Overview of Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (ACA)

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Summary

Private health insurance (PHI) is the predominate form of health insurance coverage in the United States, covering about two-thirds of Americans in 2013. The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) builds on existing sources of private health insurance coverage—the nongroup (*individual*), small group, and large group markets. The ACA private health insurance provisions follow a federalist model in which they establish federal minimum requirements and give states the authority to enforce and expand those federal standards.

The ACA includes provisions that restructure the private health insurance market by

1. implementing market reforms that impose requirements on insurers and sponsors of health insurance (e.g., employers);
2. instituting a core set of benefits and services (i.e., the essential health benefits);
3. establishing an individual mandate that requires most individuals to either maintain health insurance coverage or pay a penalty;
4. creating exchanges (*marketplaces*) in which individuals and small businesses can shop for and purchase health plans that meet or exceed federal standards;
5. providing financial assistance to qualified individuals who purchase health plans through an exchange; and
6. assessing penalties on certain employers that either do not provide health insurance or provide health insurance that is *unaffordable* or does not provide *minimum value*.

This report provides a broad overview of the PHI provisions in the ACA and directs readers to more in-depth CRS reports.

Contents

Tables

Contacts

Background

Americans obtain health insurance coverage in different settings and through a variety of methods. Although many receive coverage through publicly funded programs (e.g., Medicare and Medicaid), private health insurance is the predominate form of health coverage in the United States. The private market is often described as having three segments: nongroup (*individual*), small group, and large group.[1] In 2013, about 64.2% of the population had private health insurance.[2] Most individuals and families obtain private insurance through small or large group coverage, such as employer-sponsored insurance; some individuals and families may purchase private insurance on their own in the nongroup market.

The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) includes several provisions that affect the private health insurance market. These provisions create federal rules and incentives for entities and individuals in the market that build on and modify the existing market structure. Collectively, the provisions reflect the ACA's general goal of increasing access to health insurance coverage.

The ACA also includes an individual mandate, which requires most individuals to maintain health insurance coverage or pay a penalty for noncompliance. Many have argued that unless healthy individuals are encouraged to participate in the private market, insurance pools will primarily consist of individuals who are high users of health care services, potentially creating financially unstable situations for insurers and enrollees.[3] As of January 1, 2014, most individuals are required to maintain health insurance coverage or otherwise pay a penalty.

Under the ACA, nearly all individuals can obtain private coverage regardless of preexisting conditions or health status and insurers have limited ability to vary premiums based on an applicant's health status and other characteristics. To help accommodate individuals who have access to private health insurance as a result of these (and other) provisions, individuals and small businesses can shop for and purchase private coverage in health insurance exchanges (*marketplaces*). Additionally, some individuals can receive financial assistance toward coverage obtained in an exchange.

The ACA provides financial incentives for employers to consider when determining whether to offer employer-based health insurance to employees. Some small employers are eligible to receive tax credits for their contributions toward their employees' health insurance premiums. Certain large employers are subject to a *shared responsibility* provision. This provision does not explicitly mandate that a large employer offer employees health insurance; instead, it has the

[1] What constitutes *large* and *small* in the private market varies. Often, for the purpose of state and federal laws, a large employer has 50 or more employees and a small employer has up to 50 employees. The definitions of small and large also vary under the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended), but most often the ACA defines small as either up to 50 or up to 100 employees.

[2] U.S. Census Bureau, Current Population Survey, "Health Insurance Coverage in the United States: 2013," September 2014, available at http://www.census.gov/content/dam/Census/library/publications/2014/demo/p60-250.pdf.

[3] The intent of health insurance is to minimize the potential financial risk associated with use of health care services. One way to minimize risk in the insurance market is to spread risk among a group of people. This concept is often called *risk pooling*. A group of individuals contributes to a common pool (*risk pool*), and contributions from low-cost individuals in the pool (i.e., individuals who use few medical services) subsidize the medical costs of higher-cost individuals in the pool.

potential to impose penalties on large employers that do not provide affordable and adequate coverage to their employees. The shared responsibility provision was slated to take effect in 2014, but its implementation was delayed until 2015.

This report describes various ACA provisions that affect the private insurance market. It does not provide exhaustive information about each provision, but it includes references to Congressional Research Service (CRS) reports that contain detailed information.

