Key Insurance Market Reforms of the Affordable Care Act

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The following provisions of the Affordable Care Act (ACA) will be effective on January 1, 2014 and are applicable to all group plans and new plans on the individual health market.

Insurers may not:

• ***Deny coverage because of a pre-existing illness ("guaranteed issue").*** In the small group market (i.e., employers with 2 to 50 employees), the Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires that individuals with pre-existing conditions be eligible for insurance. However, prior to the ACA, most states allowed other insurers to deny coverage based on prior illnesses—some states had lists of more than 400 conditions for which coverage could be denied. States varied in their definitions of who could be denied coverage and in the availability of safety nets for those affected.

• ***Set lifetime or yearly limits on essential health benefits services.***

• ***Cancel insurance if an individual makes an honest mistake or left out information on an insurance form that is not directly related to health (i.e., no more frivolous cancellations).***

Insurers may:

• ***Implement risk ratings*** (i.e., community ratings) but are limited to considering age (limited to 3:1 ratio), geography, family composition, and tobacco use (1.5:1 ratio). Women may no longer be charged higher premiums than men.

Insurers must:

• ***Cover all "essential benefits"*** (e.g., preventive care)

• ***Cover preventive services free, with no co-pays or deductibles***. Such benefits include substance abuse counseling, cardiovascular disease risk screenings, colorectal cancer screenings, depression screening, sexually transmitted infections and HIV screenings, dietary counseling, and immunizations (adults and children).

• ***Account for health care costs through rate review and the 80/20 rule (the Medical Loss Ratio).*** Insurers must publicly justify any increase of 10% or more to a premium. The 80/20 rule means insurers must spend at least 80% (85% for insurers selling to large groups) of what they receive in premiums on health care and quality improvement instead of administrative, overhead, and marketing costs. If an insurer doesn't meet the 80/20 rule, insured individuals will have some of their premium dollars returned to them (e.g., a rebate check, reduction in future premium).

Grandfathered Plans Are Exempt from ACA Provisions. "Grandfathered" plans—plans that were in existence as of the date the ACA was enacted (March 23, 2010)—are exempt from most (not all) of the ACA's insurance provisions. A health plan must disclose in its plan materials if it considers itself "grandfathered."

Individuals Must Be Insured. Individuals will have to pay a small fine – as low as $95 the first year – if they do not choose their employers' insurance, Medicaid, or what is offered through the exchanges. There are exceptions for financial hardship and religious objections. The federal government will subsidize premium costs for those below 400% of the federal poverty level (about $46,000 for an individual and $94,000 for a family of four).

For more information go to "How does the health care law protect me?" at https://www.healthcare.gov/how-does-the-health-care-law-protect-me/ and "Federal subsidies: helping people afford health care" at http://101.communitycatalyst.org/aca_provisions/subsidies.

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