FOCUS on Health Reform

THE HENRY J. KAISER FAMILY FOUNDATION

JANUARY 2013

Implementing New Private Health Insurance Market Rules

The Affordable Care Act (ACA) makes major changes to rules governing private health insurance in order to promote broader pooling of risk, prohibit discrimination on the basis of health status and pre-existing conditions, foster competition to enhance insurance market efficiency and affordability, promote prevention and wellness, and institute greater consumer protections. A series of proposed regulations (known as NPRMs) issued on November 26 outlined specifics for how many of these new rules would operate starting in 2014. In some cases, implementing the various goals of the ACA involve tradeoffs, which the proposed rules seek to balance.

Three proposed regulations were issued relating to

- Private insurance market reforms http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28428.pdf
- Essential health benefits and actuarial value http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28362.pdf
- Standards for wellness programs offered or required by employers who sponsor group health plans http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28361.pdf

Market Reforms – This set of proposed rules govern the sale, pricing, and renewability of health insurance. These rules generally apply to the individual and small group health insurance markets, for coverage sold inside and outside of Exchanges. In general, these rules do not apply to so-called grandfathered health plans and policies.[1] Key provisions in this proposed rule include:

1. *Definition of group and individual health insurance markets* - The definition would be based on the ultimate purchaser of health insurance – an individual or a small employer (defined in 2014 as a firm with at least two and up to 50 employees).[2] This definition effectively changes the treatment of association coverage. Today, many individuals and small businesses purchase coverage through associations – for example, through a local Chamber of Commerce or professional association, or some other membership organization. In many states, such associations are considered to be large groups, and so coverage sold through them today may be exempt from some or all of the rules that would otherwise apply to traditional health insurance markets for individuals and small employers. Under the market reform NPRM, associations that provide health insurance coverage for individuals and small employers would be subject to the same market rules that would otherwise apply to the individual and small group markets.

[1] A grandfathered plan or policy is one that was already in effect as of the date of enactment of the ACA. Such policies can maintain grandfather status as long as they do not make significant changes to covered benefits, cost sharing, or, in the case of group health plans, employer contributions to the premium.

[2] Under the proposed rule, States would have flexibility to expand the definition of small group insurance market to include self-employed sole proprietors (also referred to as groups of one) and larger firms with up to 100 employees. Starting in 2016, the federal definition will expand to include firms with up to 100 employees.

2. *Guaranteed availability and renewability* – The proposed rule would require insurers to accept all applicants for all individual and small group market policies, regardless of health status, occupation, or other risk factors. Only limited exceptions to this guaranteed issue requirement would apply:
   - Open enrollment periods for individual health insurance – Small group issuers would be required to guarantee issue coverage year-round; but in the individual market, issuers could restrict the sale of policies to initial and annual open enrollment periods. At other times during the year, issuers would have to permit special enrollment opportunities of at least 30 days for individuals with qualifying events (such as a change in family or dependency status or the loss of eligibility for other coverage – similar to special enrollment rules that have applied to group health plans for many years).
   - Minimum participation and contribution rates – As is true under federal law today, small group issuers would be allowed to require small employer plan sponsors to contribute a minimum amount toward participants' premiums and/or to enroll a minimum proportion of eligible employees.
   - Network or financial capacity limits – Plans with a geographically distinct provider network issuers could also restrict the sale of coverage to individuals or small groups who reside outside of the plan's service area. Enrollment could also be limited by plans that can demonstrate they are at the limit of their network or financial capacity to serve new members.

   Also as current law requires, health insurance coverage would have to be renewable at the policyholder's discretion. Insurers would only be allowed to non-renew or discontinue coverage for nonpayment or late payment of premiums (the rule does not specify standards for late payment, such as requirements for notice or minimum grace periods), for an act of fraud by the policyholder, or for other limited reasons.