Private Health Insurance Market Reforms

A number of ACA provisions focus on changing how insurers and sponsors of insurance (e.g., employers) offer coverage. Collectively, the market reforms establish federal minimum requirements regarding access to coverage, premiums,[4] benefits, cost-sharing,[5] and consumer protections while generally giving states the authority to enforce the reforms and the ability to expand on the reforms.[6] Some of the reforms apply to all three segments of the private insurance market (nongroup, small group, and large group), but many of the reforms focus specifically on the nongroup and small group insurance markets. These reforms are intended to address perceived failures in those markets, such as limited access to coverage and higher costs of coverage, and to provide some parity with the large group market, which may already have many of these features.

Some of the market reforms are

Exemptions from ACA Market Reforms

Grandfathered Status

Health insurance plans that were in existence (either in the group or nongroup market) and in which at least one person was enrolled on the date of the ACA's enactment (March 23, 2010) are considered *grandfathered* and have a unique status under the ACA. As long as a plan maintains its grandfathered status, the plan has to comply with some but not all ACA provisions. Plans may lose their status if they apply certain changes to benefits, cost-sharing, employer contributions, and access to coverage.

For more information about grandfathered plans and their requirements under ACA, see CRS Report R41166, *Grandfathered Health Plans Under the Patient Protection and Affordable Care Act (ACA)*.

Transitional Policy

On March 5, 2014, the Centers for Medicare and Medicaid Services (CMS) extended a transitional policy that was first described in guidance issued by CMS in November 2013. Under the transitional policy, health insurance issuers offering non-grandfathered coverage in the nongroup and small group markets may choose to continue coverage that would otherwise be canceled. Pursuant to the policy, state insurance commissioners may choose whether to enforce compliance with specified ACA market reforms. Presumably, if state insurance commissioners choose not to enforce compliance, then issuers may renew coverage for enrollees who would otherwise receive cancellation notices. Pursuant to the extended policy, coverage renewed for a plan year beginning before or on October 1, 2016, does not have to comply with certain ACA market reforms, provided the coverage meets specified conditions.

For more information about transitional policies, see http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/transition-to-compliant-policies-03-06-2015.pdf.

[4] A premium is the amount paid for health insurance, often on a monthly basis.

[5] Cost-sharing is the share of costs an insured individual pays for services; the term often includes deductibles, coinsurance, and co-payments. A deductible is the amount an insured individual pays before his or her health insurance issuer begins to pay for services. Coinsurance is the share of costs, figured in percentage form, an insured individual pays for a health service. A co-payment is a fixed amount an insured individual pays for a health service.

[6] Private health insurance is primarily regulated at the state level. The ACA establishes uniform requirements and additional options for all states.

new to certain insurance markets; others have been in place in some capacity due to either state or federal laws. For example, guaranteed issue is the requirement that an insurer accept every applicant for coverage as long as the applicant agrees to the terms and conditions of the insurance offer (e.g., the premium). In the early 1990s, some states passed laws requiring guaranteed issue in their small group markets, with fewer states adopting types of guaranteed issue laws in their nongroup markets.[7] In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA; P.L. 104-191), which requires guaranteed issue in the small group market in all states. The ACA extends these efforts by requiring, as of 2014, that all non-grandfathered nongroup and group plans (except those that are self-insured)[8] offer coverage on a guaranteed issue basis. However, not all plans are subject to these ACA market reforms (see "Exemptions from ACA Market Reforms" text box for further information).

Table 1 provides a brief overview of the market reforms in the ACA. More specific information, including how the reforms apply to each segment of the private market, can be found in CRS Report R42069, *Private Health Insurance Market Reforms in the Affordable Care Act (ACA)*.

