hpio health policy institute of ohio

Private Health Insurance Basics 2016

Fact sheet 3

Summary of Affordable Care Act reforms

What's inside? Affordable Care Act reforms on:
Obtaining and maintaining coverage • Premium rate setting • Covered services and cost sharing • Consumer protections

The Patient Protection and Affordable Care Act (ACA), enacted in 2010, established a series of minimum federal standards governing the issuance of and access to private health insurance coverage and health plan benefit structures, and outlining consumer protections.[1] The majority of the ACA health insurance reforms took effect on Jan. 1, 2014.

ACA reforms do not apply uniformly across all health plans and can vary by market segment (e.g. non-group, small group and large group). The table starting on page 2 provides a summary of ACA reforms, identifying the market segment(s) to which each reform applies. However, market reforms do apply uniformly to individual and small group health plans offered inside and outside of the ACA health insurance marketplace.[2]

A number of key ACA reforms not included in the table are addressed in other **Private Health Insurance Basics fact sheets**, including:

- Individual mandate (**fact sheet 4**)
- ACA health insurance marketplace (**fact sheet 4**)
- Employer mandate (**fact sheet 5**)

Key terms

Grandfathered refers to health plans that were in effect at the time the ACA was passed (i.e. individuals were enrolled in the health plan prior to enactment of the ACA) and that are exempt from many of the ACA reforms. Grandfathered health plans have limits on the changes they can make to their plan benefit structure and requirements around employer contributions, access to coverage and cost-sharing.[3] If certain changes are made, a health plan can lose grandfathered status. The Summary of ACA reforms table identifies which ACA reforms apply to grandfathered plans.

Grandmothered refers to health plans that can be renewed by consumers under the federal government's transitional policy outlined in 2013. The transitional policy allows certain consumers in the individual and small group markets to renew their non-ACA compliant and non-grandfathered plans through 2017.[4] More information on these plans can be found in the **Insurance Standards Bulletin Series – Information – Extension of Transitional Policy through Calendar Year 2017**.

Fully insured health plan refers to a plan purchased by an employer from an insurance company for which the employer pays claims and assumes the risk of providing health coverage to covered employees.

Self-insured health plan refers to a company that assumes the full risk of providing health coverage to its employees and pays employees' healthcare claims to providers through its own funds.

Summary of Affordable Care Act reforms impacting the private health insurance market

Market reform	Description	Non-grandfathered			Grandfathered	
		Non-group (individual)	Small group	Large group	Non-group (individual)	Group
Obtaining and maintaining coverage						
Guaranteed availability of coverage	Requires certain health issuers and plans to accept every consumer that applies for health coverage, although the issuer may restrict enrollment in coverage to open or special enrollment periods.	✓	✓	✓		
Guaranteed renewability of coverage	Requires certain health issuers and plans to renew or continue coverage at the option of the policy holder. An issuer may discontinue coverage only under certain limited circumstances.	✓	✓	✓		
Prohibition on rescissions	Prohibits health issuers and plans from retroactively canceling an enrollee's medical coverage unless the enrollee has committed fraud or made an intentional misrepresentation of material fact.	✓	✓	✓	✓	✓
Nondiscrimination based on health status	Prohibits certain health issuers and plans from establishing rules for coverage eligibility based on health status-related factors such as a person's medical condition, claims experience, receipt of health care, medical history, genetic information or disability status.	✓	✓	✓		
Prohibition on excessive waiting periods	Prohibits certain health issuers and plans from applying a waiting period before plan coverage can become effective that exceeds 90 days.		✓	✓		✓
Extension of dependent coverage	Requires that health issuers and plans offering dependent coverage of children make such coverage available for an adult child up to 26 years of age.	✓	✓	✓	✓	✓
Premium rate setting						
Rating restrictions	Certain health issuers and plans are required to use adjusted community rating rules to set premium rates and are prohibited from setting rates based on health factors. Adjusted community rating rules allow setting of rates based on age, tobacco use, geographic rating area and whether coverage is for an individual or family.	✓	✓			
Rate review	Health plans are reviewed annually by the federal government or a state to ensure that proposed increases in premiums for health insurance coverage are not unreasonable. Justifications for premium rate increases provided by health plan issuers are publicly disclosed.	✓	✓			

Key

Only fully insured | Fully insured and self-insured

Summary of Affordable Care Act reforms impacting the private health insurance market (cont.)

