AFFORDABLE HEALTH CARE FOR AMERICA

HEALTH INSURANCE REFORM AT A GLANCE

INSURANCE MARKET REFORMS THAT PROTECT CONSUMERS

The Senate passed bill as improved by reconciliation will improve the health insurance marketplace by strengthening consumer protections and providing consumers with the information they need to choose the best health care coverage for their families.

NO DISCRIMINATION FOR PRE-EXISTING CONDITIONS, GENDER OR OTHER CHARACTERISTICS

- Insurers and health plans will be prohibited from denying individuals health insurance coverage due to a pre-existing condition and from charging individuals with pre-existing conditions higher premiums or excluding coverage for specific conditions.
- Insurers and health plans selling to individuals and small businesses will be prohibited from charging higher premiums due to gender, health status, family history, or occupation.
- Limits will be placed on how much premiums may vary based on age (3:1) or tobacco use (1:1.5) on insurers selling to individuals and small businesses.
- Because these changes are dependent upon all Americans having access to quality, affordable health insurance, they take effect when the Exchanges are operational in 2014.

NO PRE-EXISTING COVERAGE EXCLUSIONS FOR CHILDREN

- Recognizing the special vulnerability of children, all health plans will be prohibited from excluding coverage of pre-existing conditions for children, effective six months after enactment and applies to all plans.

EXTENSION OF DEPENDENT COVERAGE FOR YOUNG ADULTS

- Insurers and health plans will be required to permit adult children to stay on family policies until age 26. This provision takes effect six months after enactment and applies to all plans.

REQUIRED COVERAGE FOR PREVENTIVE CARE WITH NO COST-SHARING

- Insurers and health plans will be required to offer and provide first dollar coverage of preventive health care services. This provision takes effect six months after enactment and applies to all new plans.

PATIENT PROTECTIONS

- Patients' choice of doctors will be protected by allowing plan members to pick any participating primary care provider, prohibiting insurers and plans from requiring prior authorization before a woman sees an ob-gyn, and ensuring access to emergency care. This provision takes effect six months after enactment and applies to all new plans.

NO COVERAGE RESCISSIONS WHEN AMERICANS GET SICK

- Insurers and health plans will be prohibited from canceling health coverage when a beneficiary gets sick as way of avoiding paying that person's health care bills. The provision takes effect six months after enactment and applies to all plans.

NO ARBITRARY LIMITS ON COVERAGE

- Insurance companies and other plans will no longer be able to place lifetime limits on the dollar amount of the coverage for which they will pay, and will be restricted in their use of annual limits until 2014, when the Exchanges are operational and annual limits will be completely prohibited.

PROTECTION FROM EXORBITANT OUT-OF-POCKET COSTS

- Insurance companies will abide by yearly caps on what they may charge beneficiaries for out-of-pocket expenses in new plans, like co-payments or co-insurance charges.

NOTIFICATION AND JUSTIFICATION OF PREMIUM INCREASES

- Insurers will be required to publicly disclose the amount of any premium increase prior to the increase taking effect, and to provide a justification for the increase. This will limit the industry's current practice of hiking up insurance rates in order to push less healthy individuals and small businesses off their rolls.
- A health insurer's participation in the Exchanges will depend on its performance. Insurers that jack up their premiums before the Exchanges begin will be excluded – a powerful incentive to keep premiums affordable.

CLEAR SUMMARIES, WITHOUT THE FINE PRINT

- Insurers will outline coverage options using a simple and standard format that enables consumers to make an apples-to-apples comparison when they are choosing their health insurance plan.

INFORMATION ABOUT INSURANCE PLAN EXPENDITURES, AND A REBATE TO ASSURE VALUE

- Each year, insurance companies will report the percentage of Americans' premiums they spend on items other than health care costs, such as bureaucracy, marketing, or executive compensation.
- Americans will receive a rebate if their insurance company's non-medical costs exceed 15 percent of premium costs in the group market or 20 percent in the small group and individual market. Using cost data from this year, rebates will begin in 2011 and the policy applies to all insurance companies.

FAIR OPPORTUNITY TO APPEAL COVERAGE AND CLAIMS DECISIONS

- New health plans will be required to develop an appeals process that, at a minimum, provides beneficiaries with a notice of internal and external appeals processes and allows beneficiaries to review their file and present evidence in their appeal.

ENHANCED TRANSPARENCY

- New requirements will ensure that insurers and health care providers report on their performance, empowering patients to make the best possible health care decisions.