Table 1. Patient Protection and Affordable Care Act (ACA) Private Health Insurance Market Reforms

ACA Provision	Brief Description
Obtaining Health Insurance	
Extension of dependent coverage	Applicable plans that offer dependent coverage must make that coverage available to children under the age of 26.
Prohibition of discrimination based on salary	Applicable plans are prohibited from establishing eligibility criteria for full-time employees based on salary.
Guaranteed issue	Applicable plans are required to accept every applicant for health coverage (as long as the applicant agrees to the terms and conditions of the insurance offer).
Nondiscrimination based on health status	Applicable plans are prohibited from basing eligibility for coverage on health status-related factors.
Waiting period limitation	Applicable plans cannot establish a waiting period of more than 90 days.
Maintaining Health Insurance	
Prohibition on rescissions	Applicable plans are prohibited from rescinding coverage except in cases of fraud or intentional misrepresentation.
Guaranteed renewability	Applicable plans must renew individual coverage at the option of the policyholder or group coverage at the option of the plan sponsor.
Cost of Purchasing Health Insurance	

[7] Mila Kofman and Karen Pollitz, *Health Insurance Regulation by States and the Federal Government: A Review of Current Approaches and Proposals for Change*, Georgetown University Health Policy Institute, April 2006.

[8] A common distinction in the group market is whether plans are fully insured or self-insured. A fully insured plan is one in which the insurer or insurance sponsor purchases health coverage and the insurer assumes the risk of providing health benefits to the sponsor's enrolled members. A self-insured plan is one in which an entity (e.g., employer or association) provides coverage for its members directly by setting aside funds and paying for health benefits. Under self-insurance, the entity bears the risk for covering medical expenses, and self-insured plans are not subject to state insurance regulations.

ACA Provision	Brief Description
Review of "unreasonable" rate increases	Applicable plans must submit a justification for an "unreasonable" rate increase to the Secretary of Health and Human Services (HHS) and the relevant state prior to implementation of the increase.
Rating restrictions	Applicable plans can only adjust premiums based on certain ACA-specified factors.
Covered Benefits	
Coverage of preventive health services with no cost-sharing	Applicable plans are required to provide coverage for preventive health services without cost-sharing.
Coverage of preexisting health conditions	Applicable plans are prohibited from excluding coverage for preexisting health conditions for all individuals.
Limits on Cost-Sharing	
Prohibition on lifetime limits	Applicable plans are prohibited from imposing lifetime limits on the dollar value of the essential health benefits (EHB).
Prohibition on annual limits	Applicable plans are prohibited from imposing annual limits on the dollar value of the EHB.
Other Consumer Protections	
Medical loss ratio requirement	Applicable plans are required to spend a certain amount of premium revenue on medical claims or otherwise provide rebates to policyholders.
Standardized appeals process	Applicable plans must implement an effective appeals process for coverage determinations and claims.
Patient protections	Applicable plans must comply with requirements related to choice of health care professionals and benefits for emergency services.
Summary of benefits and coverage	Applicable plans must provide a summary of benefits and coverage to individuals that meets the requirements specified by the HHS Secretary.
Reporting requirements regarding quality of care	Applicable plans must annually submit reports to the HHS Secretary and enrollees that address plan quality.
Nondiscrimination regarding clinical trial participation	Applicable plans cannot prohibit enrollees from participating in approved clinical trials.
Nondiscrimination regarding health care providers	Applicable plans are not allowed to discriminate, with respect to participation under the plan, against health care providers acting within the scope of their license or certification.

Source: Congressional Research Service (CRS) analysis of the ACA and its implementing regulations.

Essential Health Benefits Package

Both state and federal governments have the authority to require private plans to comply with specified rules and regulations, such as offering certain benefits and services. The ACA includes a provision that expands federal requirements with regard to covered benefits and cost-sharing structures. The ACA requires that all non-grandfathered plans offered in the nongroup and small group markets (both inside and outside exchanges) offer the essential health benefits (EHB).

The ACA does not explicitly define the EHB; rather, it lists 10 broad categories from which benefits and services must be included[9] and requires the Secretary of Health and Human Services (HHS) to further define the EHB. For 2014 and 2015, [10] the HHS Secretary asked states to select a benchmark plan from four different types of plans.[11] Plans that are required to offer the EHB must model their benefits package after the state's benchmark plan.[12] Plans must supplement their benchmark plans to ensure that benefits and services from all 10 statutorily required categories are represented.

The EHB package includes limits on enrollees' cost-sharing requirements. The ACA specifies that the limits work in two[13] ways: they prohibit (1) applying deductibles to preventive health services and (2) annual out-of-pocket limits that exceed existing limits in the tax code.[14] In 2015, the limit is $6,600 for an individual plan and $13,200 for a family plan.

