PPACA Requirements for Offering Health Insurance Inside Versus Outside an Exchange

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The Patient Protection and Affordable Care Act (PPACA, P.L. 111-148, as amended) establishes new federal private health insurance standards, many of which are not required to be implemented until 2014. In addition, by 2014, states are to establish "American Health Benefit Exchanges." These exchanges cannot be insurers, but will provide eligible individuals and small businesses with access to insurers' plans in a comparable way, and will have criteria for permitting plans' participation in the exchange.

By 2014 (or earlier, in some cases), many new federal standards will apply to all insurers offering new coverage in the nongroup (also called individual) and small group markets—regardless of whether that coverage is available inside or outside an exchange. However, insurers who offer coverage through an exchange will be subject to additional requirements. Although these additional requirements, in isolation, could make plans less willing to offer coverage through an exchange, individuals who are eligible for premium tax credits and cost-sharing subsidies can only receive these subsidies through an exchange plan. For example, of the roughly 35 million individuals that CBO projects will be enrolled in nongroup coverage (including grandfathered coverage) in 2019, 24 million are anticipated to have that coverage through an exchange—of whom nearly 20 million will receive premium credits. In addition, exchanges will be required to handle some administrative functions currently handled by insurers, which may reduce insurers' administrative expenses for the nongroup and small group markets.

This report lists PPACA's private health insurance market reforms that must be in effect by 2014 for new plans in the nongroup and small group markets—with a focus on distinguishing between those that apply inside versus outside an exchange. As such, this report does not go into great detail in describing the specific provisions that apply.[1] Moreover, this report only discusses the impact on new plans—not on grandfathered plans, which cannot be offered through an exchange.[2] The legislative references are to sections of PPACA as amended by Title X of P.L. 111-148 and by P.L. 111-152, generally without the additional references to Title X or P.L. 111-152.

Nongroup and Small Group Plan Requirements Inside *and* Outside an Exchange

Requirements Effective Prior to 2014

Prior to full implementation in 2014, per §1001 of PPACA, new plans in the nongroup and small group markets (and potentially other plans[3]) will be subject to the following requirements (when

[1] For greater detail on specific provisions, see CRS Report R40942, *Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (PPACA)*.

[2] For more information on grandfathered plans and the requirements applying to them, see CRS Report R41166, *Grandfathered Health Plans Under the Patient Protection and Affordable Care Act (PPACA)*.

[3] Under PPACA, the application of market reforms to private health plans usually refers to such plans by market segment (nongroup, small group, large group) or as qualified health plans (QHPs). Nongroup and small group plans may be offered inside and outside of an exchange. Large group plans may be offered outside of an exchange, but may only be offered through an exchange at the discretion of each state. QHPs primarily will be offered through an exchange, but may be offered outside of it, and generally will provide nongroup or small group coverage. However, given that states may allow large groups to offer coverage through an exchange, such large group plans must be QHPs.

effective, as specified in PPACA), which, to the extent they continue to apply beginning in 2014, will be required regardless of whether the plan is offered inside or outside an exchange:

- prohibiting lifetime limits for essential health benefits;
- restricting annual limits for essential health benefits;[4]
- prohibiting health insurance policy rescissions (i.e., retroactive cancellation of medical coverage after a policyholder has become sick or injured[5]), except in cases where the covered individual committed fraud or made an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage;
- requiring coverage of recommended preventive services and immunizations without cost-sharing (e.g., copayments);
- extending dependent coverage up to age 26;[6]
- capping insurance company non-medical, administrative expenditures and profit generally at no more than 20% of premium revenues;
- ensuring that consumers have access to an effective appeals process;
- providing coverage for preexisting health conditions for enrollees under age 19;[7]
- ensuring patient protections regarding the choice of a primary care provider, access to emergency services and obstetrical and gynecological care, and access to medical reimbursement data;
- requiring the Secretary of Health and Human Services (hereafter referred to as "the Secretary") to develop uniform summary of benefits documents that plans will be required to implement, so consumers can make easier comparisons when shopping for health insurance;
- requiring plans to implement administrative simplification to make it easier for health care providers to have insurance claims filed, processed and paid; and
- tasking the Secretary with developing requirements for quality of care, which plans will ultimately be required to report.

In addition, §1003 of PPACA, which adds a new §2794 to the Public Health Service Act (PHSA), requires issuers[8] be subjected to annual reviews by the Secretary (in conjunction with states) of "unreasonable" premium increases,[9] beginning with the 2010 plan year. Issuers will have to

[4] For plan years beginning on or after January 1, 2014, this provision would prohibit any annual benefit limit based on essential health benefits.

[5] Retroactive cancellation leaves the individual responsible for all medical claims incurred during the time that person previously had coverage.