3. *Premium rating and rate review* – The proposed rule sets several new standards that would significantly change rating practices for individual and small group health insurance.
   - Single risk pool – Insurers would be required to consider as a single risk pool the claims experience of all enrollees in all of its individual market health plans in a state. A similar rule would apply for small group market health insurers. As a result, premium differences across health plans offered by an issuer would reflect differences in benefits covered and would not vary based on health differences of the enrollees. This rule constitutes a significant change from current rating practices which can result in sicker people paying higher premiums than healthier people for similar benefits. This single risk pool requirement would apply to all plans offered by an insurer in a market, both inside and outside of an Exchange.
   - Modified community rating – The proposed rule prohibits insurers from charging individuals or small groups differently based on pre-existing conditions, occupation, gender, duration of coverage, credit worthiness or most other factors. Premiums can only be adjusted based on certain factors, including:
     - Family coverage – Premiums can vary based the number of adults and children in a family. States may establish uniform family tiers; otherwise, federal rules apply. Under these rules, a family's premium would be the sum of the individual premiums for each

adult and each child (up to 3) under age 21 In other words, a family with two adults and three children under age 21 would not pay a higher premium if they had a fourth child. Individual premiums for children 21 and older covered under the policy are added without any limitation.

- Geography – Premiums can be adjusted for the geographic rating area in which the policy is sold. States may establish geographic rating areas, subject to federal standards and approval. The proposed rule requires rating areas must be of an adequate size (for example, no smaller than a metropolitan area) to support pooling of risk.
- Age – Premium adjustments are allowed based on age, up to a limit of three-to-one variation for adults age 21 to 64. The proposed rule would require the use of uniform, one-year age bands in the individual and small group markets. Among other things, use of a uniform age curve would simplify calculation of eligibility for premiums subsidies. (Under the ACA, premium tax credit subsidies are tied to the second lowest cost silver plan in an Exchange. If insurers applied different age curves, there could be multiple second-lowest-cost silver-plans in an Exchange, depending on a person's age.) States may require narrower age bands or prohibit age adjustments altogether, as some do today.
- Tobacco use – The ACA permits premiums to vary based on tobacco use by a factor up to 1.5. Under the proposed rule – unlike uniform age bands – insurers would be given flexibility to determine how to make this adjustment within the overall limit. The proposed rule provides one permissible example – that insurers could apply a lower tobacco premium surcharge for younger individuals and a higher one for older individuals. Using the example in the proposed rule, a younger smoker might pay a few dollars more each month while the older smoker could be charged hundreds of dollars more each month. Importantly, under the ACA, premium tax credits do not apply to the tobacco surcharge, so it is possible the surcharge could render coverage unaffordable for older tobacco users. People who would have to pay more than 8 percent of family income for coverage are excused from the requirement to have health insurance because the cost is deemed unaffordable under the law. Studies have shown that tobacco use tends to be higher among lower income individuals.[3]

  The proposed rule does not define tobacco use (for example, what products or the frequency or regularity of tobacco use) and does not specify how insurers would collect and verify information about tobacco use, but requests comment on these questions. Tobacco rating is also permitted in the group market. Under the proposed rule, insurers would not be able to apply tobacco adjustments to small group rating unless tobacco users in the small group were also offered a wellness program that provides an opportunity to avoid paying the full surcharge. (see below) States may also limit further or prohibit tobacco rating adjustments.

- Application of age and tobacco rating factors to group policies – For groups, the proposed rule requires allowable rating factors (such as age, tobacco use) to be associated with specific

[3] See for example, http://www.ihps.org/pubs/Tobacco_Rating_Issue_Brief_21June2012.pdf

employees and dependents. Issuers would be required to calculate per-member rates in order to develop a group premium. As for the amount employers would then contribute to coverage of each group member, the rule explicitly leaves to employers (of all sizes) flexibility to base their contribution either on the per member average, or on each group member's specific factors.

Essential Health Benefits and Actuarial Value – Another proposed rule relates to the content of private health insurance coverage, setting standards for covered benefits and cost sharing.