Additionally, plans offering the EHB package must meet one of four levels of generosity of coverage based on actuarial value. (See "ACA and Actuarial Value" text box for more information.)

The ACA requires plans that offer the EHB package to meet one of four generosity levels (*metal tiers*):

- bronze—60% actuarial value;
- silver—70% actuarial value;
- gold—80% actuarial value; and
- platinum—90% actuarial value.

The ACA and Actuarial Value

Actuarial value is a summary measure of a plan's generosity of coverage, expressed as a percentage of medical expenses for a standard population and a set of allowed charges estimated to be paid by the issuer. In other words, actuarial values reflect the relative proportions of cost-sharing that may be imposed. On average, the lower the actuarial value of a plan, the greater the cost-sharing for the enrollee.

However, because actuarial value is a summary measure based on a standard population, it is of varying value to individuals. Its value for an individual depends on how the individual's medical costs align with the costs of the standard population. Actuarial value also does not take into account aspects of health insurance coverage that may be important to individuals. In particular, it does not consider the cost of premiums and the adequacy of provider networks, and plans with the same actuarial value do not necessarily include the same set of covered benefits.

Individual Mandate

As of January 1, 2014, ACA requires that most individuals maintain health insurance coverage or pay a penalty for noncompliance. To comply with the individual mandate, most individuals need

[9] The 10 categories are 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 services and chronic disease management; and pediatric services, including oral and vision care.

[10] As of the publication date of this report, final 2016 guidance for the essential health benefits has not been released.

[11] 78 *Federal Register* 12834, February 25, 2013.

[12] Summaries of each state's selected benchmark plan are available at http://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html.

[13] The ACA previously limited cost-sharing in three ways. It also included deductible limits for plans offered in the small group market—generally prohibiting these plans from having deductibles greater than $2,000 for self-only coverage and $4,000 for any other coverage in 2014. However, the Protecting Access to Medicare Act of 2014 (P.L. 113-93) repealed this provision, thereby removing the limitation on deductibles for plans offered in the small group market.

[14] The existing limits are those that are applicable to high-deductible health plans that qualify to be paired with health savings accounts. For more information on consumer-driven health care, see CRS Report RL32237, *Health Insurance: A Primer*.

to obtain *minimum essential coverage*, which includes most types of private (e.g., employer-sponsored insurance and nongroup coverage) and public coverage (e.g., Medicare and Medicaid). Certain individuals are exempt from the mandate, including those with qualifying religious exemptions; those whose household income is less than the filing threshold for federal income taxes for the applicable tax year; those whose required contribution for self-only coverage for a calendar year exceeds 8% of household income;[15] those who receive a hardship exemption from the HHS Secretary; and those who are not lawfully present in the United States.

The individual mandate is often described as working in conjunction with certain ACA market reform, including guaranteed issue and renewability, nondiscrimination based on health status, coverage of preexisting health conditions, and rating restrictions (see **Table 1**). Collectively, these reforms require insurers to accept all applicants and concurrently restrict insurers' ability to vary premiums based on an applicant's health status and other characteristics. Because these reforms attempt to provide improved access to coverage for sick individuals or those at high risk of becoming ill, many argue that a provision such as the individual mandate is necessary to encourage healthy individuals to participate in the market so insurer risk pools are not limited to individuals who are high users of health care services (e.g., individuals who have multiple medical conditions).

Individuals are required to pay a penalty for each month of noncompliance with the mandate (provided they are not exempt from the mandate). The annual penalty is the *greater* of a percentage of "applicable income" [16] or a flat dollar amount assessed on each taxpayer and any dependents. **Table 2** provides the percentage of applicable income and flat dollar penalty amounts for 2014-2016. After 2016, the penalty will be adjusted for inflation.

Table 2. Individual Mandate Penalty

Year	Percentage of Applicable Income	Flat Dollar Amount
2014	1.0%	$95
2015	2.0%	$325
2016	2.5%	$695

Source: CRS analysis of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148) and its implementing regulations.

Notes: Penalty will be adjusted for inflation after 2016. The ACA caps the penalty for noncompliance; the penalty in any given year cannot exceed the national average premium for bronze-level coverage offered through exchanges (for the relevant family size).

