New Requirements for Health Insurers - 2014

The Patient Protection and Affordable Care Act (ACA) includes a variety of important insurance industry reforms that will help ensure patients have access to affordable, comprehensive insurance and establish uniformity in the volatile individual and small group insurance markets. The new regulations, most of which will be implemented in plans beginning on or after January 1, 2014, will require insurers to accept and renew insurance policies for all applicants, prevent discrimination against people with pre-existing conditions, require that a sufficient amount of premiums is directed towards medical costs, prohibit insurers from basing premiums on a person's health status, and limit waiting times for coverage, among other regulations. Lastly, insurance plans will be required to offer one or more of four benefit categories with varying cost-sharing requirements. In November 2012, the federal government released a proposed rule, which is provided below, on a number of insurance market requirements, including premium rating rules and coverage of pre-existing conditions.

Guaranteed Issue and Renewability

Beginning January 2014, new individual and group insurance plans (not including self-insured plans or plans that were established on or before March 23, 2010, also known as grandfathered plans) will be required to accept all applicants. Additionally, insurers would be required to renew policies for individuals or plan sponsors (e.g. employers) as requested.

Premiums Cannot be Based on Enrollee Health Status

Beginning January 2014, individual and small group plans (those intended for small businesses) are prohibited from basing premiums on an enrollee's health status. This requirement does not apply to large group (except for large group insurance purchased through the Exchange, where applicable), self-insured, or grandfathered plans, which are those that existed on or prior to March 23, 2010. Individual and small group plans are permitted to vary premiums based on the following factors:

- An enrollee's age (limited to a ratio of 3 to 1 for adults)
- Whether the plan covers an individual or family
- Tobacco use (limited to a ratio of 1.5 to 1)
- Where the enrollee lives

Universal Prohibition on Pre-Existing Condition Exclusions

Beginning January 2014, individual and group plans - including self-insured and grandfathered plans - are prohibited from imposing pre-existing condition exclusions on all enrollees. A pre-existing condition is a medical condition that was present prior to health plan enrollment, regardless of whether or not it was diagnosed or treated.

Universal Prohibition on Annual Dollar Limits on Coverage

Beginning January 2014, individual and group plans – including grandfathered group and self-insured plans - are prohibited from imposing annual dollar limits on coverage

Eliminate Coverage Waiting Periods

Some insurance plans delay coverage of enrollees after they've been accepted into the plan. Beginning in January 2014, group plans – including grandfathered group and self-insured plans as well as grandfathered individual plans – cannot impose a waiting period of more than 90 days.

Essential Benefits Package

Beginning January 2014, qualified health plans (Exchange-based plans or those that meet the definition of "qualified"), individual and small group insurance plans (not including grandfathered or self-insured plans), are required to provide an essential benefit package to include the following categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness and chronic disease management, and pediatric services. According to the rule and a preceding Bulletin released by the federal government, states are permitted to choose a benchmark plan, such as the state's largest-enrollment small group health plan. All qualified health plans will have to provide benefits that are substantially equal to those of the benchmark plan. (View your state's benchmark plan here.) The minimum benefit package must also be equivalent to the scope in benefits of a typical employer health plan. In November 2012, the federal government released a proposed rule on essential health benefits and a final rule followed in February 2013. The College's comments on the rule are linked in the "Additional Resources" section.

Limits on cost-sharing for essential health benefits

Beginning January 2014, non-grandfathered health plans (including large group and self-insured group plans) must abide by annual cost-sharing limits that cap the amount of allowable yearly cost-sharing at those established for high-deductible plans, which is $6,250 for individual and $12,500 for family plans in 2013; the limits are indexed in subsequent years. Deductibles for small group market plans (those sold to small businesses) offering the essential benefit package are limited to $2,000 for an individual and $4,000 for family coverage. Limits will be indexed in subsequent years based on premiums. Preventive services are exempt from the deductible. Care provided by out-of-network physicians and other health care professionals is not subject to cost-sharing limits. In 2014, separate plan services providers (such as pharmacy benefit managers) may have their own cost-sharing requirements divorced from major medical coverage. Therefore, major medical coverage will have its own set of cost-sharing limits while a separate prescription drug plan, for example, will have its own set of cost-sharing limits.[i] If a separate benefit plan with a separate administrator does not have cost-sharing limits in place, then the plan is not required to implement limits in 2014.

Additional Resources

- *Department of Health and Human Services: Proposed rule on insurance market reforms.*

  http://www.regulations.gov/#!documentDetail;D=CMS-2012-0141-0001

- *American College of Physicians: Public comments on the proposed rule regarding essential health benefits, actuarial value, and accreditation.*

  http://www.acponline.org/advocacy/ehb_proposed_final.pdf

- *Kaiser Family Foundation: Essential Health Benefits: What Have States Decided for Their Benchmark?*

http://www.kff.org/healthreform/quicktake_essential_health_benefits.cfm

- *Kaiser Family Foundation: Health Reform Subsidy Calculator*.

  http://healthreform.kff.org/subsidycalculator.aspx

[i] United States Department of Labor. FAQs about Affordable Care Act Implementation Part XII. February 20, 2013. Accessed at http://www.dol.gov/ebsa/faqs/faq-aca12.html on October 7, 2013.