The impact of national health reform on Ohio

updated August 24, 2010

Insurance market reforms

How will the insurance market change as a result of national reform?

The federal Affordable Care Act (ACA) reforms the health insurance marketplace to prohibit health plans from avoiding or dropping high-cost beneficiaries and creates new incentives to cover everyone. New health plan regulations increase consumer power and protections and compel insurers to share responsibility for national coverage as well as access to health care services. Most of these reforms will go into effect this year when employers and individuals renew their health insurance policies.

Coverage expansion

This fact sheet is one in a series created by the Health Policy Institute of Ohio to examine the coverage expansion implications of national health reform on Ohio

Federal reform timeline

2010

- **Cover young adults:** Provide dependent coverage for adult children up to age 26 for all individual and group policies. Adult children do not need be claimed as dependents on federal income taxes and they do not have to be living with their parents. Adult children may be married, although their spouses and children would not be covered. Ohio law provides for coverage of young adults up to age 28.
- **Cover children with pre-existing conditions**: Prohibit exclusions based on pre-existing conditions for children under age 19 ("**guarantee issue**").
- Establish a **temporary high-risk pool** to provide health coverage to individuals with pre-existing conditions.
- **Maintain existing coverage**: Limit insurers' ability to retroactively cancel coverage ("**rescission**"), and prohibit placing lifetime limits on coverage. Health plans must drop annual limits as of January 1, 2014.
- **Affordable prevention:** Require qualified health plans to eliminate cost-sharing for preventive services including evidence-based preventive services, routine vaccines, and preventive services particular to women and children.
- **Monitor premiums:** Establish a process for states to review increases in health plan premiums and require plans to justify those increases. States may exclude certain plans from exchanges based on unjustified increases.
- **Provide rules and resources for consumer appeals:** Consumers will have the right to appeal decisions, including claims denials and rescissions, made by their health plans. This includes a right to appeal internally (within the health plan) or to an external, independent body.

2011

- **Keep administrative costs low:** Require health plans to spend at least 85% of premium dollars on clinical services and quality ("**medical loss ratio**") for large group plans (80% for small group or individual plans) and provide consumer rebates if the medical loss ratio drops below these levels.

2013

- **Simplify health insurance administration:** Adopt a single set of operating rules for eligibility, verification, and claims status; health claims or equivalent encounter information; enrollment and disenrollment in a health plan; and health plan premium payments.

2014

- **Cover adults with pre-existing conditions:** Guarantee issue to all applicants, regardless of age, gender, health status, or other factors that may predict use of health services.
- **Limit premium variation:** Rates within the individual and small group markets and the exchanges may only vary based on age (limited to 3:1), regional costs, family composition, and tobacco use (limited 1.5:1) ("**community rating**").
- **Limit deductibles:** Cap small group market health plan deductibles at $2,000 for individuals and $4,000 for families.

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Grandfathered Plans

Why were special considerations made for plans in effect on the date of enactment (March 23, 2010)[1]?

- Aimed at providing market stability and flexibility to consumers and businesses
- Employers and plans may continue to make routine changes on cost-sharing, co-payments, and deductibles
- Plans will lose grandfather status if they choose to significantly cut benefits or increase out-of-pocket spending for consumers

PROVISIONS THAT MUST BE MET by grandfathered plans

1. No “restricted” annual limits (limits on coverage below a standard set by the HHS Secretary)
2. No lifetime limits on coverage
3. No rescission of coverage due to illness or unintentional mistake on application
4. Extension of coverage to young adults up to age 26
5. No exclusion of coverage for children with pre-existing conditions
6. Employer requirement to offer coverage
7. Excise taxes on high-cost plans
8. Medicare Part D tax provisions
9. Limits on FSAs (Flexible Savings Accounts), HSAs (Health Savings Accounts), HRAs (Health Reimbursement Accounts)

PROVISIONS THAT DO NOT APPLY to grandfathered plans

1. No annual limits on essential benefits (after 2014)
2. Prohibition of pre-existing condition exclusion or other discrimination based on health status
3. Cover preventive care without beneficiary cost share
4. Allow female beneficiaries to select their OB/GYN as their primary care physician; allow children’s pediatrician to serve as primary care physician
5. Automatic enrollment of employees of firms with 200+ FTEs
6. Early retiree reinsurance program
7. Reporting value of provided health benefits for 2011 tax year
8. Provide enrollees with a summary document of benefits

For more information on grandfathered plans,
http://www.healthreform.gov/newsroom/keeping_the_health_plan_you_have.html

1 US Department of Health and Human Services, News Release, June 14, 2010. “Regulation on “Grandfathered” Health Plans under the Affordable Care Act.

Considerations:

- Information shared in this fact sheet is based on the most updated version of federal law and analysis of Ohio data. As regulations are written and language clarified, there may be changes in HPIO’s interpretation of the impact on Ohio.