

Non-ACA compliant plans vs. ACA compliant plans

Rep. Ryden requested information on the differences between non-ACA compliant plans and plans meeting ACA requirements.

The greatest changes are to individual insurance:

- Prior to the ACA, in the individual market, carriers could deny, restrict coverage, or put a surcharge on, based on a consumer's health status. The ACA eliminated this practice of medical underwriting, and requires guaranteed issue of individual plans. This allows consumers who have a health condition to get coverage, and to change their coverage without being locked into a particular plan.
- The ACA also requires coverage of pre-existing conditions, which in the individual market pre-ACA could be denied or limited on a by-condition basis.
- The ACA requires coverage of the essential health benefits by most health insurance options. The package of essential health benefits is based upon the 10 categories of benefits required under the ACA and the benefits package is closer to group coverage than individual pre-ACA.
- Prior to the ACA most individual plans had no benefits for mental health or substance abuse.
- Also before the ACA took effect, autism benefits were not required in individual policies.

Other changes which apply to both individual and small group coverage include:

- Elimination of annual and lifetime dollar limits on essential health benefits;
- Preventive services with no cost-sharing;
- Requirement that premiums differ by age by no more than 3:1;
- Required pharmacy benefits; and
- Mental health and substance abuse coverage to equal that of physical illness treatment.

Rep. Sias questioned the decision to permit consumers to keep ACA non-compliant plans into 2015 rather than for two years into 2016.

- In preparing for implementation of the ACA, the Division began issuing Bulletins in early 2013 to advise carriers and consumers of procedures for the orderly transition to coverage under the ACA. Among the Bulletins issued by the Division were:
 - Bulletin B-4.50 on Discontinuance of Individual or Small Group Health Benefit Plans, issued April 1, 2013.
 - Bulletin B-4.59 on Discontinuance of Current Health Benefit Plans, Claiming of Plans as Obsolete, Use of Reasonable Modifications Process, and Calendar-year Renewal Schedule, issued May 10, 2013.
 - Bulletin 4-61 on Individual Market Renewal Notices – Model Language, issued on June 10, 2013.
- Many carriers offered consumer the option of continuing their 2013 policy into 2014 by "early renewing" their policy. Under these "early renewals," the same schedule of benefits, including

copayment and deductible levels, was extended for an additional period, generally covering the consumer throughout most of 2014.

- To ensure the orderly transition of products, and that consumers were receiving proper notice of their options, on July 5, 2013, the Division issued Emergency Regulation 13-E-10. This regulation became Regulation 4-2-44 effective November 1, 2013. The regulation, in accordance with state law, required carriers to provide notice of discontinuance or non-renewal, within 120 (carrier withdrawal from state) or 90 (carrier election to discontinue/non-renew a plan) days and resulted in 335,000 Coloradans receiving cancellation notices in the latter half of 2013. A significant proportion (92%) of these consumers were offered the “early renewal” option, and (according to one large carrier in the small group market) a little over one third (34.8%) exercised it.
- During the spring of 2014, an increasingly intense public focus on the issues of non-compliant ACA plan discontinuances, “early renewals,” health insurance costs, and geographic rating brought heightened awareness to many Coloradans and elected officials of the extent of change taking place within the health insurance marketplace under the ACA.
- The President’s announcement on March 5, 2014, which allowed the continuation of non-ACA compliant individual, small group, and certain large group plans through 2016, added another consideration to these discussions and the interrelated policy decisions.
- The Division sought and received feedback from many organizations regarding the policy options. The comments we received from consumers and carriers, county commissioners and other elected officials and advocacy organizations all voiced opinions ranging across the entire policy spectrum. On one hand, we heard pleas for additional flexibility to allow consumers to continue with non-compliant plans past 2014 while the broader scope of changes affecting health care coverage were taking effect. These were countered by concerns that market disruption, instability and consumer confusion would continue with the proposed extended transition.
- With no consensus on the option and recognizing the arguments both for and against continuation, the Division elected to permit continuation of non-ACA compliant plans for an additional year to the end of 2015. This did not exercise the President’s 2 year option, but provided for another year for Colorado consumers and businesses to adjust to the changes mandated by the ACA. It also provided the state with another year to achieve stabilization of the health insurance market under the ACA.