Taxpayers who are required to pay a penalty but fail to do so will receive a notice from the Internal Revenue Service (IRS) stating that they owe the penalty. If they still do not pay the penalty, the IRS can attempt to collect the funds by reducing the amount of the taxpayers' tax refund for that year or future years. However, individuals who fail to pay the penalty will not be subject to any criminal prosecution or penalty for such failure. The Secretary of the Treasury cannot file notice of lien or a levy on any property for a taxpayer who does not pay the penalty.

[15] After 2014, the 8% will be adjusted to reflect the excess rate of premium growth above the rate of income growth for the period. In 2015, the required contribution for self-only coverage must exceed 8.05% of household income.
[16] "Applicable income" is defined as the amount by which an individual's household income exceeds the applicable filing threshold for the applicable tax year.

For more information about the individual mandate, see CRS Report R41331, *Individual Mandate Under ACA*.

Exchanges (Marketplaces)

The ACA requires the establishment of a health insurance exchange (*marketplace*) in every state as of January 1, 2014. ACA exchanges are marketplaces in which individuals and small businesses can shop for and purchase private health insurance coverage.[17] To facilitate the purchase of insurance by these groups, the ACA requires the exchanges to have two parts: an exchange in which individuals can buy nongroup insurance for themselves and their families (an individual exchange) and a small business health options program (SHOP) exchange that is designed to assist qualified small employers and their employees with the purchase of insurance.

Exchanges are intended to simplify the experience of providing and obtaining coverage. They are not intended to supplant the private market outside of exchanges. The ACA requires that plans offered through an exchange are, for the most part, qualified health plans (QHPs). In general, to be a QHP, a plan has to offer the EHB package and meet certain standards related to marketing, choice of providers, and plan networks.[18] Each exchange is responsible for certifying the plans it offers.

Individual Exchange and Financial Assistance

The individual exchange is among the ACA provisions directed at the nongroup market. The ACA requires that each state establish an individual health insurance exchange. A state may set up its own exchange or create an exchange in partnership with the federal government. All health plans available through the nongroup exchanges must meet certain federally required criteria, such as offering the EHBs.

The open enrollment period for 2015 coverage through the individual exchange is November 15, 2014 to February 15, 2015. Individuals enrolled in a 2014 exchange plan can renew their current health plan or choose a new health plan through the exchange during the 2015 open enrollment period. However, if an individual enrolled in a 2014 exchange plan did not make any changes to his or her coverage by December 15, 2014, that individual was automatically reenrolled in the same health plan he or she selected in 2014.[19]

Individuals purchasing nongroup coverage through the exchange may be eligible to receive financial assistance. Financial assistance for obtaining coverage is based on income and provided through premium tax credits and cost-sharing subsidies.

[17] Individuals who approach exchanges could also potentially be screened for eligibility for public programs such as Medicaid and the State Children's Health Insurance Program (CHIP).

[18] For more information about the types of plans offered through exchanges, see CRS Report R43233, *Private Health Plans Under the ACA: In Brief*.

[19] The individual's coverage will be renewed in the same plan as his or her current plan, unless the current plan is unavailable. These individuals can also select a plan between December 16, 2014 and February 15, 2015, but the plan selection will not be effective for January 1, 2015 coverage. For additional information, see 45 C.F.R. § 155.335.

Premium Tax Credits

Premium tax credits are generally available to individuals who

- are a part of a tax-filing unit;
- purchase nongroup coverage through an exchange;
- have household income[20] at or above 100%[21] of the federal poverty level (FPL)[22] but not more than 400% FPL;[23]
- are not eligible for minimum essential coverage;[24] and
- are U.S. citizens (or legally residing in the United States).

Although the tax credits are generally directed at individuals who do not have access to coverage outside the nongroup market, certain individuals with access to employer-sponsored insurance (ESI) may be eligible for premium tax credits. An individual eligible for ESI may still be eligible for premium credits if the employer's coverage either is deemed unaffordable[25] or does not provide minimum value.[26] If this were the case, the individual could purchase nongroup coverage through an exchange with the assistance of a premium tax credit.[27]

The premium credits established under the ACA are advanceable and refundable, meaning tax filers need not wait until the end of the tax year to benefit from the credit and may claim the full credit amount even if they have little or no federal income tax liability. The amount of the premium tax credit varies from person to person. The credit is based on the household income of the tax filer (and dependents), the premium for the exchange plan in which the tax filer (and dependents) is enrolled, and other factors.

