2013: Year Of The Health Regulations

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Since the passage of PPACA, regulations to implement the law have been slow in coming. As the 2014 implementation date approaches, however, the pace has quickened. In late November 2012, three key regulations were issued covering reforms in the private health insurance market, health services that are required to be covered by policies, and standards for wellness plans offered by employers offering group health insurance. This article briefly discusses the private health insurance market reforms and the coverage requirements.

Private health insurance market reforms

A key provision of PPACA is that health insurance is to be available to everyone and guaranteed renewable. Key aspects of "being available" include who may buy, when they can buy, and how much they pay. The regulations issued in November affect the individual and small employer in all those areas. The definition of "individual purchasers" is straightforward: people buying insurance on their own for just themselves or their families. The definition of "small employer groups" is employers with 2 to 50 employees; however, there is a slight change in definition of "group" that has a large impact on current association groups.

Currently, small employers can purchase health insurance through associations such as a local Chamber of Commerce or professional associations such as a local bar association. The number of employees covered by way of the association usually results in the association being considered a "large group" for the purposes of health insurance regulations. Under the new regulations, the definition will be applied to the "ultimate purchaser" of the coverage and not to the association itself. The small local law office, doctor's office, or corner grocery store will now clearly be considered a small employer, even if health insurance is purchased through an association.

Small groups must be allowed to purchase insurance at any time, but there can be restrictions on when individuals can buy. It is common for people enrolling in group insurance to choose their coverage during an "open enrollment" period, and that choice may not be changed until the next enrollment period unless the person experiences a qualifying life event such as marriage, divorce, birth of a child, or the loss of eligibility for other health insurance. These provisions now apply to individuals purchasing health insurance and are designed to discourage people from delaying the purchase of coverage until their ambulance ride to the hospital.

The insurer may deny coverage if the person applying does not live within a reasonable distance from the health care providers in the network. The insurer may also deny coverage if the providers can demonstrate that they do not have the capacity to take on additional members.

Premium rating

Insurers are very limited regarding how premium rates can vary among purchasers. Insurers typically vary their premiums based on the experience of those covered by the policy. Under the new regulations, the pool for measuring that experience must include all individual health policies offered by that company in the state. Similarly, an insurer's small group experience must include all small group plans it sells in the state. Insurers may not run separate risk pools for policies offered through the exchange and those sold outside the exchange. Insurers are also required to use "modified community rating," meaning that premiums may vary among individuals based on only a few factors. Factors that are specifically disallowed are ratings based on pre-existing conditions, occupation, sex, duration of coverage (or lack of previous coverage), and credit or other financial factors. Factors that are specifically allowed include:

- Geography. Premiums can vary based on the geographic area in which a policy is sold. Thus, using New York as an example, premiums in New York City can be higher than premiums in rural western portions of the state, reflecting the difference in health care costs in those areas.

- Age. Insurers may vary premiums by age, but only within limits. The premium for somebody aged 64 may not be more than three times the premium for somebody aged 21.
- Tobacco use. Insurers may place a surcharge on premiums of up to 50% for people who use tobacco. The regulations do not define tobacco use and do not specify what methods insurers can use to verify information on tobacco use. Insurers may place different surcharges based on the age of the insured, and the surcharge is not included when testing whether the base premium meets the 3-to-1 rule on age ratings. If the person is eligible for a premium subsidy, the amount of the subsidy will be up to the amount of the base premium and will not cover the tobacco surcharge.
- Family status. An additional premium may be charged for every family member aged 21 and above, essentially as if each adult had a separate policy. An extra premium can be charged for each child, to a maximum of three. Any children beyond the third child are covered at no charge.

The possible premium impact of PPACA
With health insurance regulated at the state level, the states have been free to experiment with a variety of rating methods. In the 1990s, eight states enacted guaranteed issue and community rating similar to what will be required nationwide under PPACA. According to an analysis by Merrill Matthews and Mark Litow and published in a January 13, 2013, Wall Street Journal article, those states experienced large increases in premiums. They compared premiums in those states that already have provisions similar to those under PPACA and found premiums were more than twice as large compared to other states that did not have those provisions. The article also referenced an Oliver Wyman study, according to which the average premium increase in the individual market due to PPACA will be roughly 50%. In its annual investor conference on December 12, 2012, Mark Bertolini, CEO of Aetna, said “We’re going to see some markets go up by as much as 100%.”

Essential health benefits: paying more to get more
Another source of premium increases stems from the fact that many products currently sold have fewer benefits than those required under PPACA. Starting in 2014, individual policies sold must cover 10 “Essential Health Benefit” categories:

- ambulatory patient services
- emergency services
- hospitalization
- maternity and newborn care
- mental health and substance abuse disorder services
- prescription drugs
- rehabilitative and habilitative services and devices
- laboratory services
- preventive and wellness services and chronic disease management
- pediatric services, including dental and vision care

The regulations issued so far do not give specific details on precisely what services fall in each category. Instead, the regulations specify that states are to designate a “benchmark plan” that will be used as a standard. The state may choose a benchmark plan from among the most popular small group health insurance products, state employee health benefit plan options, federal employee health benefit plan options, and the largest commercial HMO plan sold in the state. Once the benchmark plan is chosen, policies will need to add benefits to cover any that are missing in each essential health benefit category.

More regulations to come
Insurance exchanges are supposed to become operational on January 1, 2014, which means companies will need to have their products designed and priced by late 2013. Many additional regulations will need to be issued to fully define how the health insurance market will work in this new environment. February 10 begins the Chinese year of the snake. At least in the U.S. health insurance market, 2013 will be the “year of the regulation.” Insurers and employers need to pay attention as these regulations emerge to avoid being bitten by rules they weren’t expecting.

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