbers will be adjusted based on the changes in the Consumer Price Index until 2014, when the cost-sharing provisions go into effect.) And, if your income is below 400% of the FPL (again, roughly $89,400 for a family of 4 and $74,120 for a family of 3), the maximum amount you can pay is less than the $5,950 and $11,900 maximums based on this formula:

- 100 to 200% of FPL: your maximum is one-third of $5,950/$11,900
- 200 to 300% of FPL: your maximum is one-half of $5,950/$11,900
- 300 to 400% of FPL: you maximum is two-thirds of $5,950/$11,900

For example, in 2010 dollars, the maximum out-of-pocket costs for someone whose income is 150% of FPL would be about $1,981 for single coverage and $3,963 for family coverage. (The calculations are by the Kaiser Family Foundation.)

Seniors and People with Disabilities

(Also see questions 37 and 38.)

Q16. I'm 58 and have a history of health problems. In the past, it's been hard for me to get health insurance at any price. I know they won't be able to reject me outright, but is there anything in the law to stop insurers from charging me more than everyone else for my health insurance?

A. The law has an extremely weak provision that somewhat helps you: premiums in the individual and small group markets and in exchange plans may vary only by family structure, geography, the actuarial value of the benefit, and age and tobacco use. The maximum ratio that a plan can vary the premium based on age is 3 to 1. These protections do not apply to self-insured plans.

Q17. I am currently on Medicare Advantage. Will I have to switch plans? How will my current benefits be affected?

A. Medicare Advantage plans provide Medicare enrollees with the option of enrolling in a private plan like a HMO for their Medicare benefits, rather than traditional "fee-for-service" Medicare. About 1 in 4 Medicare beneficiaries have Medicare Advantage. The new law gradually decreases payments to private insurers who operate Medicare Advantage plans, in response to the fact that payments by the federal government to Medicare Advantage plans average 9% to 13% higher than for traditional fee-for-service plans.

The new law does not have benefit cuts. In fact, the new law enhances benefits and protections for those enrolled in Medicare Advantage plans in various ways, including: 1) banning higher cost-sharing requirements than traditional fee-for-service Medicare for certain critical services, like chemotherapy and skilled nursing care, and 2) requiring beginning in 2014 that 85% of Medicare Advantage plan premiums be spent on medical services rather than administrative services and profits (known as the "Medical Loss Ratio," or "MLR").

This does not mean that insurers that operate Medicare Advantage plans will not respond to the payment cuts in various ways that might adversely affect some beneficiaries, like reducing their network of providers or even leaving certain markets in extreme cases. Those enrolled in Medicare Advantage will have the option, of course, of returning to traditional Medicare if they are not satisfied with their plan.

Q18. I'm on Medicare and am enrolled in the "Part D" prescription drug plan, but I'm still having trouble paying for my prescriptions. Is there anything in the Affordable Care Act to help me?

Since the creation of "Part D," seniors and people with disabilities in the program have faced the infamous "donut hole", in which, after the drug costs paid by the beneficiary and the plan combined reached roughly $3000 in a year, beneficiaries had to pay 100% of their drug costs until the total they spent reached the yearly out-of-pocket spending limit of $4550. This requirement to pay all of your drug costs is called "falling into the donut hole." In 2010, those in the donut hole received a rebate check of $250. In 2011, people in the donut hole are receiving a 50% discount on covered brand name prescription drugs, and paying less for generic drugs as well.

Q19. I receive Medicaid and Medicare, use a wheelchair, and receive assistance from a home care worker. I am managing fine now, but I am always worried about being put into a nursing home. Will the ACA help me?

A. There are a number of things that can help people in your situation. The Affordable Care Act has two provisions that are designed to encourage states to offer more Medicaid home and community-based services that will allow people with disabilities to get their care in the community, which most people prefer, rather than in an institution. The Community First Choice Option offers enhanced Medicaid matching funds for states which decide to provide statewide community-based attendant supports and services to individuals with disabilities who are Medicaid eligible and require institutional care. New York State has committed to this option. The Balancing Incentive provision offers enhanced Medicaid matching funds to states which develop a plan to increase the percentage of their long term care spending which is put towards home and community based care as opposed to institutional care.

Q20. I heard that the "essential health benefits" coverage to be offered in our future state exchange (see question 12) is to be based on the "typical employer plan." By the typical employer plan leaves out or limits a lot of benefits that are important to people with serious illnesses or disabilities. What is being done to address this problem?

A. The essential health benefits package starts from the typical employer plan, but it is also required to include rehabilitative and habilitative services and devices, treatment for mental health and substance use disorders, including behavioral health services, chronic disease management treatment, preventive and wellness services, and pediatric services, including oral and vision care. Health care advocates are working with HHS to make sure that the benefits offered are as strong as possible.