1. *Essential Health Benefits* – The ACA requires all non-grandfathered health plans in the individual and small group market, whether sold in or out of Exchanges, to cover essential health benefits (EHB). The ACA doesn't enumerate EHBs, but specifies 10 categories of EHBs that must be covered:
    a. Ambulatory patient services
    b. Emergency services
    c. Hospitalization
    d. Maternity and newborn care
    e. Mental health and substance use disorder services including behavioral health treatment
    f. Prescription drugs
    g. Rehabilitative and habilitative services and devices
    h. Preventive and wellness services and chronic disease management
    i. Pediatric services, including vision and dental care

    The proposed rule relies on benchmark plans to fill in the details of EHB, at least for 2014 and 2015. Under the proposed rule, states would be able to select a benchmark plan from a choice of ten popular (as measured by enrollment) private health plans today. These include the three largest small group health insurance products sold in a state, the three largest state employee health benefit plan options, the three largest federal employee health benefit plan options, or the largest commercial HMO plan sold in a state. If a state doesn't select a benchmark, the default choice will be the largest small group health plan. Any covered benefit under the benchmark plan would automatically be considered an essential health benefit. And any limits on the amount, scope, or duration of coverage under the benchmark plan would also be included in the definition of essential health benefits for that state (for example, if the benchmark plan limits rehabilitative therapies to 20 visits per year). However, separately, the ACA applies mental health parity rules to individual and small group health insurance policies.

    In most states the benchmark plan would need to be supplemented because it lacks coverage for at least some EHB categories. For example, many existing private health plans today do not cover pediatric vision or dental benefits; many also do not cover habilitative services. The proposed rule specifies that supplementation is necessary if the benchmark plan does not cover any benefits in a category, and outlines a process for supplementation that generally relies on other benchmark plans.

Once the benchmark is established, issuers in a state must offer benefits that are substantially equal to the EHB benchmark plan. However, issuers have some flexibility to modify the EHB benchmark plan benefits. Under the proposed rule, within a category of EHB, issuers could substitute benefits or sets of benefits that are actuarially equivalent to those being replaced.[4] Issuers that make such substitutions would be required to submit evidence of actuarial equivalence to the substituted benefits, to the state.

Separate rules apply to coverage for prescription drugs. For each therapeutic category or class of prescription drugs (for example, as defined by the United States Pharmacopeia or USP), health plans must cover the greater of one drug per class or category, or the same number of drugs per class or category as covered by the benchmark plan. Drugs in a class or category must be therapeutically distinct (for example, different doses of the same drug are counted as one drug, as are brand drugs and their generic equivalents.)

Some areas of ambiguity remain regarding how essential benefit rules will work in practice. For example, the proposed rule does not specify how services in the benchmark plan should be assigned to categories, within which insurers can modify and substitute benefits on an actuarially equivalent basis. Certain categories – such as "maternity and newborn care" – are quite specific and self-explanatory. However, others – such as ambulatory care – are broad and not well defined, leaving questions about which services are included. For instance, would home health or durable medical equipment best be categorized as ambulatory services or rehabilitative services? What category would apply to organ transplants? Also, some plans today cover expensive injectable drugs (such as chemotherapy drugs) as a medical service, not under their drug benefit. Would plans be able to continue to categorize chemotherapy in this way, and if so, follow substitution rules that apply for other medical benefits rather than apply the rules governing drug formularies? If so, plans may be able to apply restrictive limits to these medications. Finally, plans today vary in how they cover supplies used in the management of diabetes, which can easily cost thousands of dollars per year.[5] Depending on the plan, blood glucose test strips and meters, syringes, and lancets may be covered as medical equipment and supplies, or under the prescription drug benefit, or under a separate disease management benefit, or just under broad category of ambulatory medical care and services. If insurers have flexibility to define the content of EHB categories in this way, the limitation on substitution only within categories would be less constraining.

