Health Insurance Company Responsibilities Under the Affordable Care Act

Affordable Care Act Basics: Part 3 of 8

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New Mexico's Health Insurance Marketplace

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Introduction

The Affordable Care Act (ACA) requires health insurance carriers to provide standard information so consumers can easily understand their coverage and compare it to other available options. They are also required to provide coverage that offers a core, comprehensive set of benefits to consumers, including those with pre-existing conditions.

Main Topics

1. Carrier Requirements
2. Helping Consumers Understand Coverage
3. Required Coverage
4. Pricing, Rate Increases, and Premium Income Allocation

Carrier Requirements

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- Health insurance companies are also referred to as "carriers."
- The Affordable Care Act (ACA) requires most carriers and the plans they offer to:
  - Provide a standardized Summary of Benefits and Coverage (SBC) so consumers can easily understand their coverage and compare it to other available options.
  - Provide coverage for consumers with pre-existing conditions.
  - Refrain from terminating coverage after they have already agreed to cover consumers (unless an exception applies).

Carrier Requirements (Continued)

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- The ACA limits the premiums that carriers can charge and requires the rates be reviewed by insurance regulators. It also requires most carriers and the plans they offer to:
  - Offer a core, comprehensive set of benefits, called essential health benefits (EHB), when offering coverage to individual consumers and small employers.
  - Prohibit annual and lifetime dollar limits on coverage of EHB.
  - Have limitations on the premiums they can charge and review of rate increases.
  - Use most of the premium to pay for health care.

Helping Consumers Understand Coverage

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- Carriers are required to provide clear, consistent, and comparable information about consumers' health benefits and coverage by providing a standard SBC for each plan they offer.
- Each plan's SBC must be written and presented in a standard format and use basic terms.
- Carriers must also provide consumers with a uniform glossary of commonly used terms.

Required Coverage: Pre-Existing Conditions

- Pre-existing Conditions
  - Pre-existing conditions are health problems (e.g., diabetes or cancer) that started before an individual's health insurance went into effect, regardless of whether medical advice or treatment was received or recommended.
  - **Remember**: Carriers can no longer refuse to sell coverage to consumers with pre-existing conditions or charge more for that coverage.

Required Coverage: Recission of Coverage

- Rescission of Coverage
  - Rescission is the retroactive cancellation of a health policy after the policy has been purchased and is in effect.
  - With limited exceptions, carriers must also refrain from rescinding a consumer's coverage as long as any premiums are paid.
  - Under the ACA, carriers can only cancel a consumer's coverage retroactively if the consumer committed fraud and/or made an intentional misrepresentation of material fact.

Required Coverage: EHB

- EHB
  - The ACA requires health plans sold to individuals or small employers to cover at least ten comprehensive, core services, or EHB.
- The ACA requires that EHB:
  - Reflect appropriate balance among the ten EHB categories;
  - Do not discriminate based on age, disability, or expected length of life; and
  - Consider the health care needs of diverse segments of the population.

Required Coverage: EHB (Continued)

The EHB include:

1. Ambulatory patient services (outpatient care without being admitted to a hospital)
2. Hospitalization (such as surgery and overnight stays)
3. Mental health and substance use disorder services, including behavioral health treatment (includes counseling and psychotherapy)
4. Emergency services
5. Laboratory services
6. Prescription drugs
7. Pre-natal, maternity, and newborn care (both before and after birth)
8. Preventive and wellness services and chronic disease management
9. Rehabilitative and habilitative services and devices (to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)
10. Pediatric services, including oral and vision care (adult dental and vision coverage are not considered EHB)

Required Coverage: Limits

Definitions:

- Annual limits are dollar limits on what plans will pay for covered benefits over the course of the plan year.
- Lifetime limits are dollar limits on what plans will pay for covered benefits during the entire time consumers are enrolled in a plan.

Required Coverage: Limits (Continued)

- Carriers generally cannot set dollar limits on what they spend for coverage of EHB.
  - This includes both annual and lifetime limits.
  - However, carriers can still set lifetime or annual dollar limits on what they will spend on covered benefits that are not considered EHB.
- **Note**: While no dollar amount limits are allowed for EHB, some services can have limits on the number of units allowed.
  - For example, a carrier can limit physical therapy services to 20 visits annually.

Pricing, Rate Increases, and Premium Income Allocation (1 of 3)

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- The ACA provides two ways to hold insurance companies accountable and help keep consumer costs down:
  - Rate Review
  - The 80/20 rule

Pricing, Rate Increases, and Premium Income Allocation (2 of 3)

- Rate Review
  - Any proposed rate increase by individual or small group market carriers above a certain percentage will be reviewed by the state insurance department to make sure it is justified. Carriers must state their justification for premium increases before they impose them. They also must post them prominently on their websites.
  - Carriers must price coverage based on geographic areas, with an age ratio of no more than 3:1 for adults 21 and older.
    - This means consumers 64 and older cannot be charged more than three times what a 21-year-old consumer is charged for their premium.
    - New Mexico has five rating areas.

Pricing, Rate Increases, and Premium Income Allocation (3 of 3)

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- The 80/20 rule
  - Carriers must spend a minimum of 80% of premium dollars they take in on health care and quality improvement activities, rather than on administrative overhead and marketing costs. This is known as the Medical Loss Ratio (MLR).
  - If the carrier does not spend 80% or more on health care and quality improvement activities, the carrier must return the excess to consumers as rebates.
  - 20% of premium dollars can go to administrative and marketing costs.

Reminder

Important Note for Agents and Brokers

It is the agent/broker's responsibility to make sure they are appointed and contracted with all carriers offering qualified health plans (QHP) through BeWell.

Payment of commissions is governed by the agreement between the agent/broker and the carrier. Agencies and individual brokers must have the correct portal account established to receive commissions. Carriers will only pay commissions to individual brokers. Agencies must add the principal agent and individual brokers under their agency portal to assure commissions.

Key Points

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- The ACA requires carriers to provide standard information so consumers can easily understand their coverage and compare it to other available options.
- The ACA requires carriers to offer EHB without annual or lifetime limits.
- The ACA provides two ways to hold insurance companies accountable and help keep consumer costs down:
    1. Rate Review
    2. The 80/20 rule


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