Affordable Care Act
What Must Insurance Cover Under the ACA?
Sept. 19, 2012

On June 28, 2012, the U.S. Supreme Court ruled that the Affordable Care Act (ACA) was constitutional. All coverage provisions in the ACA remain. All non-grandfathered insured products offered in the individual and small group health insurance markets (within and outside of the health insurance exchanges) will be required on January 1, 2014, to provide benefits within the following categories: inpatient, outpatient and emergency room services, rehabilitation, mental health and substance abuse treatment, maternity and newborn care, preventive and wellness services, chronic disease management, prescription drugs, laboratory services, and pediatric services.

Background

- Young adults up to the age of 26 who meet the guidelines will be able to remain on their parents' insurance policies.

- Preventive care, including mammograms, immunizations, cholesterol test, etc., will continue to be considered preventive services with no out-of-pocket costs. For a complete list see "Prevention & Wellness" at www.healthcare.gov.

- Grants and technical assistance will be available to employers to establish wellness programs to encourage healthy lifestyles. Premium discounts, waivers of cost-sharing requirements, or new benefits may be allowed to encourage participation.

- A health plan cannot cancel coverage once an individual becomes ill unless the individual committed fraud when applying for coverage.

- Children with pre-existing conditions cannot be denied coverage. The same provision applies to adults beginning in 2014.

- Insurers are prohibited from putting a lifetime dollar limit on most benefits. The law also restricts and phases out the annual dollar limits a health plan can place on most benefits, and does away with these limits entirely in 2014.

- Private health plans must demonstrate that at least 80 percent of premiums for plans in individual and small group markets, and 85 percent of premiums for plans in the large group markets are used for actual care of the insured. Plans not meeting this threshold are required to rebate the differences back to the

employer or the individual. Rebate notification for Oklahoma insurance companies was announced in July 2012.

- Private health plans must submit rate increase justification to the state insurance commissioner to increase premiums more than 10 percent.

- Plans must require guarantee issue and renewability allowing for rate variations based on age, premium rating area, family composition and tobacco use.

Coverage for Medicare recipients

- Continues rebates for drug costs to Medicare recipients and donut hole will continue to shrink until it is completely closed by 2020. Medicare recipients will then be responsible for 25 percent of their prescription costs. Pharmaceutical discounts will remain in place.

- Requires Medicare Advantage plans to remit partial payments if the plan has a medical loss ratio of less than 85 percent in 2014.

- Provides for a 10 percent bonus payment to primary care physicians who take care of Medicare patients from 2011 through 2015. General surgeons practicing in health professional shortage areas will also receive a 10 percent bonus payment from 2011 through 2015.

- Eliminates cost sharing for certain Medicare covered preventive services as well as an annual physical. For a complete listing, go to www.medicare.gov/Publications/Pubs/pdf/10110.pdf.

- Independent Payment Advisory Board remains to recommend reductions to Medicare and Medicaid drug reimbursements and Medicare and Medicaid spending. The Board is prohibited from submitting proposals that would ration care, increase revenues or change benefits, eligibility or Medicare beneficiary cost sharing.

The Oklahoma Hospital Association has prepared Fact Sheets on numerous topics related to the ACA of interest to hospitals. The Fact Sheets may be accessed at www.okoha.com/aca.