[6] For additional information, see CRS Report R41220, *Preexisting Exclusion Provisions for Children and Dependent Coverage under the Patient Protection and Affordable Care Act (PPACA).*

[7] For additional information, see CRS Report R41220, *Preexisting Exclusion Provisions for Children and Dependent Coverage under the Patient Protection and Affordable Care Act (PPACA).*

[8] A health insurance issuer, as defined in the PHSA, is licensed by a state to sell insurance in that state, and, therefore, subject to state law.

[9] PPACA did not define "unreasonable" premium increases. Given the Secretary's responsibility to establish the (continued...)

submit a "justification for an unreasonable premium increase prior to the implementation of the increase. Such issuers shall prominently post such information on their Internet websites. The Secretary shall ensure the public disclosure of information on such increases and justifications for all health insurance issuers.… Beginning with plan years beginning in 2014, the Secretary, in conjunction with the States … , shall monitor premium increases of health insurance coverage offered through an Exchange and outside of an Exchange."

The new PHSA §2794 also appropriates $250 million to the Secretary for grants to states during the five-year period beginning with FY2010 for carrying out these premium reviews. One of the conditions of these grants is that states must provide the Secretary with information about trends in premium increases.

Requirements Effective Beginning 2014

Of the nongroup and small group market reforms effective in 2014, the following apply both inside and outside of exchanges:

- Health insurance premiums must abide by adjusted community rating rules.[10] Rates may not vary based on health factors. Rates may vary only by (1) age (by no more than a 3:1 ratio across age rating bands established by the Secretary), (2) tobacco use (by no more than 1.5:1 ratio), (3) self-only or family enrollment, and (4) rating area[11] (as specified by the state).
- Coverage must be offered on a guaranteed issue and guaranteed renewal basis.
- Eligibility for health insurance coverage may not be based on health factors.
- Employer-sponsored (group) coverage cannot have waiting periods greater than 90 days.
- Qualified individuals may not be denied participation in clinical trials.
- Coverage must include the "essential health benefits package"[12] as required under §1302(a) of PPACA, which requires plans to do the following three things:
    - cover essential health benefits;[13]
    - limit annual cost-sharing to the thresholds applicable to high-deductible health plans (HDHPs) that are qualified for Health Savings Accounts

(...continued)

premium review process, the Secretary presumably will issue guidance defining this concept.

[10] Adjusted, or modified, community rating prohibits issuers from pricing health insurance policies based on health factors, but allows it for other key characteristics such as age.

[11] As an example, some states have enacted rating rules in the individual and small group markets that include geography as a characteristic on which premiums may vary. In these cases, the state has established rating areas. Typically, states use counties or zip codes to define those areas.

[12] PPACA §1201: PHSA §2707(a).

[13] PPACA §1302(b) enumerates a list of broad categories of "essential health benefits": ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness and chronic disease management, and pediatric services (including oral and vision care).

(HSAs)[14]—and additionally for small group plans, limit deductibles to no more than $2,000 for self-only coverage, or $4,000 for any other coverage in 2014 (annually adjusted thereafter);[15] and

- standardize benefit packages into specified bronze, silver, gold, and/or platinum levels of coverage.[16]

- Issuers must consider all enrollees in all nongroup plans offered by the issuer as members of a single risk pool, including enrollees in a nongroup plan outside an exchange. Issuers must also do the same for all their small group plans. States may also merge their individual and small group markets, requiring issuers to have a single risk pool combining both the nongroup and small group enrollees.[17]
- All insurers (including third-party administrators of self-insured plans) must contribute to a temporary reinsurance[18] program for individual policies. The temporary reinsurance program will be administered by a nonprofit reinsurance entity in each state. Each state must establish the reinsurance program for the individual market by no later than January 1, 2014, with it lasting through 2016.[19]
- All insurers must participate in risk-adjustment[20] programs that states are required to establish, in which plans with enrollment of less-than-average risk will pay an assessment to the state, and states will provide payments to plans with higher-than-average risk.[21]

Nongroup and Small Group Plan Requirements *Only Inside* an Exchange

Health Insurance Issuers and Qualified Health Plans

To be available in an exchange in 2014, a plan must be certified by an exchange as being a qualified health plan (QHP).[22] Among the basic requirements for an *issuer* that offers QHPs are the following:

[14] PPACA §1302(c)(1). For 2010, the out-of-pocket maximum for HSA-qualified HDHPs is $5,950 for single coverage and $11,900 for family coverage.

[15] §1302(c)(2).

[16] §1302(d).

[17] §1312(c).

[18] "Reinsurance" typically is thought of as insurance for insurers. When issuing policies, an insurer faces the risk that the premiums it collects will not be sufficient to cover its expenses and generate profit. For a health insurer, unusually high health care claims could lead to significant financial loss. Reinsurance shifts the risk of covering such high expenses from the primary insurer to a reinsurer.