Market reform	Description	Non-grandfathered			Grandfathered	
		Non-group (individual)	Small group	Large group	Non-group (individual)	Group
Covered services and cost-sharing limits						
Essential health benefits	Health plans are required to provide coverage for a core set of essential health benefits (EHB) that must include 10 broad benefit categories outlined by the federal government. Health plan EHB coverage is also based on a state-specific benchmark plan, which sets a floor for minimum benefit coverage.	✓	✓			
Coverage of preventive health services	Certain health issuers and plans must provide coverage for certain preventive health services without imposing any cost-sharing requirements on plan enrollees.	✓	✓	✓		
Prohibition of preexisting condition exclusions	Certain health issuers and plans are prohibited from limiting or excluding an individual from receiving benefits relating to a condition based on the fact that the condition was present before the date of enrollment into the health plan, whether or not any medical advice, diagnosis, care or treatment was recommended or received before such date.	✓	✓	✓		✓
Annual limit on cost-sharing	Health plans are required to comply with annual cost-sharing limits that restrict the amount individuals can be required to pay out-of-pocket for certain covered health services.	✓	✓	✓		
Actuarial value requirements	Certain health issuers must ensure that the plans they offer comply with one of four levels of actuarial value. Actuarial value refers to the generosity of a plan's coverage including cost-sharing thresholds. Actuarial value is defined as the percentage a health plan will pay towards covered medical expenses, based on a standard population.	✓	✓			
Prohibition on lifetime limits	Health issuers and plans are prohibited from setting limits on the amount they will spend on essential health benefits for an individual during the entire time an individual is enrolled in the plan.	✓	✓	✓	✓	✓
Prohibition on annual limits	Certain health issuers and plans are prohibited from setting limits on the amount they will spend on essential health benefits for an individual over the course of a year.	✓	✓	✓		✓

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Summary of Affordable Care Act reforms impacting the private health insurance market (cont.)

Market reform	Description	Non-grandfathered			Grandfathered	
		Non-group (individual)	Small group	Large group	Non-group (individual)	Group
Consumer protections						
Summary of benefits and coverage	Health issuers and plans must provide to applicants, enrollees and policyholders or certificate holders a uniform summary of benefits and coverage that accurately describes the benefits and coverage under the applicable health plan or coverage.	✓	✓	✓	✓	✓
Medical loss ratio	Health issuers are required to report information on their medical loss ratios (MLR) to the U.S. Secretary of Health and Human Services. MLR is defined as the percentage of premium revenue spent on healthcare services by an issuer, in the aggregate, in a particular market. The minimum MLR is 80 percent for the individual and small group markets and 85 percent for the large group market. Issuers not meeting the MLR minimum in a market must provide refunds to their customers in that market.	✓	✓	✓	✓	✓
Appeals process	Certain health issuers and plans are required to implement an effective appeals process for appeals of coverage determinations and claims.	✓	✓	✓		

Key

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Note: This figure provides a summary of ACA reforms to the private health insurance market for informational purposes only and is not intended to be a comprehensive statement of law or policy.
Sources: Adapted from Mach, Annie L., and Bernadette Fernandez. Private Health Insurance Market Reforms in the Patient Protection and Affordable Care Act (ACA). Washington, D.C.: Congressional Research Service, 2016. See also, Mach, Annie L., and Namarata K. Uberoi. Overview of Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (ACA). Washington, D.C.: Congressional Research Service, 2016.

Sources

1. Mach, Annie L., and Bernadette Fernandez. *Private Health Insurance Market Reforms in the Patient Protection and Affordable Care Act (ACA).* Washington, D.C.: Congressional Research Service, 2016. https://www.fas.org/sgp/crs/misc/R42069.pdf
2. Ibid.
3. Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Office of Consumer Information and Insurance Oversight, Department of Health and Human Services. Rules and Regulations. "Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act." Federal Register 75, no. 116 (June 17, 2010): 34538. https://www.gpo.gov/fdsys/pkg/FR-2010-06-17/pdf/2010-14488.pdf. See also, Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Office of Consumer Information and Insurance Oversight, Department of Health and Human Services. Rules and Regulations. "Amendment to the Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act." *Federal Register* 75, no. 221 (November 17, 2010): 70114. http://edocket.access.gpo.gov/2010/pdf/2010-28861.pdf
4. A state can elect to extend the transitional policy for shorter periods of time than designated by the federal government. States may also limit the transitional policy to only the individual market or only the small group market. Counihan, Kevin. Center for Consumer Information and Insurance Oversite. "Insurance Standards Bulletin Series – INFORMATION – Extension of Transitional Policy through Calendar Year 2017." Bulletin, February 29, 2016. https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/final-transition-bulletin-2-29-16.pdf