

Health Reform Changes Insurance Rules

The Affordable Care Act (ACA) will greatly increase the availability of health insurance and broadly impact the delivery of health care in America. This Fact Sheet looks specifically at key changes being made in the way private insurance works.

The ACA makes significant changes to insurance rules that are intended to improve access, coverage, oversight of premiums, consumer protections, and information. Key changes are described below.¹

Improved Access to Coverage

New Guarantees of Access in the Individual Market

While insurers in group markets have been unable to turn down groups on the basis of the health status of their members for more than a decade, the same has not been true for those in the individual market who buy their insurance directly from an insurer or a broker or an agent.

Starting in 2014, insurers in the individual market must accept all applicants, including those with preexisting medical conditions. Insurers will no longer be able to turn down applicants or charge higher premiums based on their health status or claims experience, nor will they be able to exclude preexisting medical conditions from coverage. However, insurers will be allowed to continue to limit enrollment to an open enrollment period or special enrollment periods for events such as birth, marriage, and loss of eligibility for prior coverage.

Plans Can No Longer Cancel Coverage

In the past, some people have had their coverage canceled or rescinded, even if their premiums were paid.

As of September 2010, insurers may no longer cancel coverage once a person is covered unless there has been fraud or intentional misrepresentation of information. In this case, plans must provide at least 30 days' notice to the covered person if they seek to cancel coverage.

Length of Waiting Periods Limited

Some employer plans impose a waiting period before new enrollees may use their health benefits. As of 2014, employers and group insurers will not be able to impose a waiting period longer than 90 days.

Health Benefit Exchanges for Individuals and Small Groups to Access Insurance

Starting in January 2014, individuals and small businesses (those with fewer than 100 employees) will be able to purchase qualified health plans through health benefit exchanges.

Individuals with incomes up to 133 percent of the federal poverty level (FPL), who are otherwise not eligible for Medicare, will be eligible for coverage through Medicaid.

Premium tax credits and cost-sharing subsidies will be available only for

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eligible individuals and families buying coverage in the exchange.

Premium assistance tax credits will be set on a sliding scale up to 400 percent of FPL. In 2011, 400 percent of FPL equaled \$43,560 for an individual and \$89,400 for a family of four.

Subsidies will reduce cost sharing on a sliding scale for people up to 250 percent of FPL.

Improvements in Benefit Structure

No more Lifetime and Annual Limits on Benefits

Since September 2010, group health plans and insurers offering group or individual coverage have not been allowed to impose lifetime limits on the dollar value of benefits.

In plan years that start before January 2014, group health plans and insurers offering group or individual² coverage may impose a restricted annual limit on the dollar value of essential health benefits.

The secretary of Health and Human Services (HHS) has defined “restricted annual limit” for essential health benefits for an individual in interim final rules. The rules³ set the limit at no less than \$750,000 for plan years starting in 2010 and gradually raise the limit to \$2 million for plan years starting in 2012. HHS has issued temporary waivers of the rules if it determined workers would otherwise face significant premium increases or a decrease in access to coverage. But as of 2014, annual limits on essential benefits will not be allowed.

Coverage of Preventive Health Services

As of September 23, 2010, group health plans and insurers offering group and individual policies must cover certain preventive services without any cost-sharing requirements.⁴ These services include the following:

- Evidence-based items and services with a rating of A or B in the current recommendations of the United States Preventive Services Task Force
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
- Evidence-informed preventive care and screenings for infants, children, adolescents, and women supported by the Health Resources and Services Administration

Comprehensive Coverage with Limits on Cost Sharing

As of January 2014, in order to sell coverage in state-based exchanges, health insurers will have to offer plans that cover essential health benefits. Insurers offering plans in the exchanges will also have to offer the plans in the market outside the exchanges. The following benefits must be covered:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Regulations will further define “essential health benefits,” but the law requires that the scope be equal to the scope of benefits in a typical employer plan. The secretary of the Department of Labor has

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conducted a survey to determine the benefits typically covered by employers to inform the definition of essential benefits. Plans may include additional benefits if they choose.

The essential benefits package must include a limit on cost sharing. The annual limit on cost sharing under the plan cannot be more than those in effect for Health Savings Accounts-qualified high-deductible health plans. (In 2011, the maximum out-of-pocket limit is \$5,950 for individual and \$11,900 for family coverage.)

Small-group market plans may not have deductibles of more than \$2,000 for an individual and \$4,000 for a family. These amounts will be adjusted in future years based on the average per capita health insurance premiums.

The law establishes four levels of essential benefit plans. The levels are Bronze, Silver, Gold, and Platinum; they cover 60, 70, 80, and 90 percent of the benefit costs of the plan (actuarial value), respectively.

In addition, the law allows for a catastrophic plan that covers essential benefits but at a lower actuarial value than the Bronze plan. Eligibility for this plan level is limited to those not yet 30 years old and to those certified as exempt from the individual responsibility requirement because other coverage options are not affordable or because of hardship.

Limitations on Factors That Can Be Used to Determine Premium Variation

Starting in 2014, insurers⁵ will be able to vary premiums only for small groups and individuals on the basis of four factors:

- Family size
- Geographic rating area, as set by the state

- Age, except that the highest rate for an adult may not be more than three times the lowest rate for an adult
- Tobacco use, except that the rate for users may not be more than 1.5 times that for nonusers

While health status will no longer be used to set premiums, the law allows for some variation in premiums related to health promotion and disease prevention.

