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Individual Insurance Under Healthcare Reform: A Boon for Policyholders

A recent study of health insurance coverage under individual insurance plans in effect between 2001 and 2008 indicates that many policyholders would have saved money if the Patient Protection and Affordable Care Act (ACA) had been in effect during this time period.[1] In addition, the study showed that more generous insurance coverage is associated with a lower risk of high out-of-pocket spending, and that the probability of very high out-of-pocket spending is expected to be reduced for everyone who purchases insurance through a health insurance exchange (exchange). Compared to employment-related plans, individual plans have less favorable benefits, including higher copays and deductibles, as well as inferior prescription drug coverage, all of which contribute to greater out-of-pocket spending by individual plan policyholders. When the ACA's individual mandate and exchange provisions take effect in 2014, individual plan policyholders may experience more generous benefits and reduced out-of-pocket costs. However, insurers may struggle to comply with the new requirements.[2] States will play an active role in both the design of their exchanges and in the selection of their respective exchange's benchmark insurance plan. Federal funding is still being distributed to assist them in these tasks.[3] With the constitutionality of the ACA settled, as of the June 28, 2012 Supreme Court decision, states and the healthcare industry must begin implementation of insurance-related changes required under the ACA, and consumers may look forward to improved plan options and lower out-of-pocket costs.

By January 1, 2013, states must notify the U.S. Department of Health and Human Services (HHS) whether they will operate a state designed exchange or implement an exchange operated by HHS.[4] Regardless of the type of exchange in place, insurance plans in both the individual and small group markets must offer "*essential health benefits*," which HHS has defined as requiring at least ten categories of benefits, including: hospitalization; emergency services; maternity and newborn care; prescription drugs; preventive and wellness services and chronic disease management; mental health, substance abuse, and behavioral health treatments; rehabilitative devices and services; pediatric services, including vision and oral care; laboratory services; and, ambulatory care.[5] Within these categories, however, insurers will have some discretion as to which specific services they will cover, such as the types and number of treatments allowed.

Flexibility provided to insurers in designing plans to offer in the exchanges, may lead to some variation between state exchanges. This variety will be within the ACA mandated categories listed above. In addition, insurers will continue to have some discretion in determining a plan's actuarial value (AV), which is the proportion of a policyholder's healthcare costs that the plan will cover.[6] Unless a plan is "*grandfathered*," the ACA requires plans to offer four different tiers of coverage that vary based on AV, which in turn gives consumers different options of cost-sharing in the form of copays, coinsurance, and deductibles.[7] "*Bronze*" plans will have an AV of 60 percent; "*silver*" plans will have an AV of 70 percent; "*gold*" plans will have an AV of 80 percent; and, "*platinum*" plans will have an AV of 90 percent, with each tier imposing progressively less cost-sharing on policyholders.[8] The ACA requires every plan tier to provide coverage for preventive services without imposing any cost-sharing on policyholders, and it generally sets plan out-of-pocket maximums at the same out-of-pocket limit for Health Savings Account-qualified plans.[9]

Beginning in 2014, most Americans will have to purchase a plan that is at the bronze level or higher in order to avoid paying the associated tax.[10] Currently, individual plans tend to have an AV between the two lowest tiers, bronze and silver, as compared to employment-based plans, which typically have an AV between gold and platinum.[11] For lower income consumers who purchase individual insurance through an exchange and have a family income of up to four times the federal poverty level, premium and cost-sharing subsidies may be available. These individuals may also be eligible for plans that do not fall within one of the standard four metal tiers, but that offer higher AVs and lower out-of-pocket costs.[12] Thus, many individuals who purchase health insurance through their state's exchange will be able to select a plan which imposes less cost-sharing and also provides greater coverage than their current individual policy offers.

States will also determine the specifics of their exchanges, by selecting a benchmark plan to determine standard benefits. In designating a benchmark plan, states may choose either the state's largest health maintenance organization (HMO) plan, one of the three

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largest state employee plans, or one of the three largest small group plans.[13] This breadth of choices is intended give states a certain degree of flexibility in designing their benchmark plan, though state plans will all look fairly similar due to the required categories for essential health benefits.[14] In order to receive, at least, conditional approval of their respective exchanges by the January 1, 2013 deadline, states must submit an "*Exchange Blueprint*" by November 14, 2012, which leaves little time for those states who deferred action pending the outcome of the Supreme Court's decision.[15]

With the constitutionality of the ACA established, the healthcare industry and the consumers it serves must move forward and achieve compliance with the law. States must take swift action with respect to the design and operation of their exchanges, and insurers must evaluate and if necessary, augment, their current products in order to comply with all applicable legal requirements and effectively compete for valuable new customers. Consumers should thoroughly research the insurance plans available in their respective state's exchange and select the plan which offers the coverage and pricing best suited to their needs. Regardless of the plan chosen, however, individual policyholders are likely to see an improvement over their current plan's coverage as well as a reduction in their out-of-pocket costs.

1 "Individual Insurance Benefits to Be Available Under Health Reform Would Have Cut Out-of-Pocket Spending in 2001-08" By Steven C. Hill, Health Affairs, Vol. 31, No. 6 (June 2012), p. 5.
2 Ibid, p. 2.
3 Ibid; "More States Work to Implement Health Care Law" U.S. Department of Health and Human Services, News Release (May 16, 2012), Accessed at http://www.hhs.gov/news/press/2012pres/05/20120516a.html/ (Accessed 6/28/12).
4 "Implementation Timeline" Kaiser Family Foundation, 2012, http://healthreform.kff.org/Timeline.aspx (Accessed 6/28/12).
5 "Private Insurance Benefits and Cost-Sharing Under the ACA" By Larry Levitt et al., Health Reform Source, Kaiser Family Foundation, February 28, 2012, http://healthreform.kff.org/notes-on-health-insurance-and-reform/2012/february/private-insurance-benefits-and-cost-sharing-under-the-aca.aspx (Accessed 5/28/12).
6 Ibid.
7 "What the Actuarial Values in the Affordable Care Act Mean" By Larry Levitt and Gary Claxton, Kaiser Family Foundation, April 2011, p. 2; Larry Levitt, February 28, 2012.
8 Larry Levitt, February 28, 2012.
9 Larry Levitt April 2011, p. 1-2; Larry Levitt, February 28, 2012.
10 Larry Levitt April 2011, p. 2.
11 Larry Levitt, February 28, 2012.
12 Larry Levitt April 2011, p. 2.
13 Larry Levitt, February 28, 2012.
14 Ibid.
15 "Draft Blueprint for Approval of Affordable State-Based and State Partnership Exchanges" The Center for Consumer Information and Insurance Oversight, Centers for Medicare and Medicaid Services, May 16, 2012, p. 4.

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