Children and Young Adults

Q21. My 9 year old son is being treated for cancer. I'm worried that my child's illness is so severe that there will be limits to how much the insurance company will pay. Does the ACA help me? (Also see question 1.)

A. Yes. The ACA prevents health insurers from setting limits on how much care is covered by an insurance company in a child's lifetime (called "lifetime limits"). By January 2014, the law will also prevent insurance companies from setting limits on how much they will pay a year (called "annual limits"). Prior to that date, plans may only place annual limits as determined by HHS. The lifetime and annual limits provisions protect adults too.

Q22. My 22 year old daughter is graduating from college and doesn't have a job. Is there any way I can get her coverage at a reasonable rate?

A. Young adults up to 26 years of age can stay on their parents' plans under the new *federal* law. The cost should be similar to the amount the parent is currently paying. In addition, because of a recent *state* law, young adults between the ages of 26 and 29 living in New York can also choose to stay on their parent's coverage, but the parent or child will be responsible for a separate premium for this young adult option (over and above what the parent pays for their group coverage). To find out how to keep your child covered, speak to your employer's human resources office.

Q23. I have two children enrolled in Child Health Plus (CHP) in New York and I'm satisfied with the program. Will I be able to continue to stay on CHP?

A. CHP will remain the same for at least the next 8 years. All uninsured children are eligible for free or low-cost health insurance under CHP. You may be required to pay an affordable monthly premium depending on your income.

Q24. My child is undocumented. Will he or she still be eligible for CHP?

A. Yes. Undocumented children are still eligible for Child Health Plus regardless of their parents' immigration status.

Q25. I used to be charged a co-payment every time I took my child to a doctor's visit. Did the new law change that?

A. Because of the new law, you are no longer required to make co-pays for any doctor's visit that is considered preventive. This includes vaccinations and preventive care for infants, children and adolescents.

Q26. I am a young adult in foster care. Does the new law help me?

A. The new law will provide Medicaid coverage to youth aging out of foster care up until their 26th birthday.

Immigrants

Q27. I am an immigrant and have been living in New York legally for 3 years now, and my income is very low. What are my health insurance options under the new law?

A. Lawfully residing immigrants in New York will remain eligible for Medicaid and Family Health Plus if they meet the income criteria. This includes green card holders (lawful permanent residents), refugees, asylees, and even individuals who are applying for their green cards or for another immigration status. Lawfully residing immigrants will also be eligible for the subsidies under the new law (called "premium credits") that will make buying insurance more affordable, and for the NY Bridge Plan. (See question 14 for a general explanation of premium credits and question 2 for an explanation of the NY Bridge Plan.)

It's important to note that legal immigrants face no waiting periods in New York for public health insurance or for the new premium credits. Also, using these programs should not affect your ability to get your green card or to naturalize. Facilitated enrollers at community-based organizations and health plans speak many languages and can help you with your application for public health insurance.

Q28. Are immigrants eligible for the premium tax credits being offered by the federal government?

A. Naturalized citizens and "lawfully present" immigrants will have the same access to affordable health insurance as U.S. born citizens in the new insurance exchanges scheduled to be established in 2014. They will be required to get health insurance and must pay a tax penalty for not having health insurance. They can also apply for tax credits to make health insurance more affordable and for an exemption from the requirement to buy health insurance if it remains unaffordable.

On the other hand, although many undocumented immigrants pay taxes and would like to pay their fair share for health insurance, they will not be allowed to get premium tax credits to help make insurance more affordable. Fortunately, citizen or legal immigrant children of undocumented parents will be able to apply for these tax credits on their own.

(See question 12 for general information on exchanges, question 14 for information on premium tax credits, and question 13 for information on exceptions to the requirement to obtain health insurance.

Q29. I have a green card, but my wife and one of my children still don't have proper immigration papers. Is there a way for them to see a doctor?

A. Yes. While undocumented adults will remain ineligible for most public health insurance programs such as Medicaid and Family Health Plus, as well as for the new subsidies (premium credits), nearly all children and adolescents, including those who are undocumented, are eligible for Child Health Plus. In addition, if your wife's household income is low enough, she may qualify for emergency Medicaid, which she should ask for at the hospital if she has an emergency. If she's pregnant, she may be eligible for Medicaid for prenatal care and the labor and delivery of the baby.

Importantly, hospitals and community health centers must also offer sliding scale bill reductions for low-income people, regardless of immigration status. Individuals are not required to document their immigration status before seeing a doctor, and no one should report any patient to U.S. immigration officials for using health care.

Q30. I will soon be able to apply for citizenship. I have lost my job, and I need to see a doctor. However, I hear that the new law is strict toward immigrants, and that I should not apply for Medicaid, as that will jeopardize my naturalization process. Is that true?

