Patient Protection & Affordable Care Act (PPACA)
Frequently Asked Questions (FAQ's)

1. **Does Florida have its own state-based exchange?**
   No, Florida is currently being served by the Federally-Facilitated Exchange (Exchange), also known as the Marketplace, administered by the Department of Health & Human Services. For more information, visit the website at: https://www.healthcare.gov/.

2. **What are "Exchanges"? Can I still purchase coverage through my agent?**
   Exchanges are the central mechanisms created by the health reform bill to help individuals and small businesses purchase health insurance coverage. The Exchange, operated by the federal government, will provide information to consumers about their coverage options and what assistance is available to them. The exchanges will also administer the new health insurance subsidies and facilitate enrollment in private health insurance, Medicaid, and the Children's Health Insurance Program (CHIP) – in Florida, it is referred to as "Healthy Kids". The federal law does not require anyone to purchase health insurance through the Exchange, though subsidies will only be available for plans sold through the Exchange. You will be able to purchase this coverage right on the Exchange's website or through your agent if he or she is approved to sell Exchange plans. If you would rather buy other health insurance through an insurance agent or broker, you will be free to do so.

3. **What are the different levels of coverage and what does each include?**
   The levels of coverage (also called "metal levels") are defined as follows:

   - **Bronze Level** –Covers 60% of expected costs for the average individual
   - **Silver Level** – Covers 70% of expected costs for the average individual
   - **Gold Level –** Covers 80% of expected costs for the average individual
   - **Platinum Level** – Covers 90% of expected costs for the average individual
   - **Catastrophic Plans** – These are high-deductible plans available only for those under age 30 or for individuals who receive a hardship exemption.

All plans must design their cost-sharing (deductibles, copayments, and coinsurance) to fit into the specific levels of coverage. In general, a bronze plan is expected to have lower monthly premiums but higher deductibles and copayments than a gold plan or a platinum plan.

4. **Will I be required to give up my pre-PPACA plan?**
   Potentially - all plans that were in effect as of March 23, 2010, are grandfathered under the law and will be considered "qualified coverage" that meets the mandate to have health insurance as long as the issuer continues to offer it without substantial changes. However, insurance companies are not required to keep grandfathered plans in force, and may non-renew these plans with proper notification to consumers. A policy sold after March 23, 2010, is not grandfathered.

   Health plans that were sold between March 23, 2010, and December 31, 2013, are referred to as transitional or "grandmothered" plans. On February 23, 2017, the Centers for Medicare and Medicaid Services (CMS) issued a notice authorizing the extension of transitional plans by allowing renewals beginning on or before October 1, 2018. However, any plans renewed under CMS' transitional policy must not extend past December 31, 2018 unless CMS authorizes a subsequent extension. Insurance companies are not required to keep transitional plans in force, and may non-renew these plans with proper notification to consumers.
   November 14, 2013 Office Statement – Commissioner McCarty Issues Statement on President's Health Care Changes

5. **What benefits must my PPACA plan include?**
   Plans sold or renewed in the individual and small group market after January 1, 2014, must include all the benefits in a "benchmark" plan – a plan chosen for the state based on coverage currently available in the state – and will cover services in the following categories:

   - Ambulatory patient services
   - Emergency services
   - Hospitalization
   - Maternity and newborn care

- Mental health and substance abused disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

The Florida essential health benefits benchmark plan (includes vision) is:
http://www.floir.com/siteDocuments/EHBFloridaBenchmark.pdf
For information on the dental benchmark plans in Florida:
https://www.opm.gov/healthcare-insurance/dental-vision/plan-information/premiums/dental-rating/
https://www.benefeds.com/Portal/EducationSupport?EnsSubmit=dental_plans&ctoken=5HX5OXIE

6. **How will my out-of-pocket costs be impacted?**
   Plans sold or renewed in 2017, limit the out-of-pocket exposure of consumers to $7,150 for individuals and $14,300 for families. In 2018, these limits will increase to $7,350 for individuals and $14,700 for families. However, out-of-pocket amounts are affected by the metal level of the plan and many plans have lower out-of-pocket limits than the stated maximum amounts.

7. **Will insurers be able to charge me more because of my age?**
   Yes, though they may not charge the oldest individuals (64 years old) a premium that is more than 300% of the premium charged to the youngest adult (21 years old) with the same rating factors.

8. **What are other factors that can be accounted for when determining my rate?**
   Insurers may not vary rates based on health, claims, genetic information, or any other health-related factors. However, insurers may vary rates by age (within limits), tobacco use, geography (county of residence), and the number of family members covered.

9. **Can my plan cover my adult children?**
   Under federal law, insurers and employers are required to provide coverage to adult children of enrollees up to their 26th birthday. Florida law exceeds this and requires insurers to provide coverage to adult children until the age of 30 if certain conditions are met – although this option will only be available for "off-exchange products." Please note that adding an adult child to your plan will likely increase the amount you pay in premiums.

10. **Can I still have a Health Savings Account (HSA)?**
    Yes, nothing in the legislation would infringe upon the ability of an individual to contribute to a HSA or discourage an individual from doing so. The minimum level of coverage required to meet the individual mandate was specifically designed to allow for the purchase of a qualified high deductible health plan that would complement the HSA.

11. **How much will my penalty be if I do not obtain coverage?**
    Please refer to the "Questions and Answers on the Individual Shared Responsibility Provision" on the IRS's website (http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision).

12. **Who do I call for a PPACA-related insurance complaint, question or other issues regarding my insurance?**
    The Department of Financial Services (DFS) Division of Consumer Services can provide assistance with a PPACA-related insurance complaint. They can be reached at 1-877-MYFLCFO (1-877-693-5236) or (850) 413-3089.

Source: *Portions of information were derived from FAQ's on PPACA from the National Association of Insurance Commissioners (NAIC)*