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Economic Affairs Interim Committee

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Background Material for Insurers' Review of Affordable Care Act Impacts and Next Steps

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As the U.S. Supreme Court justices hold the fate of the Affordable Care Act in their hands, insurers presumably are making contingency plans for the question "what happens next"? That question is germane whether the Affordable Care Act or portions of it are upheld or the Affordable Care Act is overturned in part or in whole. Provided below are components of the Affordable Care Act that particularly impact insurers, along with a brief description[1] to help provide fodder for questions on the panel discussion of insurers on June 11.

- **Individual Mandate** - The Affordable Care Act included a requirement for individuals to have insurance coverage that meets minimum standards used by health insurance exchanges. If an individual does not have this type of insurance, there is a tax penalty. Exemptions for the tax penalty are provided to Indians and individuals who can demonstrate financial hardship. The requirement is seen as a way to prevent individuals from buying insurance only when they get sick. Also, if more people buy insurance then the higher costs that insurers face with other Affordable Care Act requirements--like coverage regardless of preexisting conditions--can be spread among more people, which theoretically keeps costs from going as high as they would with a smaller insured pool of sicker and older individuals.
- **Health Insurance Exchange** - The marketplace where individuals and small businesses can compare qualified health plans. Some states already are moving forward with health insurance exchanges while others, like Montana, are expecting a federally operated health insurance exchange. How are health insurers that operate in different states dealing with the different statuses?
- **Coverage of those under 19 with pre-existing conditions.*** The rule applies whether or not the pre-existing condition is know or was treated before the insurance application was submitted. There is an exception for "grandfathered" individual insurance policies.
- **Coverage of those 19 and over with pre-existing conditions.** This goes into effect in 2014.
- **Coverage of children under a parent's policy until the child is 26.*** The Affordable Care Act provides that a child may stay on a parent's plan until the child turns 26 years old (whether married or not) unless the child's parents have a group health plan and the child is offered insurance at work (that exception applies only for employer group health insurance and only until 2014.) Montana law 33-22-14(5) currently provides that a "dependent" includes:
  (b) an unmarried child under 25 years of age:
  (i) who is not an employee eligible for coverage under a group health plan offered by the child's employer for which the child's premium contribution amount is no greater than the premium amount for coverage as a dependent under a parent's individual or group health plan;
  (ii) who is not a named subscriber, insured, enrollee, or covered individual under any other individual health insurance coverage, group health plan, government plan, church plan, or group

[1]Information for some terms is from HealthInsurance.Org, http://www.healthinsurance.org/glossary/. For other terms see the Affordable Care Act timeline at http://www.healthcare.gov/law/features/costs/limits/index.html.

health insurance;
(iii) who is not entitled to benefits under 42 U.S.C. 1395, et seq.; and
(iv) for whom the insured parent has requested coverage;

- **No lifetime limits.*** Many policies have had lifetime limits of $2 million or some other amount. The Affordable Care Act removed lifetime limits on essential health benefits (a federally defined term) on policies issued or renewed on or after Sept. 23, 2010.
- **Restricted annual limits for essential benefits.*** Annual dollar limits for employer-sponsored group health plans and individual health insurance plans issued between Sept. 23, 2011 and Sept. 23, 2012 may have limits up to $1.25 million a year. Prior to Jan. 1, 2014, policies or plans issued on or after Sept. 23, 2012, may have limits up to $2 million a year. After Jan. 1, 2014, no annual dollar limits are allowed on essential health benefits. Grandfathered individual market policies are excepted.
- **Rate Review.**** Starting Sept. 1, 2011, health insurers had to justify to either state authorities or the federal government if the state does not have rate review authority (as Montana does not) any increase of 10% or more. The explanations are posted on HealthCare.gov. Grandfathered plans are exempt from the federal state review requirement.
- **Medical Loss Ratios.***** The individual and small employer group markets must use 80% of their premium dollars to pay customers' medical claims and for activities that improve the quality of care; the rest may be spent on administrative costs that include salaries, marketing, agent commissions, and profits (if a for-profit insurer). The large employer group market must use 85% of its premium dollars for customers' medical claims and activities that improve the quality of care.
- **Gender Equity.** As of Jan. 1, 2014, insurers no longer would be able to charge more based on gender or health status. Montana law 49-2-309 already prohibits discrimination solely on the basis of sex.
- **No cost-sharing for preventive care and wellness.*** All nongrandfathered health plans must cover certain preventive services, including mammograms and colonoscopies, without charging a deductible, a co-pay, or coinsurance.
- **Rescissions limited to fraud or misrepresentation of material fact.*** The Affordable Care Act's intent is to prevent a health insurer from canceling coverage for minor, unintentional mistakes on a policy. Fraud or intentional misrepresentation of material fact remain reasons to retroactively cancel health insurance policies. The Affordable Care Act is stronger than Montana law on rescissions.

Among questions for the Economic Affairs Committee to ask, on the premise that the Affordable Care Act is upheld by the U.S. Supreme Court, are:

- If the Affordable Care Act is upheld generally, is your insurer planning on offering a qualified health plan on the health insurance exchange? Would you also offer a similar insurance plan in Montana but not through the exchange--depending on what policies are in place from the federal government or the state?
- If the Affordable Care Act is upheld generally, are you planning on withdrawing from any particular market?
- If the Affordable Care Act is upheld generally, how would you expect to compete if all insurers in the state offer the essential health benefits package required by the Affordable Care Act?
- If the Affordable Care Act is upheld generally, do you expect small employers to stop offering health insurance and seek to move their employees to purchase insurance on the health insurance exchange?
- If the Affordable Care Act is upheld generally, how does your company plan to work with insurance producers?

The provisions with single asterisks (*) behind them have been in effect for all policies issued or renewed after September 23, 2010. Rate review Medical loss ratios (***) have been in effect since January 1, 2011.