

American Medical Association Journal of Ethics

August 2015, Volume 17, Number 8: 754-759

HEALTH LAW

The Affordable Care Act and Insurer Business Practices

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Health insurer business practices are regulated at both the federal and state level. State law plays a role in regulating business practices such as the types of coverage offered and payment of claims [1]. For example, states can mandate coverage for certain medical treatments or conditions like [autism](#) [2]. State law also regulates how quickly insurers have to pay claims for health care services, referred to as prompt pay laws [3]. Federal law, most notably the [Affordable Care Act](#) (ACA), has brought about market reforms to make health insurance [more accessible](#), affordable, and adequate [4]. While the ACA sets forth market reform requirements that apply to private health insurance, these requirements are not applicable to all types of plans. Some requirements only apply to the nongroup (i.e., individual) and small group markets, whereas others apply across the board to the nongroup, small group, and large group markets [5]. “Group health plans” refers to employer-sponsored insurance, with the number of employees defining the type of market [6].

Major ACA provisions related to health insurance practices are summarized below.

Access to Health Insurance Coverage

- Health insurance plans must accept every applicant who agrees to the terms and conditions of the insurance (e.g., paying the monthly premiums); such plans are referred to as “guaranteed issue” [7, 8]. Health plans may not discriminate on the basis of pre-existing health conditions or health factors [9].
- Health plans cannot place annual or lifetime dollar limits on essential health benefits [10].
- If insurers offer coverage to dependents, then they must make that coverage available to them until they are 26 years old [11].
- Health plans cannot cancel coverage after an enrollee incurs medical expenses unless that enrollee has engaged in fraud or intentional misrepresentation [12].

Affordable Health Insurance Coverage

- Insurers must make sure that enrollees’ out-of-pocket costs do not exceed a certain amount each year. “Out-of-pocket cost” refers to expenses that enrollees must pay while they have coverage (see table 1) before the insurance plan begins

paying 100 percent of costs for covered services. Once an enrollee reaches his or her maximum out-of-pocket amount (MOOP), an insurer must pay 100 percent of further costs for covered services that are provided within the network. For 2015, the maximum out-of-pocket cost is \$6,600 for self-only coverage and \$13,200 for family coverage; these costs increase slightly to \$6,850 and \$13,700 in 2016. After 2016, the individual cost-sharing limits apply to all consumers, whether they are on a self-only or family plan: if the out-of-pocket maximum for a family plan is \$13,700, each covered family member's out-of-pocket costs only have to reach \$6,850 before the insurer has to pay 100 percent of further costs for covered in-network services for the individual [13].

Table 1. Typical out-of-pocket health care costs for insured patients in the US

Deductible: an amount an enrollee must pay before benefits “kick in.” For example, a plan might entail that enrollees pay \$1,500 out-of-pocket for health care services before it begins to cover costs. In general, consumers are billed by clinicians for deductible amounts.

Co-pay: a fixed amount that an enrollee pays every time for a given type of covered health care service at the time of service. For example, a plan could require a \$10 co-pay for each prescription and a \$20 co-pay for a doctor's visit. Health plans can also set higher co-pays for specialists.

Co-insurance: a fixed percentage of costs an enrollee pays for covered services. For example, 20 percent co-insurance means the health plan will pay 80 percent of costs for a covered service. In general, consumers are billed for co-insurance amounts by the organization where they receive care.

- Large group health plans must be affordable, meaning that an employee's premium contribution for self-only coverage for the lowest-cost plan offered cannot exceed 9.56 percent of his or her household income [14, 15].

Adequate Health Insurance Coverage

- Individual and small-group health plans must provide coverage for the following benefits, referred to as essential health benefits (EHB): ambulatory patient services (outpatient care); emergency services; hospitalization; maternity and newborn care; mental and behavioral health and substance use disorder services; prescription drugs; [rehabilitative and habilitative](#) services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services including oral and vision care [16, 17]. While the ACA requires health plans in the individual and small-group

markets to provide these *categories* of services, states have the discretion to pick a benchmark plan that sets out lists of specific services that must be included within each category [16].

- Large group health plans must meet or exceed the [minimum value](#) set by the federal government, currently defined as paying for at least 60 percent of medical expenses on average for a standard population [17, 18]. Federal guidance states that hospital and inpatient services must be substantially covered for the plan to count as providing this minimum value [19].
- Health plans cannot impose cost sharing, such as co-pays or co-insurance, for preventive services (except for plans in existence prior to March 10, 2010 that have not had substantive changes since that date, referred to as “grandfathered plans” [20]). Various federal entities make evidence-based recommendations about what should be in this category [21-23]. For example, federal agencies recently clarified that the anesthesia accompanying a preventive colonoscopy falls within the scope of a preventive service and must be covered without cost sharing [24].
- Health plans cannot prohibit enrollees from participating in federally approved clinical trials and must pay routine costs associated with a clinical trial, including drugs, procedures, and services that the health plan would normally cover [25].
- Health plans are prohibited from requiring referrals for obstetrical or gynecological (OB/GYN) care [26, 27].
- Health plans are prohibited from requiring prior authorization for emergency services, regardless of whether the clinician is in or out of network. Health plans must pay for out-of-network emergency services at either the in-network amount, the amount for other out-of-network services, or the amount that Medicare pays [26, 27].
- Health plans (except grandfathered plans) are required to allow enrollees to designate a primary care provider (PCP). Health plans can still designate a PCP but must allow the enrollee to change that designation. This includes allowing parents to choose in-network pediatricians for their children [26, 27].

Other Consumer Protections

The ACA establishes other consumer protections that regulate how insurers operate. For example, under the medical loss ratio (MLR) requirement, an insurer must spend a certain percentage of premium revenues on health care claims and quality improvement expenses or rebate the difference between those costs and their premium charges to enrollees. For individual and small-group plans, insurance companies must spend 80 percent of premium revenues on medical care; for large-group plans, the amount is 85 percent [28].

The ACA also requires all health plans to have an appeals process that allows consumers to appeal insurer decisions—for example, to deny a medical claim to pay for a service. Under the ACA, the appeals process must involve both an internal and external review (e.g., by an independent third party), and health plans must follow certain timeframes for decisions in general and in special circumstances (e.g., urgent care) [29]. While the ACA establishes a federal minimum for appeals, states may have processes that are more protective of consumers [30].

Conclusion

Five years after the passage of the ACA, there has been a 35 percent reduction in the number of uninsured people in the US; there are approximately 16.4 million newly insured people [31]. The ACA is making health insurance much more accessible and affordable. As implementation of the law continues, the question of whether existing coverage is adequate is likely to be raised, particularly as the newly insured begin using their coverage and insurer business practices continue to evolve. Subsequently, how well the ACA protects consumers and what gaps exist will become more evident.

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ISSN 2376-6980**