Plans may vary premium and cost-sharing contributions for individuals as a reward for participating in wellness and health promotion or disease prevention programs.

Prior regulation allowed such rewards but limited any variation in premiums or cost sharing to no more than 20 percent of the total premium cost (employer and employee contributions). The new law permits rewards that vary enrollee costs up to 30 percent of the total premium cost. If the secretaries of HHS, Labor, and Treasury determine that it is appropriate, this could be increased to 50 percent.

Premiums Subject to Review and New Standards

Review of Premium Increases

The ACA requires HHS together with the states to establish a process to review “unreasonable” premium increases prior to their implementation. HHS has issued proposed regulations establishing the review process for determining how a proposed premium increase will be found to be unreasonable.

Insurers will have to submit proposed premium increases to the secretary of HHS and the state with a justification for “unreasonable” increases. They will also have to prominently post the justification for “unreasonable” increases on their Web sites. The secretary of HHS is responsible for public disclosure of this information for all health insurers.

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HHS has made an initial round of grants to states to assist with the rate review process, and is making additional grants available between now and 2014 to build on this work.

The premium review initiative also involves states providing the secretary with information on trends in premium increases in the state and making recommendations on whether an insurer should be excluded from participating in the exchange based on a pattern of excessive or unjustified premium increases.

Oversight of the Share of Premiums Spent on Care

To help ensure that consumers are getting value for their premium dollars, the law requires insurers to report to HHS the share of premiums spent on payments for care and services received by enrollees and on improving health care quality.

If spending on these activities does not account for at least 85 percent of premium revenues for large groups and 80 percent for small groups and individual market products, insurers will have to provide rebates to enrollees. Regulations have been issued that clarify which costs may be included and how they are to be treated in the calculation.

If a state can show that applying the 80 percent standard will destabilize its individual market, the law gives HHS authority to adjust the standard. HHS has established a process for reviewing state applications for adjustments.

As of 2010, the spending ratio of health care benefits to administrative costs will be calculated on an annual basis; as of 2014, it will be calculated for a three-year period to help smooth the effect of the move to new market rules.

Enhanced Consumer Protections

As of September 2010, group and individual health plans⁶ must have an internal process in place for consumers to appeal claims, as well as an external review process.

Interim rules with technical guidance on internal appeals standards and procedures and external review have been issued by the secretary of Labor for group plans and by the secretary of HHS for individual market plans. To allow plans and insurers to come into compliance, the departments have allowed a grace period for enforcement of the new standards.

People enrolled in health plans that require designation of a primary care provider may pick any participating primary care provider, including a pediatrician for children. In addition, women in such plans may not be required to get authorization to see a participating obstetrician/gynecologist.

Plans that cover benefits in a hospital emergency department have to cover emergency services without prior authorization, regardless of whether the provider participates in the plan. If the emergency services are provided out of network, cost sharing may not be greater than it would have been for a network provider.

Improved Access to Consumer Information

In 2010, the secretary of HHS, in consultation with states, began providing information to help consumers identify affordable coverage options.

On July 1, 2010, HHS launched the www.HealthCare.gov Web site. The site features information to help consumers understand coverage options, including

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private insurance plans, public programs, the Pre-Existing Condition Insurance Plan (PCIP), and community services available by zip code. It also has information for employers to learn about small business tax credits and the Early Retiree Reinsurance Program, as well as content on prevention, care quality, and understanding the new law.

Medicaid and Children's Health Insurance Program (CHIP) information includes eligibility criteria by state, a summary of services available in the programs, and links to more detailed program and contact information.

For high-risk pools, the name and contact information is posted, along with eligibility criteria, coverage description including limitations on coverage, and general premium information.

Since October 2010, more detailed information on benefits and pricing has been available for private options, showing estimated premiums and cost-sharing information as well as comparative information about plans. Additional details on Medicaid, CHIP, and PCIP (the new temporary high-risk pool program) are also available.

Consumers may also get help through independent state offices. HHS has awarded grants to states to create, support, or expand offices of health insurance consumer assistance or health insurance ombudsman programs.

Summary

Implementation of these broad insurance changes will entail a multitude of policy

and operational decisions and issuance of regulations and other guidance at both the national and state levels. This Fact Sheet provides an early overview of some of the changes that lie ahead related to insurance market rules; this information will be updated as health reform implementation proceeds and more details are known.

¹ The rules described here do not apply to private insurance products that supplement Medicare; they are regulated separately under Medicare law.

² The provisions related to annual limits do not apply to grandfathered health plans—plans that were in effect March 23, 2010—in the individual market.

³ The rule allows the secretary to waive the annual dollar limits specified if they would result in a significant decrease in access to benefits under the plan or health insurance coverage, or would significantly increase premiums for the plan or health insurance coverage.

⁴ These provisions do not apply to grandfathered health plans in group or individual markets.

⁵ These new rating factors do not apply to grandfathered health plans in group and individual markets.

⁶ This provision does not apply to grandfathered health plans.

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