The ACA applies two other general EHB standards to qualified plans. First, plans must not design covered benefits in ways that discriminate against individuals based on age, health status, or related

[4] Actuarial equivalence involves measuring the value of a particular health benefit for a standardized population. To offer a simplified example, if a plan covers 20 home health visits per year and home health visits cost $100 on average, then the home health benefit would cost $2000 for everyone who uses it fully. If only 1 percent of a standardized population uses 20 home health benefits in a year, then, actuarially, that benefit is worth $20. If a plan wanted to eliminate coverage for home health visits, it would have to replace it with coverage for another benefit within the same category as home health that is actuarially worth $10.

[5] See http://policyinsights.kff.org/en/2012/august/transparency-and-complexity.aspx.

factors. Second, plans must ensure an appropriate balance among the categories of EHB so that benefits are not unduly weighted toward any category. These rules apply to states as they select and supplement benchmark plans, as well as to insurers as they modify their own plan designs relative to the benchmark. The proposed rule does not elaborate at length on the definition of "discriminatory" or "balance," although it does specify that plan marketing practices and benefit designs should not have the effect of discouraging the enrollment of individuals with significant health needs. The proposed rule seeks comment on these issues and encourages states to develop programs and procedures to monitor for and correct discriminatory or unbalanced benefit designs.

2. *Actuarial value* - While all individual and small group health insurance policies must cover the EHB, plans can vary in the level of cost sharing they apply to covered benefits. The ACA requires plans to be designated according to categories, based on their actuarial value (AV), which is a measure of the overall level of cost sharing required under a plan.[6] The AV categories specified in the ACA would reflect whether plans require low, medium, high, or very high levels of cost sharing. These categories, also referred to as metal tiers, are
   - Bronze (for plans with an actuarial value of 60 percent)
   - Silver (actuarial value of 70 percent)
   - Gold (actuarial value of 80 percent)
   - Platinum (actuarial value of 90 percent)

   Insurers have flexibility to vary cost sharing features within these overall levels. For example, one insurer might design a bronze plan with an annual deductible of $4,350, followed by coinsurance of 80 percent, while a different insurer might design its bronze plan with an annual deductible of $2,750 followed by coinsurance of 70 percent. To standardize calculations of AV as much as possible, the proposed rule requires plans to use a common AV calculator developed by HHS. To the extent plans have cost sharing features that don't fit the parameters of the AV calculator, they are allowed make their own actuarial value calculations certified by an actuary.

   The ACA also sets standards for the maximum cost-sharing (such as deductibles, co-pays, and coinsurance) that applies to EHBs provided in network. The annual out-of-pocket maximum for all types of cost sharing cannot exceed that established by the Internal Revenue Service for qualified high deductible health plans. That amount is indexed and updated each year; for 2014 it will be approximately $6,500 for a self-only policy, and $13,000 for a non-self-only policy. After the out-of-pocket maximum is reached, the plan must cover services at 100 percent for the remainder of the year. (Note that actuarial values and out-of-pocket limits apply only to in-network cost-sharing. There are no limits on out-of-network cost-sharing.)

   In addition, for small group health plans, the ACA provides that deductibles cannot exceed $2,000 per year per individual. However, the rule notes that it may be difficult to design a bronze plan subject to this limit and the overall out-of-pocket limit, so it permits insurers to exceed the $2,000 small group policy deductible limit if they cannot reasonably reach an AV tier without doing so.

[6] For further background on actuarial value, see http://www.kff.org/healthreform/upload/8177.pdf

Overall, the EHB and AV standards will likely increase what health plans cover today and raise premiums for some policies as a result – especially in the individual market, where policies may impose very high cost sharing (such as annual deductibles of $10,000 or more) or lack coverage for key benefits such as maternity care, mental health care, rehabilitative services, and prescription drugs. The EHB and AV requirements are also intended to make health insurance more standardized. Standardization reinforces risk spreading by limiting opportunities to attract or discourage enrollees based on benefit design. It also simplifies the process of comparing health plans for consumers.