The amounts received in premium credits are based on the household's prior year's income tax returns or estimates of household income for the current year. These amounts are reconciled in the next year when individuals file tax returns for the actual year in which they receive premium credits. If a tax filing unit's income decreases during the tax year and the filer should have

[20] In this instance, household income is modified adjust gross income.

[21] Lawfully present immigrants with income below 100% of the federal poverty line (FPL), who are ineligible for Medicaid for the first five years that they are present in the United States, are also eligible for premium tax credits. For the purpose of the credits, these individuals will be treated as though their income were exactly 100% FPL.

[22] The guidelines that designate the federal poverty level are used in a variety of federal programs for eligibility purposes. The poverty guidelines vary by family size and by whether the individual resides in the 48 contiguous states and the District of Columbia, Alaska, or Hawaii. Office of the Assistant Secretary for Planning and Evaluation, "Frequently Asked Questions Related to the Poverty Guidelines and Poverty," http://aspe.hhs.gov/Poverty/faq.cfm#programs.

[23] For 2015, the income range corresponding with 100% FPL and 400% FPL is $11,670-$46,680 for a single individual and $23,850-$95,400 for a family of four. FPL amounts are higher in Alaska and Hawaii.

[24] The types of coverage that have been statutorily designated as minimum essential coverage include government-sponsored programs, employer-sponsored plans, plans in the individual market, and grandfathered health plans. 45 C.F.R. § 156.604.

[25] *Affordable* in this context means the individual's required contribution toward the plan premium for self-only coverage does not exceed 9.5% of his or her household income.

[26] *Minimum value* in this context means the plan pays for at least 60%, on average, of covered health care expenses.

[27] In this scenario, the individual's employer could be subject to a penalty. See "Employer Requirements and Penalties Related to the Offer of Insurance."

received a larger tax credit, this additional credit amount will be included in the tax refund for that year. Any excess amount that was overpaid in premium credits will have to be repaid to the federal government as a tax payment. The ACA limits the amount of required repayments for lower-income enrollees. [28]

For more detailed information about premium tax credits, see CRS Report R41137, *Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA)*.

Cost-Sharing Subsidies

Under the ACA, some individuals will also be eligible to receive financial assistance in the form of cost-sharing subsidies that go toward cost-sharing expenses, such as deductibles, coinsurance, and co-payments. To be eligible, individuals must be eligible for premium tax credits and enrolled in a nongroup silver plan through an exchange.[29]

Cost-sharing assistance is provided in two forms, and both forms are based on income. Some individuals may receive both types of cost-sharing subsidies if they meet the applicable eligibility requirements. The first form of cost-sharing assistance reduces the annual out-of-pocket limits for individuals with income between 100 % FPL and 250% FPL.[30] The second form, which also applies to individuals with income between 100% FPL and 250% FPL, involves reducing eligible individuals' cost-sharing requirements to ensure that the plans in which they have enrolled cover a certain percentage of allowed health care expenses, on average. This form of cost-sharing assistance directly affects cost-sharing requirements, such as deductibles, coinsurance, and co-payments.

For more information about the cost-sharing subsidies, see CRS Report R41137, *Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA)*.

Small Business Health Options Program Exchange

The small business health option program (SHOP) exchanges are among the ACA provisions directed at the small group market. SHOP exchanges are marketplaces in which private health insurance issuers sell health insurance plans to small employers. Like the individual exchanges, all health plans available through SHOP exchanges must meet certain federally required criteria, such as offering the EHB.

Small employers that offer health insurance coverage to all of their full-time employees are eligible to use the SHOP exchange.[31] Prior to January 1, 2016, the ACA allows states to define a

[28] The caps have been modified a few times since the ACA's enactment. For more information, see CRS Report R41137, *Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA)*.

[29] The ACA establishes different cost-sharing subsidy eligibility criteria for American Indians and Alaskan Natives. For more information, see CRS Report R41152, *Indian Health Care: Impact of the Affordable Care Act (ACA)*.

[30] In 2015, the annual limit is $6,600 for an individual plan and $13,200 for a family plan.

