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In the Spotlight: ACA - New Game, New Players

The Affordable Care Act (ACA) passed in March of 2010, transformed the way health care is and will be delivered across all health-related industries, but none more than health insurance. There are restrictions on everything from what insurers can sell to how they sell it. ACA even introduces new kinds of competition. Some of the provisions may seem like they have nothing to do with insurance but may affect carriers the most.

Changing Products

The crux of ACA is to extend coverage to an additional 32 million[1] individuals, but the law did not stop merely at extending coverage. Congress wanted that coverage to have "meaning," so it set up a standard package that all policies must cover called essential health benefits. States will choose from the three largest small group plans in the state or the Federal Employees Health Plan to create a benchmark plan that will provide, in detail, the essential health benefits for that state. (If states do not choose a plan, the default benchmark plan will be the largest small group plan in the state.)

For coverage sold over the Exchanges, there will be four levels of plans (bronze, silver, gold, and platinum) that will indicate how much each policy is worth (the actuarial value) to the consumer. While this represents a relative standardization, there are other measures by which many people purchase coverage: quality of customer service; network; and so on.

New Marketplaces

The practice of selling and purchasing insurance will also change dramatically as health care reform is fully implemented. Almost everyone has probably heard of the individual mandate. This provision of ACA compels everyone to obtain minimum essential health coverage or pay a penalty, forcing millions more individuals into the changing market.

The introduction of online marketplaces (Exchanges) will increase the pressure to keep premium costs low. Individuals and small businesses will be able to shop on Exchanges and compare prices for fairly standardized benefit and cost-sharing packages all on one site, making the most obvious differentiator cost.

All insurers will have to provide a uniform summary of benefits and coverage with the sale of a policy, as well. This means that consumers will be able to compare, apples-to-apples, how policies' coverage may differ for a specified set of services.

New Competitors

ACA also opened the door for some non-traditional insurance concepts. Accountable Care Organizations (ACOs), Consumer Operated and Oriented Plans (Co-ops), and multi-state plans will create new competition for the more traditional health insurance companies. There are advantages and disadvantages from a consumer perspective to bringing these newer players into the market. While competition and choices are generally beneficial for consumers, some of these newer competitors are not subject to state law and the consumer may not always know what, exactly, they are purchasing.

[1] This number has frequently been disputed and amended but, in the interest of consistency, we continue to use the White House estimate upon passage of the law.

Multi-state plans are large, national plans. In an attempt to foster competition, ACA requires that, in each Exchange, two of the qualified health plans be multi-state plans. However, insurance regulators have expressed concerns that, if the rules for multi-state plans are less stringent, it will draw business away from those plans that are subject to state-by-state laws, creating an unfair advantage.

Co-ops are *new* private, non-profit entities that are directed by customers. They are also guaranteed to be on the Exchanges. ACA directs that "substantially all" of co-op business is supposed to be small group/individual. Insurers have expressed concern about directing new, inexperienced businesses at this higher risk and often problematic part of the market.

ACOs are newly identified plans by Centers for Medicare and Medicaid Services (CMS), distinguished by the way providers are paid. In ACOs, a provider has a vested interest in keeping their patients healthy; meaning, the provider becomes accountable for the cost *and* quality of care. CMS has created an ACO program within the broader Medicare program. Some insurers, like BCBSNC, are also partnering with providers to bring ACO competition into the individual and small group markets. In July of 2012, BCBSNC partnered with Wilmington Health to launch an ACO to benefit consumers in southeastern North Carolina.

BCBSNC Views

Blue Cross and Blue Shield of North Carolina (BCBSNC) supports a competitive market on a level playing field. Health insurance issuers are subject to a host of state-level requirements under ACA, such as rate review, risk adjustment, and medical loss ratio reporting and rebates. BCBSNC believes that Multi-State qualified health plans must be priced at the state level given the application of state requirements. We believe HHS should ensure that grants and loans for co-ops are only available to those applicants that demonstrate – without waiver of existing standards for health plans – that they have the capital, business plans, and management capacity to remain viable in the individual and small employer markets in 2014 and beyond. We see a need for flexibility for ACOs so that insurers and providers may implement innovative payment schedules to promote quality-based care. We recognize there is not yet a clear "best practice" to reimburse providers to get the outcomes a patient needs at a cost that society can afford. We have some concerns about the potential for ACOs to have undue market power that would force out competitors and could raise the cost of medical care for everyone. A level playing field is essential to providing consumers with secure health plan choices, structuring effective competition, and protecting government investments.

For More Information

Information on the Affordable Care Act: www.nchealthreform.com

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