Top 5 health care reform FAQs

Clearing up questions about the not-so-new law

Two years after it became law, health care reform is still making headlines. A lot of people still aren't sure what the law does – and doesn't – do. These frequently asked questions may help clear things up.

What does "grandfathered" mean?

This word describes health plans that were already in effect on the day the health care reform bill became a law (March 23, 2010). The law has special rules for these plans. For example, they don't have to cover in-network preventive care with no cost to you. To learn if your plan is grandfathered, check your plan materials. Grandfathered plans have to include a special notice on things like benefit summaries.

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 health coverage on the W-2 form. But this is a reporting rule only. It doesn't change the tax-free status of employer-sponsored health plans.

How will the health insurance exchanges work?

Starting in 2014, individuals who don't get affordable (as defined by the health care reform law) minimum essential coverage at work may be able to shop through an exchange. Some small businesses will also be able to use exchanges to find plans for their employees. The exchanges will be run by the state or federal government. Plans in the exchange will have to meet federal requirements around cost-sharing to help make it easier for consumers to shop for coverage. For example, a "gold" plan will pay more of your costs than a "bronze" plan. Subsidies will be available to low-income people who meet eligibility requirements, and qualifying small businesses may receive premium tax credits when they buy coverage through an exchange.

Is it true that I'll pay a penalty if I don't have health coverage?

This is the most controversial part of the law – and the key reason the Supreme Court is involved. As the law is written, all Americans (including people from other countries who are in the U.S. legally) will need to have some type of health coverage starting in 2014. This could be an employer's plan, an exchange plan or something else. Those who don't will pay a penalty. The penalty starts out small in 2014, but it will get bigger over time. And there are exemptions for reasons like low income or religious objections.

Why does the law require people to get coverage?

Starting in 2014, you can't be turned down for a health plan 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: A 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 buy coverage. That makes the balance shift even more. See the cycle? The "individual mandate" helps to prevent this cycle, which helps to keep coverage affordable for everyone.

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