[31] An employer's Small Business Health Options Program (SHOP) exchange eligibility depends on size and whether the employer offers coverage to all full-time employees. ACA and its implementing regulations set forth methods and definitions with respect to determining employer size and whether an employee is full time. For more information about the definitions and methods employers must use to determine size, see CRS Report R43771, *Small Business Health Options Program (SHOP) Exchange*.

small employer as having either 100 or fewer employees or 50 or fewer employees.[32] In 2016, all states must define a small employer as having 100 or fewer employees. In 2017, states will have the option to allow large employers to use the SHOP exchange.

For more information about the SHOP exchange, see CRS Report R43771, *Small Business Health Options Program (SHOP) Exchange*.

Small Business Tax Credit

The ACA includes provisions whereby certain small employers may be eligible for a tax credit, provided they contribute at least 50% toward their employees' health insurance premiums. The small business health insurance tax credit is generally available to qualifying nonprofit and for-profit employers with fewer than 25 full-time equivalent (FTE) employees with average annual wages that fall under a statutorily specified cap. [33]

Small employers can claim the *full* credit amount if they meet the following two criteria:

- The employer has 10 or fewer FTEs.
- The employer's average taxable wages are $25,400 or less in 2014 (adjusted for inflation in subsequent years). This figure is calculated by dividing the aggregate amount of wages paid to employees during the year by the number of FTEs (and then rounding to the nearest $1,000).

In 2014, the credit was phased out as the number of FTEs increased from 10 FTEs to 25 FTEs and as average employee compensation increased from $25,400 to $50,800.[34] The full credit in 2014 covered up to 50% of the for-profit employer's contribution and 35% of the nonprofit employer's contribution. From 2014 onward, the credit is only available to an employer for two consecutive tax years and to employers who obtain coverage through a SHOP exchange.[35]

For more information about the small business tax credit, see CRS Report R41158, *Summary of the Small Business Health Insurance Tax Credit Under ACA*.

[32] According to a March 2014 report published by the Commonwealth Fund, all states chose the 50-employee limit for 2014. See the Commonwealth Fund, Implementing the Affordable Care Act: State Action to Establish SHOP Marketplaces, March 2014.

[33] Full-time equivalent employees (FTEs) are calculated by dividing the total hours worked by all employees during the tax year by 2,080 (with a maximum of 2,080 hours for any one employee). For calculating the number of FTEs and their wages, the term *employee* includes all individuals who are considered employees under the common law standard, including those who do not work full time. However, the term excludes seasonal workers (persons working no more than 120 days during the year). In addition, the term excludes self-employed individuals, 2% shareholders in an S-corporation, 5% owners of an eligible small business, and anyone who is a relation or dependent of these people.

[34] The amounts will be adjusted for inflation using the Consumer Price Index-Urban in subsequent years.

[35] The Internal Revenue Service (IRS) provides transition relief for certain small employers that cannot obtain a qualified health plan (QHP) offered through a SHOP exchange because the small employer's principal business address is in a county in which a QHP through a SHOP was not available in 2014. The IRS has identified counties in Washington and Wisconsin to which this transition relief applies. See IRS Notice 2014-6 for more details.

Employer Requirements and Penalties Related to the Offer of Insurance

Certain large employers are subject to a *shared responsibility* provision. This provision does not explicitly mandate that a large employer offer employees health insurance; instead, it has the potential to impose penalties on large employers that do not provide affordable and adequate coverage to their full-time employees (and those employee's dependents).

The ACA includes an employer penalty that was to be imposed in 2014. However, based on guidance issued by the IRS, the penalty will not be assessed until 2015. The employer requirements and penalty is being phased in—the requirement applies to large firms with 100 or more FTE employees in 2015 and employers with 50 or more FTE employees in 2016.[36]

A large employer, regardless of the offer of coverage, may be subject to a penalty if any of its full-time employees[37] obtain coverage through an exchange and receive a premium tax credit. Calculation of the penalty amount depends on whether the employer offers coverage and the total number of full-time employees working for the employer. Large employers that offer coverage will only have to pay a penalty if a full-time employee receives a premium tax credit. An employee will receive a premium tax credit only if his or her self-only coverage from the employer either exceeds 9.5% of household income or pays for less than 60%, on average, of covered health care expenses. Large employers that do not offer coverage may be subject to a penalty only if at least one full-time employee receives a premium tax credit.

