2014 Insurance Reforms under the Patient Protection and Affordable Care Act (PPACA)

Many of the provisions in the new National Health Care Reform law (PPACA) that begin to expand coverage to approximately 31 million Americans do not actually take effect until January 1, 2014. Three fundamental provisions have received much of the spotlight, including

- the requirement for people to have health insurance
- new health insurance Exchanges where people can purchase coverage—many people will receive federal subsidies to purchase coverage
- penalties for many employers that do not offer health insurance if their employees receive subsidized coverage in Exchanges

But significant changes will occur with the insurance market in 2014, and they go hand in hand with the reforms listed above. The insurance market will be subject to new rules on how to treat individuals and groups that apply for coverage. These rules must be applied consistently to all health insurers (there is a level playing field section in the new law) and are intended to ensure a stable, viable market that provides broad access to people purchasing health care coverage. Some insurance commissioners and state officials are also discussing the merits of phasing in some of these rules earlier than 2014 to avoid a large disruption of the market and "rate shock," which is a spike in the price of insurance due to all of the new changes starting at one time.

This paper focuses on the new rules insurers will follow beginning Jan. 1, 2014.

Guarantee Issue and Renewal

All carriers in the individual and small group markets will have to offer coverage to any individual or group that applies. However, PPACA permits carriers to limit this guarantee issue period to certain times each year using open enrollment and special enrollment periods. If used, carriers are not required to offer coverage to all applicants outside of these open enrollment periods.

Carriers will also have to continue to renew policies if the subscriber requests it.

Adjusted Community Rating

All carriers in the individual and small group markets will only be able to vary premiums charged to beneficiaries by family size, geography, tobacco use and age. Geography and family size will be fairly standardized while age can be used to vary the price of the premium for the oldest policy holder in a plan by up to three times the premium of the youngest policy holder. Tobacco users may also have their premium varied by up to 50 percent higher than a non-tobacco user. Other rating factors will be prohibited. For example, carriers are not allowed to charge women higher rates than men or very small groups higher rates than larger groups.

PPACA also prohibits health status rating, meaning people with serious illnesses, such as cancer or diabetes, cannot be charged higher premiums than healthier people. Carriers cannot use any past or current health events or indicators of health status, such as claims experience or medical history to charge people higher rates for coverage.

Prohibition on Pre-Existing Condition Exclusions

Carriers are prohibited from denying access to necessary medical services and items related to a pre-existing medical condition, regardless of the length of the exclusion period. This means that someone with high blood pressure newly receiving coverage from a carrier cannot be denied treatment for this condition unless all other persons in that plan, with and without high blood pressure, are also prohibited from receiving treatment for this condition.

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Excessive Waiting Periods

Some employer-provided health plans do not offer benefits to new employees until they have been with the company for an extended period of time. Under PPACA, these general waiting periods are limited. Group health plans offered either directly by an employer or indirectly from a health insurer cannot impose a waiting period for benefits to take effect longer than 90 days. This reduces the gap in coverage that many persons experience when they begin a new job.

Essential Benefits Package

PPACA specifies benefit requirements that carriers must offer if they are offering coverage in the individual and small group markets (for example, maternity coverage and hospitalization coverage). This includes medical services and items at varying cost-sharing options that are deemed by the Department of Health and Human Services (HHS) as the "essential health benefits package." HHS has still not defined what essential health benefits are.

Uniform Application of Rating Reforms

States will have to provide a level regulatory playing field for all carriers by applying the new reforms uniformly to all insurers in the market to promote fair competition and benefit consumers.

IMPACT IN MICHIGAN

Currently, only Blue Cross Blue Shield of Michigan (BCBSM) guarantee issues coverage year round. Health maintenance organizations (HMOs) guarantee issue one month each year. Commercial carriers are not required to guarantee issue. All carriers besides BCBSM are allowed to rate applicants on a host of factors, including health status. BCBSM instead uses adjusted community rating. All carriers in Michigan currently use pre-existing condition exclusions. However, BCBSM and HMOs limit these exclusions to six months, and commercial carriers limit these exclusions to twelve months.

Requiring all carriers to operate on a level playing field under these 2014 reforms will increase competition in Michigan, limiting the ability of some carriers to offer coverage to only healthy applicants and providing more choice for the sickest consumers most in need of health coverage.

KEY CONSIDERATIONS FOR STATES

States will need to take legislative and regulatory action to implement federal requirements on a local level. Additionally, state decision makers will determine the appropriate path for the numerous provisions in PPACA, such as, how to implement the provisions and also what should be legislated and what should be regulated.

As states review their policy options to require carriers to comply with the new requirements, a key decision will be determining the role of the Insurance Commissioner in the process, and whether state statute will detail how the Insurance Commissioner should regulate carriers, or if the details will be left for the Insurance Commissioner.

National organizations such as the National Association of Insurance Commissioners and American Academy of Actuaries will recommend guidelines and model laws that states can consider using. A strong stakeholder process will also help provide further recommendations and insight.

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