[19] §1341, §10104(r).

[20] "Risk adjustment" refers to a mechanism that adjusts payments to health plans to take into account the risk that each plan is bearing based on its enrollee population.

[21] §1343.

[22] In general, exchange plans must be qualified health plans (with certain exceptions), but not all qualified health plans must be offered in the exchange. In addition to QHPs, exchanges may offer dental-only coverage, and plans that provide catastrophic coverage with limited primary care.

- be "licensed and in good standing to offer health insurance coverage in each State in which such issuer offers health insurance…";
- offer at least one QHP in the silver level and at least one plan in the gold level in an exchange;
- "charge the same premium rate for each qualified health plan of the issuer without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the issuer or through an agent"; and
- "complies with [other requirements described in greater detail below] and such other requirements as an applicable Exchange may establish."[23]

In order to be certified as a QHP, the following are *minimum* criteria to be established by the Secretary (i.e., the Secretary may require additional criteria) through regulation (per §1311(c)(1)), which will not be required of nongroup and small group plans that are not QHPs outside an exchange:

- "meet marketing requirements, and not employ marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs";
- "ensure a sufficient choice of providers … , and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers";
- "include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals";
- "be accredited with respect to local performance on clinical quality measures…";
- implement a quality improvement strategy that provides increased reimbursement or other incentives for the following, per §1311(g)(1):
  - improvement of "health outcomes through the implementation of activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan or coverage";
  - "implementation of activities to prevent hospital readmissions";
  - "implementation of activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage";
  - "implementation of wellness and health promotion activities"; and
  - "implementation of activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings."

[23] §1301(a)(1)(C).

- use a uniform enrollment form that individuals or employers obtaining or offering coverage through an exchange may use (either electronically or on paper);
- "utilize the standard format established for presenting health benefits plan options;
- "provide information to enrollees and prospective enrollees, and to each Exchange in which the plan is offered, on any quality measures for health plan performance … ; and
- "report to the Secretary at least annually and in such manner as the Secretary shall require, pediatric quality reporting measures consistent with the pediatric quality reporting measures established under section 1139A of the Social Security Act," which was established by the Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3).

Exchanges and Exchange Plans

The other paragraphs of §1311(c) include requirements for the Secretary that will affect only plans offered through an exchange. The Secretary must develop the following:

- A system for rating exchange plans "in each benefits level on the basis of the relative quality and price."
- An "enrollee satisfaction survey system that would evaluate the level of enrollee satisfaction with [exchange plans] that had more than 500 enrollees in the previous year."
- Enrollment periods for exchange plans—in particular, exchange plans' initial enrollment period (i.e., the first time exchange coverage is made available), the annual open enrollment period (after the initial enrollment period), specific special enrollment periods (i.e., opportunities to enroll outside the annual open enrollment period because of particular circumstances),[24] and special monthly enrollment periods for Indians.[25]

Under §1311(e) of PPACA, exchanges have the authority to certify a health plan as meeting the qualifications to be considered a qualified health plan. Exchanges are to require plans to meet additional criteria to be certified as QHPs, which will not apply to nongroup and small group plans that are not QHPs outside an exchange:

- "An Exchange may certify a health plan as a qualified health plan if … the Exchange determines that making available such health plan through such

[24] This provision points two special enrollment periods in prior law, under §9801(f) of the Internal Revenue Code (IRC) and under Medicare Part D (regarding the Medicare prescription drug benefit). The IRC special enrollment periods generally apply when a person loses other coverage or when a person becomes a "dependent" of an enrollee through marriage, birth, or adoption or placement for adoption. In addition, the special enrollment periods under Medicare Part D also include a beneficiary's change in residence, a plan's material violation of provision of its contract, a plan inadequately informing beneficiaries of the plan coverage, an enrollment-related error by a federal employee (e.g., enrolling an individual in the wrong plan), and other "exceptional conditions."

[25] As defined in the Indian Health Care Improvement Act.

Exchange is in the interests of qualified individuals and qualified employers in the State or States in which such Exchange operates, except that the Exchange may not exclude a health plan—(i) on the basis that such plan is a fee-for-service plan; (ii) through the imposition of premium price controls; or (iii) on the basis that the plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange determines are inappropriate or too costly." This means that, except for the three reasons specified above, an exchange will have wide authority to deny a plan QHP status if the exchange does not believe granting that certification would be "in the interests" of exchange enrollees.

