



FEDERAL HEALTH CARE REFORM: HEALTH INSURANCE REQUIREMENTS

by Elizabeth Burger

In March 2010, the Affordable Care Act (ACA) was adopted by the U.S. Congress and signed by the President. The ACA enacted a number of provisions to increase access to health care coverage through private insurance and public health care programs.

This issue brief, part of a series on the ACA, discusses the act's requirements related to health insurance coverage. Other issue briefs in this series address changes to Medicaid and requirements for the establishment of state-based health insurance exchanges.

The ACA's Requirements for Insurance Coverage

Individual coverage. The act requires individuals to maintain health insurance meeting certain requirements beginning in 2014. Those who do not maintain adequate coverage are subject to a financial penalty. The penalty is the greater of:

- \$695 per year up to a maximum of three times that amount (\$2,085); or
- 2.5 percent of household income.

The penalty is phased-in, taking full effect in 2016, and is not assessed when an individual:

- claims an exemption based on his or her religious beliefs;
- is not covered for a period of less than three months;

- is required to pay more than 8 percent of his or her household income toward insurance premiums;
- has a taxable income of less than 100 percent of the federal poverty level (FPL);
- is a Native American; and
- documents a hardship with respect to obtaining coverage.

Employer coverage. The act requires employers with more than 200 employees to automatically enroll new employees in a health care plan, continue coverage for current employees, and provide information about how the employee can opt out of coverage. Employers must also provide information to employees about the health insurance exchange that each state is required to establish.

The act imposes fines on large employers (employers with 50 or more employees) if they have an employee who receives a tax credit to purchase health insurance through the exchange. The penalty varies based on whether the employer offers health insurance, but generally is either:

- \$2,000 per full-time employee, excluding the first 30 employees from the assessment; or
- \$3,000 for each employee who receives a premium tax credit.

Small employers are not subject to penalties for failing to offer health insurance coverage. Tax credits for the cost of health insurance are available for

businesses with 25 or fewer employees and pay an average annual wage of less than \$50,000.

The ACA's Changes to Health Insurance Regulation

The ACA enacted a variety of changes to regulations governing health insurance plans, including changes to coverage requirements, oversight of rates, and required reporting on plan premiums and expenses.

Health plan coverage requirements. Beginning September 23, 2010, the ACA:

- prohibits plans from establishing lifetime or annual limits on most benefits;
- prohibits an insurer from rescinding coverage, except in the case of fraud;
- requires insurers to provide coverage, without any cost sharing, for immunizations and other preventative health services;
- requires health plans that offer coverage for dependent children to continue coverage for an adult child up to 26 years of age; and
- prohibits pre-existing coverage limitations for dependents under 19 years of age.

Beginning in 2014, the ACA:

- prohibits plans from applying coverage limitations for pre-existing conditions;
- specifies that premiums may not vary based on a person's health status or medical condition and only on the following factors:
 - family size;
 - geographic area;
 - age; and
 - tobacco use;
- requires health insurers to offer coverage to any individual or group that applies, and to renew coverage at the option of the plan sponsor or covered individual; and
- prohibits a plan from applying a waiting period for coverage longer than 90 days.

Health insurance rate review. The ACA requires the implementation of an annual review process of insurance premiums to determine if increases in rates are unreasonable. Grants will be awarded to states to provide information and recommendations on rate reviews and to establish centers to collect, analyze, and organize medical reimbursement information.

Medical loss ratios and rebates. The act requires each insurer to publicly report the insurer's premium/loss ratio. Insurers must provide an annual rebate to each plan enrollee if the premium/loss ratio is less than 85 percent for large group markets or 80 percent for small group and individual markets.

Consumer assistance. The act implemented a number of provisions to allow consumers to access information about insurance coverage. Specifically, the act requires:

- insurers to implement an effective process through which enrollees can appeal coverage determinations and claims;
- the establishment of a website to allow residents of a state to identify affordable coverage options in the state;
- insurers to provide uniform summary of benefit forms; and
- the distribution of grants to states to establish or expand offices or ombudsmen to assist consumers with insurance-related issues.

High-risk pool. The act requires the establishment of high-risk pools to provide health insurance coverage to individuals with pre-existing conditions who cannot obtain coverage elsewhere. The high-risk pool will be in place until 2014, when state health insurance exchanges are established.

In July 2010, Colorado formed a high-risk pool called GettingUsCovered to comply with the provisions of the act. The pool is jointly administered by Rocky Mountain Health Plans and CoverColorado. In order to qualify for coverage through the pool, individuals must be U.S. and Colorado residents, have been uninsured for at least six months, and have a pre-existing condition that has prevented them from obtaining commercial health insurance in the past.