The proposed rule recognizes that standardization can also limit choice in benefit design and cause some market disruption to the extent new plan standards are very different from what is offered today. The proposed rule seeks to balance these tradeoffs, at least at the outset, by defining EHB in the context of existing benchmark plans that are familiar to many privately insured people today, and by allowing insurers flexibility to modify plan designs within constraints of the overall standards. It remains to be seen how insurers – who may be accustomed to using benefit design as a risk selection tool today – will use flexibility in reformed markets, and whether regulators will be able to monitor and correct such practices starting in 2014.

Wellness – Finally, the third proposed rule would amend an earlier, final regulation governing the design and application of wellness programs offered in connection with employer-sponsored group health plans. Wellness programs are intended to provide support and incentives to employees to adopt healthier lifestyles or take other actions to improve health and, by so doing, help to control health care costs. Since the enactment of HIPAA, which established the federal law that employer-sponsored group health plans cannot discriminate against group members based on health status, special exceptions have been permitted for wellness programs that offer discounts on premiums for health benefits, and these exceptions have evolved over time through regulatory and statutory interpretation.

Interim final rules to implement HIPAA, issued in 1997, permitted group health plans to establish premium discounts or rebates or to modify cost sharing under the plan in return for adherence to wellness programs.[7] The 1997 rule made clear that under no circumstances could wellness programs condition receipt of the reward based on health-status-related factors. The 1997 rule noted, for example, that a program that provides premium discounts only to enrollees who can achieve a blood cholesterol count under 200 would be considered to discriminate impermissibly based on a health status-related factor.

In 2006, the Bush Administration reinterpreted the nondiscrimination rule and modified the wellness program exception for group health plans.[8] The 2006 rule recognized two types of wellness programs – those that condition a reward based on an individual's ability to achieve a health-status-related factor,

[7] http://www.gpo.gov/fdsys/pkg/FR-1997-04-08/pdf/97-9124.pdf
[8] http://www.gpo.gov/fdsys/pkg/FR-2006-12-13/pdf/06-9557.pdf

and those that do not. Health-factor based wellness programs would not be considered discriminatory if they met 5 standards:

- Reasonably designed – The rule defined a reasonably designed program as one that has a reasonable chance to promote health or prevent disease, is not overly burdensome, is not a subterfuge for discrimination based on health status, and is not highly suspect in the method chosen to promote health or prevent disease. The preamble to the 2006 rule stressed that the "reasonably designed" standard was designed to prevent abuse, but otherwise was "intended to be an easy standard to satisfy…There does not need to be a scientific record that the method promotes wellness to satisfy this standard. [It] is intended to allow experimentation in diverse ways of promoting wellness. For example a plan…could satisfy this standard by providing rewards to individual who participated in a course of aromatherapy."
- Limit on the reward – The 2006 rule said that under a health-factor based wellness program, the reward can be in the form of a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanisms (such as deductibles or copays), the absence of a surcharge, or the value of a benefit that would not otherwise be provided under the plan. The size of the reward could not exceed 20 percent of the entire cost (employer and employee contribution combined) of self-only coverage or, if spouses and children can participate in the program, of family coverage.
- Reasonable alternative standard – The 2006 rule required plans to also offer a reasonable alternative standard for obtaining the reward for certain individuals. The alternative standard must be available for individuals for whom it is medically inadvisable or difficult to satisfy the otherwise applicable standard. The rule noted it is permissible for a plan to devise a reasonable alternative standard by lowering the threshold of the existing health-factor-related standard, substituting a different standard, or waiving the standard.
- Opportunity to qualify for the reward – Under the rule, individuals had to be given at least one opportunity each year to qualify for the reward.
- Notice – All plan materials that describe the terms of the program must also disclose the availability of a reasonable alternative standard.

In addition, the 2006 regulation specified that "Compliance with this section is not determinative of compliance with … any other State or Federal law, such as the Americans with Disabilities Act…" The ADA, for example, limits an employer's ability to even request information from employees about their health status related factors, including outside of a voluntary wellness program.