- Exchanges will require plans seeking QHP certification to submit a justification for *any* premium increase prior to its implementation, which will be posted on the plan's website. "The Exchange shall take this information, and the information and the recommendations provided to the Exchange by the State under section 2794(b)(1) of the Public Health Service Act (relating to patterns or practices of excessive or unjustified premium increases), into consideration when determining whether to make such health plan available through the Exchange. The Exchange shall take into account any excess of premium growth outside the Exchange as compared to the rate of such growth inside the Exchange, including information reported by the States."
- Plans seeking QHP certification will also be required by exchanges to submit the following information to the exchange, the Secretary and the state health insurance commissioner (and to disclose the information publicly): "(i) Claims payment policies and practices. (ii) Periodic financial disclosures. (iii) Data on enrollment. (iv) Data on disenrollment. (v) Data on the number of claims that are denied. (vi) Data on rating practices. (vii) Information on cost-sharing and payments with respect to any out-of-network coverage. (viii) Information on enrollee and participant rights under this title. (ix) Other information as determined appropriate by the Secretary." This information must be provided "in plain language," as specified in PPACA.
- Plans seeking QHP certification will also be required by exchanges to "permit individuals to learn the amount of cost-sharing (including deductibles, copayments, and coinsurance) under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider in a timely manner upon the request of the individual. At a minimum, such information shall be made available to such individual through an Internet website and such other means for individuals without access to the Internet."

If individuals who apply for exchange coverage are determined to be eligible for Medicaid or the State Children's Health Insurance Program (CHIP), those individuals must be enrolled in those programs rather than exchange coverage. This "screen and enroll" provision will not apply to plans outside an exchange. Thus, beginning in 2014, a person who is eligible for Medicaid may only be able to obtain nongroup coverage outside an exchange; [26] there are no guarantees that such coverage would be affordable.

[26] There are a number of screen-and-enroll provisions in PPACA, including §1311(d)(4)(F).

The Secretary's ability to provide federal grants to exchanges is not available past January 1, 2015.[27] "[T]he State shall ensure that such Exchange is self-sustaining beginning on January 1, 2015, including allowing the Exchange to charge assessments or user fees to participating health insurance issuers, or to otherwise generate funding, to support its operations."[28] It is not clear whether states would make such fees apply only to plans within an exchange, or also to plans outside an exchange.

In addition to insurance requirements, it is worth noting some major provisions, which might be considered "advantages" by some, that apply only to exchange plans.

- Individuals who are eligible for federal premium tax credits and cost-sharing subsidies for nongroup coverage can only receive these subsidies through an exchange plan.[29]
- If a state mandates small group and nongroup plans to cover certain benefits above what is federally required in 2014, then exchange plans (or their enrollees, as applicable) must be reimbursed by the state for the additional costs associated with those benefits.[30]
- Exchanges will be required to handle some administrative functions currently handled by insurers, which may reduce insurers' administrative burden and expenses for the nongroup and small group markets. For example, exchanges will be responsible for operating a toll-free telephone hotline to respond to requests for assistance, maintaining a website through which enrollees and prospective enrollees shop for plans, enrolling applicants in the plan of their choice, and coordinating with other federal and state agencies regarding potential subsidies that would go to plans on behalf of eligible individuals.[31, 32]
- Exchange plans will participate in a risk corridor[33] program established by the Secretary to operate from 2014 through 2016. Given all the new requirements that will be in place for insurers in the nongroup and small group markets, the risk corridor program could be seen as a way to protect insurers from huge losses as exchange coverage begins in 2014.[34]

[27] §1311(a)(4)(B).

[28] §1311(d)(5).

[29] §1401(a): IRC §36B(c)(2)(A)(i), and PPACA §1402(c)(4).

[30] §1311(d)(3)(B), as amended. Originally, PPACA had this provision apply only to exchange enrollees who were receiving federal premium credits and cost-sharing subsidies. However, the scope of this provision was expanded to all exchange enrollees per §10104(e)(1). PPACA makes clear that federal assistance is not available for the costs attributable to state-mandated benefits (§1401(a): IRC §36B(b)(3)(D), and PPACA §1402(c)(4)).

[31] See, for example, required exchange functions in §1311(d)(4).

[32] Although the exchange may make these tasks easier than they otherwise would be, plans outside an exchange will not have to deal with certain requirements that could increase administrative expenses and even reduce enrollment. For example, to enroll in an exchange, individuals must be lawfully present in the United States (§1312(f)(3)) and have that lawful presence verified (§1411); for plan enrollment outside an exchange, this is not required.

[33] "Risk corridors" refer to a mechanism which adjusts payments to plans according to a formula based on each plan's actual, allowed expenses in relation to a target amount. If a plan's expenses exceed a certain percentage above the target, the plan's payment is increased, and vice versa.

[34] §1342.

- With respect to the rate review grants to states described above (per PPACA §1003, creating a new PHSA §2794), "a State, through its Commissioner of Insurance, shall … make recommendations, as appropriate, to the State Exchange about whether particular health insurance issuers should be excluded from participation in the Exchange based on a pattern or practice of excessive or unjustified premium increases" beginning in 2014.

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