A. The new law does not change immigrants' eligibility for Medicaid in New York. Naturalized citizens and lawfully residing immigrants remain eligible for all public health insurance programs. You cannot be denied U.S. citizenship or permanent residence for receiving benefits that you're eligible for, including Medicaid. You also cannot be denied U.S. citizenship for applying for the new subsidies.

Women

Q31. Which women's health services are included in the coverage that will be made available under the health reform law?

A. The law outlines broad categories of services that insurers must cover, such as hospitalizations, doctor services, prescription drugs, and rehabilitation and mental health services. There are also provisions that apply specifically to women and women's health. Here are a few examples.

- Maternity coverage is mandated.
- Women's preventive health services and screenings, such as mammograms and Pap smears, will be covered, in many cases, without the requirement for a co-pay or deductible.
- Low-income women who want to give birth at free-standing birthing centers will find it easier to do so, because licensed practitioners at these centers will become eligible for Medicaid reimbursement.

The law allows states to decide whether to allow insurers to cover abortion care in the health plans that will be offered in exchanges. If a state does not prohibit or restrict abortion coverage, then insurers can choose whether or not to offer it. See additional details on this topic in question 33.

Q32. As a young woman, one of my most important health needs is contraception. Will the law help me get affordable contraceptives?

A. Yes. The health reform law requires all new health plans to cover preventive services and screenings and to eliminate cost-sharing (e.g., co-payments and deductibles) for those services. In August of 2011, HHS issued a rule adding a number of women's preventive services, including all FDA-approved contraceptives, to the list of covered preventive services. This new rule goes into effect in August 2012 for all new health plans or existing plans to which enough changes have been made to qualify them as "new." (Note that the changes may not occur until the start of your insurer's next new plan year after August 2012. So this could be as late as January 2013.)

Moreover, as many more people become eligible for Medicaid or for premium credits (subsidies) to help them purchase private insurance in 2014, an estimated 12.4 million women of reproductive health age will gain contraceptive coverage. All of the new private health plans that will be offered in the NYS insurance exchange will have to cover contraceptives, because they will be new plans issued after August of 2012. Medicaid already covers a wide range of contraceptive services.

Before 2014, young adult women will be able to maintain coverage for birth control by staying on their family insurance plans up to age 26 and to 29 under a state law (see question 22). New York State already has a "contraceptive coverage" law requiring employers to include prescription contraceptives in any prescription drug plan they offer their employees.

Q33. What about abortion coverage? I heard so much controversy about it that I'm not sure whether it will be available under the ACA.

A. It will depend on two things: 1) where you live, and 2) whether you will receive your insurance coverage through the expansion of Medicaid to more low-income people, or through a subsidized private insurance plan.

Let's start with Medicaid coverage. The new law maintains the existing ban on use of federal funds -- such as federal Medicaid dollars -- to pay for abortions (except in case of rape, incest or when the woman's life is in danger) However, 15 states (including New York) use state funds to pay for abortion care for women on Medicaid. So, if you live in New York or one of those other states, your Medicaid coverage will include abortion services.

If you make too much money to qualify for Medicaid, but are eligible to receive a federal subsidy to help you buy private insurance through an exchange, you may be able to purchase abortion coverage if you live in a state that permits it. The health reform law gives states the power to decide whether to allow or prohibit abortion coverage in the state insurance "exchanges" that will open to consumers in 2014. New York must make this decision through legislation. (See question 12, which describes the legislative process for creating a New York State exchange.)

If New York ultimately does permit insurance companies to offer abortion coverage as part of the insurance policies they sell through the exchange, no federal subsidy dollars can be used to purchase the abortion coverage. Your insurance company will have to use only your private premium dollars to pay for this portion of your insurance policy. You will be billed for your regular premium payment and for a separate abortion coverage payment.

Q34. What does the new law say about sex education?

A. There are some mixed messages in the new law, resulting from political compromises. On the one hand, the law allocates $75 million per year for five

years to pay for a "personal responsibility education program" that will make grants to states for evidence-based, age-appropriate and medically accurate programs that educate adolescents about preventing pregnancy and sexually transmitted infections. On the other hand, the law revives the discredited Title V abstinence-only-until-marriage program and gives it $50 million a year for five years.

Q35. I've heard the health reform law supports working women who want to breastfeed. Is that true?

A. Yes. There is a requirement that employers provide breastfeeding women with break time and private space (not the women's bathroom) to express milk. New York State also has several protections in place for breastfeeding mothers. In 2009, the New York State Department of Health released the Breastfeeding Mothers Bill of Rights, which explains the protections afforded to breastfeeding women in New York. It can be found here: http://www.health.ny.gov/publications/2028.pdf.

There is also a new provision that goes into effect in August 2012 requiring all new health insurance plans (or existing plans to which enough changes have been made to qualify them as "new") to cover breastfeeding supports, such as rental of breast pumps, without charging co-pays. This is because of the new Women's Preventive Services rule issued by HHS in August of 2011.

