The Affordable Care Act and Surgery

Common Questions and Answers

American College of Surgeons, Ohio Chapter
May 2014

On January 1, 2014, several key provisions of the Affordable Care Act (ACA) went into effect. Many of these provisions will impact where and how consumers purchase insurance, what services will be covered, and what out-of-pocket costs must be paid. Members of the Ohio Chapter of the American College of Surgeons are committed to providing the best care and information possible to their patients. This document should help answer some of the common questions that you might have regarding surgery and the ACA.

Where can I go to find insurance coverage?

Your coverage options will depend greatly on your income and whether or not you have employer-sponsored health insurance. If you do not receive coverage from your place of work, and your income is above 138% of the federal poverty line ($11,490 for an individual, $23,550 for a family of four), then you can enroll via the federal insurance marketplace: https://www.healthcare.gov/. You can also sign-up for income-based subsidies to help with insurance costs through this website.

If your income is less than 138% of the federal poverty line, then you may be eligible for coverage through the Ohio Department of Medicaid; you can determine your eligibility for Medicaid and other public assistance programs by visiting: http://benefits.ohio.gov/. It is important to note that the federal exchange website and the state Medicaid website are connected and can share eligibility information. This connectivity ensures you know all of your options before making a decision about coverage.

The ACA also created a navigator program to provide assistance to individuals seeking coverage through the marketplace. You can find a navigator in your area from the Ohio Department of Insurance: http://insurance.ohio.gov/Company/Pages/NavigatorExchangeInformation.aspx. If you do not have access to a computer then you can contact the Ohio Association of Foodbanks for assistance at **1-800-648-1176.**

What surgery-related services does my policy cover?

Beginning on January 1, 2014, all insurance plans (except grandfathered plans) are required to cover a minimum, essential health benefits package. Essential health benefits are defined in the ACA as: ambulatory services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

While specific coverage may vary between plans, medically-necessary surgeries, diagnostic exams, and rehabilitation should be covered. Depending on your plan, you may have some out-of-pocket expenses. For specific details regarding coverage and cost, you should consult your health insurance carrier.

What are my out-of-pocket expenses?

In addition to your monthly premium, your health insurance plan may also require you to pay a deductible or copay. Plans that are purchased through the marketplace have 'metal levels' that determine the amount of healthcare costs your insurer will pay. The metal levels are: Bronze (60%), Silver (70%), Gold (80%), and Platinum (90%). The lower the percentage of cost covered by your insurer, the lower your premiums will be

and the higher your deductible will be. Higher percentage plans will have a lower deductible, but higher premiums. The most common plan is the bronze level.

Typically, Medicaid coverage does not include copays for surgical procedures. Most employer-sponsored and marketplace plans have annual caps on out-of-pocket expenses. You should consult your insurance carrier for details on deductibles and copays that are required under your health insurance plan.

What if I don't have my insurance card yet?

There were some complications with the federal health insurance marketplace that may have caused delays in obtaining coverage and receiving proof of insurance. If you have recently purchased health insurance, but have not received your card yet, you should immediately contact your insurance carrier to verify your coverage. If you do not have your insurance card and you undergo surgery or receive treatment you may be asked to pay either all or part of the cost of that procedure at the time of service. As long as you have verified that you have coverage, your insurer should reimburse you for any services provided.

If you have any questions, or are having issues with your insurance carrier, please contact the Ohio Department of Insurance consumer hotline at **1-800-686-1526**. If you are a Medicaid beneficiary, please contact the Ohio Department of Medicaid at **1-800-324-8680**.

How do I comply with the 'individual mandate'?

Beginning on January 1, 2014, every individual is required to have insurance coverage or face a financial penalty. There are some exemptions to the individual mandate including affordability, citizenship status, and religious preference. You can find out more information on these exemptions here: http://www.irs.gov/uac/ACA-Individual-Shared-Responsibility-Provision-Exemptions.

Health insurance status will be reported on your annual tax filing to the Internal Revenue Service beginning next year. If a penalty is assessed, it will first be deducted from your tax return. Individuals who are enrolled in an insurance exchange plan or in Medicaid will receive a certificate indicating they have minimum essential coverage. The IRS website has a Frequently Asked Questions page for reference: http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision.

Why is my Hospital/Provider no longer part of my 'in-network' coverage?

In an effort to control costs, some insurers reduced their coverage networks for exchange-based insurance plans. Both federal and state statutes set minimum standards for provider access within an insurance network, however there is always the risk that your family physician or local hospital could become an 'out-of-network' provider. Typically, going to an out-of-network provider could mean paying higher copays or coinsurance. Your insurance carrier or healthcare provider can determine coverage status for you.

The Obama Administration is currently working on rules to address this issue and potential increase network adequacy standards so more providers become in-network. While this change is still in the works, it could restore coverage for your preferred physician. If you have questions or complaints about insurance coverage, please contact the Ohio Department of Insurance's Consumer Hotline: **1-800-686-1526**.

The Affordable Care is a complex piece of legislation and is constantly changing. It has dramatically reshaped our health insurance marketplace and overall healthcare system. The Ohio Chapter of the American College of Surgeons will continue to monitor ACA implementation at the federal and state levels. As an additional resource, the American College of Surgeons provides resources on the ACA for fellows, patients, and consumers. You can view those resources here: http://www.facs.org/ahp/aca/index.html.