NAR Frequently Asked Questions
Health Insurance Reform

PLAN DETAILS

Q-1: What type of health services will be available under these new plans? Will I lose access to types of services I have now?

A: Insurance policies will be required to cover a comprehensive range of health services in order to satisfy the new requirements. The list is more inclusive than current state benefit mandate laws. Required covered benefits include:

- hospitalization
- physician/other health professional services
- prescription drugs
- preventive services
- maternity care
- well baby/child care
- pediatric and non-pediatric dental, vision and hearing services and equipment
- outpatient hospital services
- outpatient clinic services
- emergency room services
- rehabilitation services
- mental health services
- substance abuse disorder services

Q-2: Will there only be one type of insurance plan available through the Exchange?

A: No. The approved Acts spell out an array of insurance policies that participating insurers may offer via the Exchange.
Insurers who choose to participate in the Exchange can offer four levels of coverage – a Bronze, Silver, Gold and Platinum plan - that all offer the same types of coverage but that vary in terms of their deductibles or co-pays.

Q-3: What will my policy cost? Who determines the cost?

A: The price of a policy will be determined just as it is today by the insurer who offers the policy. Premiums will be subject to the new rating rules and all pricing will remain subject to the review/approval of the state insurance commissioners.

As under current practice, policy premiums will depend upon a number of individualized factors. These include the number and ages of individuals covered the type of policy chosen, deductible levels, and the community where the covered individuals reside. Tobacco users may be subject to an additional surcharge on top of premiums. Thus, it is impossible to determine the cost of a policy at this time. A major goal of the reform effort is to reduce costs for consumers, health care providers and the insurance providers (including Medicare).

The Acts pursue the goal of reducing costs for consumers by making rating rules (i.e. pricing rules) more consumer-protective and merging the individual and small group insurance markets into one pool where risks could be spread across larger numbers of participants. Larger risk pools should lead to greater administrative efficiency and reduced costs, as well. Even the individual and employer mandates, while potentially burdensome during the transition to the new rules, are designed to reduce costs over the long term. In theory, as more individuals and families have health insurance, those with insurance will not be subsidizing those without insurance but to whom health care providers are often required to provide uncompensated care as is now the case. This phenomenon, known as "cost-shifting", will be eliminated. The Acts also provide for credits for low and moderate income individuals and families, as well as small employers, which will help make coverage more affordable.

Q-4: How do the Acts handle prescription costs?

A: Prescription drug coverage is specifically listed as one of the "essential benefits" that must be covered by a "qualified" insurance policy both within the Exchange and by any new traditional market policy within five years after enactment (House). The size or amount of any deductibles or co-pays will depend on the policy option chosen. Out of pocket prescription costs would be counted as part of a plan's limitations on annual out of pocket expenses.

Q-5: Will healthy lifestyle discounts/incentives or higher premiums for unhealthy choices such as smoking be allowed?

A: The Acts allow insurers to offer incentives for healthy lifestyles, wellness programs and other preventive measures. In fact, wellness and health lifestyle incentives are seen as a key means of incentivizing healthy behavior. Under the Reconciliation Act, tobacco users can be assessed a $200 annual surcharge on their premiums. Like many issues, incentives, discounts or higher premiums would depend on the insurance coverage plan an individual selects.

Q-6: Will health savings accounts (HSAs) still be available?

A: For the most part, the Acts are silent on the treatment of existing health savings accounts but do acknowledge HSA policies as acceptable coverage. (A health savings account allows individuals who purchase some types of high deductible health insurance to also set aside tax-free amounts to cover the cost of routine health care.)

Q-7: Will the government decide what medical procedures/treatments would be allowed? Wouldn't there be rationing?

A. No. The bill does not give the federal government any authority to decide what treatments would be allowed. Decisions as to whether a particular covered benefit is an appropriate one for a patient are left to the policy holder and his/her health care professional.

The only role the federal government has is to spell out what services insurers are required to include in policies, just as state law spells out what services must be covered by state-regulated policies.