Q36. What does the new law do to help new mothers and newborns?

A. The law provides $1.5 billion over five years to pay nurses and other health practitioners to make home visits to new mothers and their newborns. The program is designed to help mothers who are considered "at risk" and need additional support. For example, teenage mothers with their first babies may need instruction in how to care for a newborn and how to breastfeed. It also sets up a Pregnancy Assistance Fund that makes $25 million per year available to states to support services that help pregnant and parenting teens and women. Another important provision prohibits insurance companies from denying coverage to newborns or children because of pre-existing conditions.

Q37. How does the law help the one in four women who get health insurance coverage through a spouse or partner and are vulnerable to losing their coverage because of divorce, widowhood or when their older spouse goes on to Medicare?

A. Once the state insurance exchanges open in 2014, women who lose their dependent health insurance coverage will be able to obtain their own personal coverage. They may qualify for the expanded Medicaid program. Or, they can purchase a private insurance policy through the exchange, and may qualify for a federal subsidy to help make the insurance affordable.

Q38. How does the law help women 65 and older?

A. Women tend to live longer than men, and along the way, provide personal care and medical care coordination for their spouses. There are several provisions of the health reform law that will be especially important to older women. First, the "donut hole" in the Medicare Part D prescription drug plan is being gradually closed; see question 18 for details. Next, the law offers people on Medicare a free annual wellness visit, beginning in 2011.

Q39. I've been paying higher rates for insurance than men I know who have a similar health status. Does the law stop that kind of abusive practice?

A. Yes. Starting in 2014, new health plans will be prohibited from using gender to set premium prices. (New York already prohibits this practice, but it occurs in a number of other states.) In addition, effective immediately, insurance companies that receive funding from or are operated by the federal government are prohibited from discriminating on the basis of sex.

Q40. I've been turned down for health insurance because I was once in an abusive relationship and insurance companies tell me I'm not a good insurance risk. Will the law help me?

A. Yes. It's outrageous that insurance companies have been denying coverage to survivors of domestic violence based on the excuse that it's a pre-existing condition. But as of January 2014, insurers will no longer be allowed to deny coverage to people who have pre-existing conditions, such as cancer, diabetes, or domestic violence.

In addition, starting in August 2012, all new insurance plans (or existing plans to which enough changes have been made to qualify them as new) will be required to cover screening for domestic violence and counseling services, without charging co-pays. This is because of the new Women's Preventive Services rule issued by HHS in August of 2011.

Consumer Assistance and High Rates

Q41. My premium rates are going up and up. Is there anything I can do about this?

A. A new *state* law passed in 2010 restored the right of the State Insurance Department (now known as the Department of Financial Services, or "DFS") to review proposed rate increases by health insurers in the individual and small group markets and to reject or modify them if DFS finds that the premium increase is "unreasonable, excessive … or unfairly discriminatory." Policyholders are entitled to written notice of the rate increase. Policyholders and other consumers can submit written comments to DFS on rate increases to influence its rate decisions. Information on the law and filing comments is available on the DFS web page: http://www.dfs.ny.gov/insurance/health/prior_app/prior_app.htm. Health

Care for All New York also provides information on recently filed rate increase requests at: http://hcfany.files.wordpress.com/2011/10/summary-of-hcfany-rate-increase-comlaints.pdf; a template letter to challenge a rate increase request also appears on the HCFANY web page: www.hcfany.org. For the rate increases scheduled to go into effect in January of 2012, two million affected New Yorkers saw their health plan's proposed rate increase reduced by an average of 4.5%.

Health insurers are also required by the ACA to devote at least 82% of health insurance premium dollars for small group or individual plans to the payment of health insurance claims or other health care purposes, rather than profits, advertising, and executive salaries. (The 82% is known as a "Medical Loss Ratio," or MLR.) The ACA adds to the New York protections by requiring a MLR of 85% for the large group market (large employers).

Q42. I have a dispute with my health insurer over the amount of a bill. Is there any help or advice available on how to handle that?

A. With funding provided under the ACA, New York State now has an excellent program called Community Health Advocates (CHA) that provides free advice and assistance to consumers on virtually any health issue, including selecting a health plan, bill disputes with hospitals and other providers, health insurance coverage, and finding low-cost alternatives for prescription drugs. CHA uses a network of non-profit organizations throughout New York State that are thoroughly trained on consumers' legal rights and how to be effective advocates. To find more information about CHA, or finding a CHA agency that can help you where you live, visit: http://www.communityhealthadvocates.org/.

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We will continue to update this publication on a regular basis to add new questions that come up. If you have suggestions for questions or corrections, please contact Bob Cohen of PPEF at bcohen@citizenactionny.org.