Health Reform

Guidance on New Health Insurance Market Rules

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The Department of Health and Human Services issued proposed regulations to implement health care reform's considerable changes to the way health insurance will be packaged and sold beginning in 2014 for small, insured, non-grandfathered groups and Exchange plans. It is important to note that changes may also apply to large insured plans in 2017.

Background

Effective for plan years beginning on or after January 1, 2014, insurance carriers will be subject to new underwriting rules with respect to small, insured, non-grandfathered groups. Instead of using experience rating, which is a method used to determine pricing of premiums for different groups or individuals based on the group's or individual's claims history, carriers will use community rating, which requires carriers to offer health insurance policies within a given territory at the same price to all persons without medical underwriting, regardless of health status. Additionally, rating variations will be restricted to (a) benefit coverage elected (plan and tier), (b) geographic area,, (c) age, limited to a ratio of 3 to 1 for adults, and (d) tobacco use, limited to a ratio of 1.5 to 1. Further, insurance carriers offering non-grandfathered coverage in the group market are subject to certain guaranteed-renewability requirements.

Proposed Regulations: Rating

All non-grandfathered health insurance coverage in the individual and small group markets is subject to the requirements in this section. Additionally, health insurance coverage in the large group market is subject to these requirements, inside and outside an Exchange, if a state permits such coverage to be offered through an Exchange starting in 2017. Self-insured plans are not subject to these requirements.

Rating Factors

Rating factors currently in use by carriers, such as health status, claims experience, gender, industry, occupation, and duration of coverage will no longer be permissible.

Single Risk Pool

Effective January 1, 2014, health carriers are required to establish a single risk pool for all non-grandfathered coverage (both inside and outside the Exchange) in the small group market (and a separate single pool for the individual market, unless the state opts to merge the risk pools).

Tobacco Use

The rating variation for tobacco use applies based on the portion of the premium that is attributable to each family member covered under the plan. A state law may prescribe a narrower ratio or prohibit varying rates for tobacco use altogether. Further guidance is needed to define tobacco use and how carriers may obtain tobacco use information from participants. If a carrier charges a higher premium for tobacco users in the small group market, it would be required to give tobacco users an opportunity to avoid the higher cost by participating in a wellness program for quitting tobacco use.

Guaranteed Availability and Renewability

Health carriers generally would be prohibited from denying or renewing coverage to people because of a preexisting condition or any other factor. Carriers must offer coverage to and accept any individual or employer in the state that applies for such coverage, regardless of health status, risk, or medical claims and costs, with limited exceptions. Carriers would be required to offer all products that are approved for sale in the applicable market. Carriers are required to renew all coverage except for nonpayment of premium, fraud, failure to comply with contribution/participation requirements (group only), moving out of the service area, or if the carrier stops offering the type of coverage or exits the market.

Proposed Regulations: Special Enrollment

In addition to the existing special enrollment triggers under HIPAA (loss of other group coverage, gaining a spouse or dependent, gaining premium assistance under Medicaid or a state's children's health insurance program (SCHIP), losing eligibility for Medicaid or SCHIP), under the proposed regulations, carriers would have to offer special enrollment periods to individuals experiencing a COBRA qualifying event (e.g., divorce or death of the employee). Note that COBRA qualifying events should also be HIPAA Special Enrollment Events; thus, this addition appears to be redundant.