Key Health Care Reform Provisions Affecting Cancer Patients and Survivors that Must Be Protected

Current federal requirements provide crucial protections that ensure health insurance coverage is comprehensive, not arbitrarily limited, available to all and more affordable. These protections are especially important for cancer patients, survivors, and those at risk for cancer. The following is a list of the most important provisions in current law for the cancer community:[1]

Prevention and Early Detection

- Coverage for U.S. Preventive Services Task Force (USPSTF) prevention services with an "A" or "B" rating. This coverage must be provided without cost-sharing
- Expanded and sustained national investment in prevention and public health programs through the Prevention and Public Health Fund
- Coverage without cost-sharing for vaccinations recommended by the Advisory Committee for Immunization Practices, including the HPV vaccine
- Additional funding for community health centers
- Grant funding for state, local and community-based prevention programs and services
- Provisions to strengthen the primary care workforce through student financing, additional primary care residency programs at teaching health centers, and training in cultural competency, prevention, and public health
- Implementation of the National Prevention Strategy

Meaningful Coverage: Availability, Affordability, Adequacy, and Administrative Simplification

Private Insurance

Availability

- No pre-existing medical condition restrictions
- Plans are prohibited from rescinding or cancelling coverage when someone gets sick except in instances of fraud or misrepresentation
- Availability and renewability of coverage is guaranteed

Affordability

- Plans are only able to charge more or less in premiums based on family structure, geography, the generosity of the benefit, age (limited to a ratio of 3 to 1), and tobacco use (limited to a ratio of 1.5 to 1)
    - Plans cannot charge higher premiums because an individual has had a cancer diagnosis
    - Plans can charge older Americans no more than 3 times what they charge younger persons. This keeps health insurance more affordable for older Americans
- Refundable tax credits provide premium assistance for individuals and families up to 400 percent of the federal poverty level for coverage in a marketplace plan
- Out-of-pocket spending maximums for individuals and families

Adequacy

- No lifetime and annual coverage limits
- Coverage of preventive health services with no cost sharing
- Requires all plans to provide a minimum level of benefits. Plans offered in the small group and individual markets have additional requirements to provide coverage of 10 categories of

essential health benefits.
- Requires plans to spend at least 80 percent of premiums on healthcare and quality improvement

Administrative Simplicity

- Standardized summary plan documents that make it easier for consumers to compare plans when shopping
- Insurance companies are required to streamline insurance appeals process to provide consumers with information about their appeals and the opportunity for external appeals
- Plan navigators and other health insurance enrollment specialists help consumers apply for and understand coverage in the marketplaces and Medicaid

Medicaid

- At the option of states, expanded eligibility and federal matching funds for individuals with income below 133% of the federal poverty level (FPL)
- Increased access to prescription and over-the-counter tobacco cessation medications and products
- Incentives for Medicaid programs to cover preventive services for eligible adults in Medicaid
- Coverage of comprehensive tobacco cessation services for pregnant women in all Medicaid programs
- States can use incentives to encourage enrollees to participate in chronic disease prevention programs
- Simplified Medicaid enrollment

Medicare

- Reduction in Part D prescription drug coverage gap ("donut hole")
- Improved Medicare coverage of annual wellness visit including a personalized prevention plan
- No cost sharing and deductibles in Medicare for U.S. Preventive Services Task Force (USPSTF) prevention services with an "A" or "B" rating
- Medicare Advantage plans must spend 80 percent of their premium income on healthcare and quality improvement.

Improved Quality of Life for Cancer Patients and Survivors

- The HHS Patient Navigator program assists patients with maneuvering through the health care system, provides outreach and education for patients to encourage preventive screenings, and addresses needs that may impact compliance with screening and treatment
- Commercial health insurance plans and the Federal Employee Health Benefits Plan (but not private self-insured plans) are required to cover the patient care costs associated with participation in clinical trials that are approved or funded by a variety of federal agencies
- Implementation of the National Strategy for Quality Improvement in Health Care
- Implementation of IOM recommendations in Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education and Research
- Training grants in family medicine, general internal medicine, general pediatrics, physician assistantship, and geriatrics, with a priority in programs that apply team-based approaches to care
- Expanded career development awards to advanced practice nurses, clinical social workers, pharmacists, and psychologists

[1] Note: most items on this list that pertain to requirements or prohibitions for insurance plans do not apply to plans that existed before March 2010 and were grandfathered into the Affordable Care Act.