The Affordable Care Act codified the main features of the 2006 rules, changing one. It said wellness programs that establish incentives or rewards based on health-status-related factors are allowed, as long as they meet at least the five standards outlined in the 2006 regulation. The ACA increased the maximum allowable reward to 30 percent of the plan cost and gave the Secretary authority to increase it further to 50 percent. It also gave the Secretary authority to publish implementing regulations.

The wellness NPRM proposes amendments to the 2006 rule. It maintains a requirement of reasonable design, restating the 2006 language that this requirement is intended to be an easy standard to satisfy. Proposed amendments would change the 2006 standards in the following ways:

- Limit on reward – The proposed rule would increase to 30 percent the maximum reward allowable under reasonably designed programs. In addition, to the extent that a wellness program targets tobacco use and assigns at least 20 percentage points of the reward toward that goal, the maximum reward allowable could be 50 percent of plan costs.
- Reasonable alternative standard – The proposed rule makes several changes in this standard. First, it requires that all individuals who cannot satisfy the initial standard must be offered a reasonable alternative means to qualify for the reward. Employers have flexibility to design the reasonable alternative means; however, if the alternative involves a class or program that charges a membership fee, the employer must pay that fee. In addition, an individual's physician has the final say on whether it is medically inadvisable for that person to satisfy the initial or alternative standard, and if so, a medically appropriate standard for that person must be offered or the standard must be waived.

The proposed rule offers illustrations of programs that would be considered reasonably designed. Under one example, the wellness program might offer a reward to any employee whose blood cholesterol level is under 200, but offer to anyone who fails that standard an alternative way to earn the reward by simply participating in a walking program three times a week, regardless of whether this results in actually lowering cholesterol levels. Whether other program designs would be considered reasonable is not so clearly spelled out or illustrated.

Allowing variation in health insurance premium contributions, cost sharing or benefits based on health status as an incentive to promote wellness, by definition, involves tradeoffs. On the one hand, if such programs effectively promote wellness and prevent disease, they could help limit overall health care spending and promote affordability of coverage. On the other hand, to the extent such programs make it more expensive for individuals with health problems to participate in group health plan benefits, they might also undermine risk pooling and promote loss of coverage for some individuals with poorer health status.[9]

The KFF employer health benefits survey finds that while most employers offering health benefits today also offer wellness programs (for example, subsidizing gym memberships or providing smoking cessation classes), only 14 percent have adopted wellness incentives that involve health insurance premium or cost-sharing discounts for individuals who pass certain health standards. However, starting in 2014, other changes in the small group health insurance market could also change the context in which employers and insurers make decisions about wellness incentives. For example,

[9] One program marketed to small employers notes that health plan savings can be realized, in part, because some employees will choose to leave the plan. See http://www.benicompadvantage.com/index.php?option=com_content&view=article&id=16:employer-faqs&catid=4:resources-a-tools&Itemid=20

