



What's in Health Reform for Consumers

No Discrimination for Pre-Existing Conditions, Gender or Other Characteristics

- Insurers 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 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 or tobacco use.
- 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.

Coverage of Pre-Existing Conditions for Children

- Recognizing the special vulnerability of children, health insurers will be prohibited from excluding coverage of pre-existing conditions for children.

Coverage for Young Adults

- Insurers will be required to permit children to stay on family policies until age 26. This provision applies to all new plans in any market, existing plans in the individual market, and existing employer plans if a young adult is not eligible for coverage through their own employer.

Required Coverage for Preventive Care with No Cost-Sharing

- Insurers will be required to provide free coverage of preventive health care services.

Patient Protections

- Patients' choice of doctors will be protected by allowing plan members to pick any participating primary care provider, prohibiting insurers from requiring prior authorization before a woman sees an ob-gyn, and ensuring access to emergency care.

No Coverage Rescissions when Americans get Sick

- Insurers will be prohibited from dropping health coverage as way of avoiding paying a beneficiary's health care bills when that person gets sick.

No Lifetime Limits on Coverage

- Insurers will be prohibited from imposing lifetime limits on benefits.

Regulated Annual Limits on Coverage

- Insurance plans' use of annual coverage limits will be tightly regulated to ensure access to needed care. When the Exchanges are operational in 2014, the use of annual limits will be banned for all new plans and existing employer plans.

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, like co-payments or co-insurance charges. This will ensure that Americans are not forced to file bankruptcy due to high health care costs. This provision takes effect when the Exchanges are operational in 2014 and applies to all new plans in all markets.

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 provision takes effect in 2011 and applies to all new plans, with the exception of self-insured plans.
- A health insurer's participation in the Exchanges will depend on its performance. Insurers that increase their premiums before the Exchanges begin will be excluded – this will serve as a powerful incentive to keep premiums affordable. This provision is effective 2014 and applies to new plans in the individual and small group markets.

Clear Summaries, Without the Fine Print

- Insurance companies must begin outlining coverage options using a simple and standard format that helps consumers make an apples-to-apples comparison when choosing their health insurance plan. This provision takes effect within 24 months and applies to all new and existing plans in all markets.

Information about Insurance Plan Expenditures, and a Rebate to Assure Value

- Each year, insurers will report the percentage of Americans' premiums they spend on items other than health care costs, such as administration, marketing, or executive compensation.
- Americans will receive a rebate if their health insurer'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 2010, rebates will begin in 2011 and the policy applies to all insurance plans, with the exception of self-insured plans. This provision takes effect January 1, 2011.

Fair Opportunity to Appeal Coverage and Claims Decisions

- Health insurers will 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 require that insurers and health care providers report their performance, empowering patients to make the best possible decisions.