- Under the proposed rule, wellness programs would be allowed to condition rewards/penalties based on biometric measures, including blood glucose levels. As a result, under some plans, individuals with diabetes or pre-diabetes could have to pay thousands of dollars more per year to enroll in coverage. What practical opportunity insurers or plan sponsors may have to discourage enrollment of people with diabetes is not entirely clear. The NPRM notes that a reasonably designed program cannot be a subterfuge for discrimination based on health status, but it does not define "subterfuge" or specify standards or examples that would define or help identify impermissible program designs.
- Older workers potentially could face more costly wellness incentives. The market reform NPRM allows employers to assign to each worker their underlying cost of coverage, adjusted by age and tobacco use. That rule also permits flexibility for tobacco adjustments to vary by age (e.g., a 10 percent tobacco surcharge might apply for younger individuals but a 50 percent surcharge for older individuals.) The wellness NPRM doesn't specify whether or not employers and insurers could also vary wellness rewards and incentives by age.
- How wellness programs would interact with the employer responsibility provisions of the ACA has yet to be specified. The ACA requires that large employers must offer affordable health benefits; when an employee's contribution for coverage exceeds 9.5% of her income she can seek subsidized coverage in the Exchange and, if she does, her employer can be liable to pay a tax penalty. How will premium surcharges resulting from wellness programs be considered in determining the affordability of employer-sponsored coverage? Taking them into account might deter employers from adopting wellness programs with premium-based incentives as large as the ACA allows. Not taking them into account, though, could allow employers to set premium contributions that are less affordable for sicker employees without triggering tax penalties.
- Also yet to be spelled out is how wellness programs would interact with ACA standards for the actuarial value and minimum value of group health plans. The wellness NPRM allows deductibles and other cost sharing to vary by up to 50 percent of total plan cost, which could amount to thousands of dollars for an individual. Under the ACA, however, the annual per person deductible under small group health plans may not exceed $2000. The ACA also limits total cost sharing for an individual in a year to roughly $6500 in 2014. Could wellness programs result in some group plan participants facing cost sharing above these limits? The ACA also sets actuarial value standards for plans which, essentially, measure plan cost sharing. Large employer plans are required to offer a minimum value (MV) of 60 percent. Would the AV or MV standard for a plan be evaluated taking into account wellness incentives, or without regard to them?

Finally, it is not clear how employer-sponsored wellness programs authorized under ERISA may be treated under other federal laws, such as the Americans with Disabilities Act (ADA.) The ADA, for example, prohibits employers from collecting health information about employees except under limited circumstances. One exception is when information is collected as part of a voluntary wellness program. Would wellness programs authorized under the ACA be considered voluntary under the ADA? The NPRM notes that the wellness program reward can take the form of the absence of a surcharge. In such programs, all employees could be considered to be auto enrolled in

the penalty, and only those who enroll in the wellness program and meet its standards can qualify for the reward. Regulations defining "voluntary" under the ADA have yet to be issued, so the answer to this question remains open for now.

Conclusion

Overall, the market reform rules would likely lead to significant changes in private health insurance compared to how it is sold today. Requirements for guaranteed issue, guaranteed renewability, and modified community rating would prevent insurers from turning people down or charging them more based on health status, making insurance more accessible and affordable for people who have expensive health conditions. The proposed regulation's requirement that insurers consolidate all of their products in a market into a single risk pool reinforces risk spreading, as does the requirement that association coverage follow the rules that apply in traditional individual and small group markets.

While risk spreading equalizes access to coverage for all market participants, relative to how most state insurance markets operate today, these market reforms inevitably have redistributive impacts. The most dramatic effects will surely occur in the individual market, where older and sicker individuals face many barriers to coverage today. Taking down those barriers and requiring individual health insurance to provide more comprehensive coverage will likely raise premiums relative to those charged today, particularly for participants who are younger and healthier. However, in 2014 premium subsidies will also be offered through new Exchanges, and most individuals who buy in these new markets will qualify for subsidies, shielding them from these redistributions.

In 2014, it will continue to be the case that most privately insured people will be covered by employer-sponsored group health plans. In such plans, risk pooling tends to occur more naturally, some key market reforms, such as nondiscrimination, have long been in place, and employer premium contributions help stabilize risk pools by making coverage affordable for most participants. Under the new proposed rules, however, some key exceptions to risk pooling within groups are allowed in order to promote other goals – increasing take up rates of younger workers and promoting personal health responsibility and wellness. How these exceptions are ultimately implemented could have significant implications for the affordability of coverage for people who are older or in poorer health.

This publication (#8399) is available on the Kaiser Family Foundation's website at www.kff.org.

THE HENRY J. KAISER FAMILY FOUNDATION www.kff.org
Headquarters: 2400 Sand Hill Road Menlo Park, CA 94025 650.854.9400 Fax: 650.854.4800
Washington Offices and Barbara Jordan Conference Center: 1330 G Street, NW Washington, DC 20005 202.347.5270 Fax: 202.347.5274