No employer may be subject to a penalty based upon health coverage for any part-time employee, even if the part-time employee receives a premium credit.

For more information, see CRS Report R41159, *Potential Employer Penalties Under the Patient Protection and Affordable Care Act (ACA)*.

Consumer Operated and Oriented Plan Program

The ACA creates the Consumer Operated and Oriented Plan (CO-OP) program to foster nonprofit, member-run health insurance companies that would offer qualified health plans in the nongroup and small group markets. The HHS Secretary is required to use funds appropriated to the CO-OP program to finance start-up and solvency loans for eligible nonprofit organizations applying to become CO-OP issuers. Awarded entities are to use the start-up loans for assistance with costs associated with creating the CO-OP, and the solvency loans must be used to help the entity meet state solvency requirements.[38] All loans must be repaid with interest; the start-up

[36] Generally, both full-time and part-time employees are included in the calculation to determine the number of FTEs the employer has, but the calculation does not include full-time seasonal employees who work for up to 120 days during the year.

[37] Full-time employees are those working 30 hours per week or more.

[38] States generally set standards for and monitor state-licensed insurers' financial operations to ensure that insurers have adequate reserves to pay policyholders' claims.

loans must be repaid within 5 years and the solvency loans must be repaid within 15 years (from the date of disbursement).

As of the publication date of this report, 23 entities have received loans totaling over $2.1 billion.[39] As enacted, the ACA appropriated $6 billion of federal funds for the CO-OP program, but the American Taxpayer Relief Act of 2012 (ATRA; P.L. 112-240) rescinded most of the unobligated CO-OP funds. The funds remaining for the program must be used to support the 23 entities that have already received CO-OP loans.[40]

The entities that have received loans are required to meet certain standards with regard to the types of health plans they offer. Two-thirds of the plans offered by CO-OP issuers must be QHPs offered in the nongroup and small group markets; up to one-third of a CO-OP issuer's plans can be other types of plans, such as Medicaid managed care plans. With regard to how CO-OP issuers are expected to interact with exchanges, CO-OP plans must be offered at the silver and gold levels in the nongroup market in each exchange that serves the geographic regions in which the CO-OP loan recipient is licensed and intends to provide health care coverage. CO-OP plans must be offered at both the silver and gold levels in the small group market in each SHOP that serves the geographic regions in which the entity is offering coverage if the CO-OP loan recipient offers at least one plan in the small group market outside an exchange.

Multi-State Plan Program

To increase the number of plan choices offered through the exchanges, the ACA directs the Office of Personnel Management (OPM) to contract with private insurers in each state to offer at least two[41] comprehensive health insurance options, known as multi-state plans (MSPs). Some MSP options also offer in-network care for out-of-state services, but not all do. Individuals interested in MSP options would have access to the same financial assistance for premium tax credits and cost-sharing subsidies as enrollees in other plans.

OPM administers the contracts in a similar manner as the Federal Employee Health Benefits Program (FEHBP). This includes negotiating plan benefits, monitoring performance, and overseeing compliance with ACA provisions. MSPs must cover the EHBs and comply with ACA cost-sharing limits. Carriers must be licensed in each state and comply with state laws. Because the EHBs differ among states, MSPs can choose to follow a particular state's EHB package or one of the three largest by enrollment FEHBP packages.

[39] One additional entity, an organization in Vermont, received Consumer Operated and Oriented Plan (CO-OP) loans, but the Centers for Medicare and Medicaid Services terminated the entity's loan agreement in 2013. For more information about the 23 loan recipients, see http://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html.

[40] The Department of Defense and Full-Year Continuing Appropriations Act, 2011 (P.L. 112-10) rescinded $2.2 billion of the appropriated funding, and the Consolidated Appropriations Act, 2012 (P.L. 112-74) rescinded an additional $400 million from the program. The American Taxpayer Relief Act of 2012 (ATRA; P.L. 112-240) rescinded nearly all other unobligated CO-OP funds. ATRA directed the Secretary of Health and Human Services (HHS) to create a fund to be used to support all nonprofit insurance issuers that were awarded CO-OP program loans prior to the date of the law's enactment (January 2, 2013). The fund contains 10% of any unobligated CO-OP funds, and the Act rescinded all other unobligated CO-OP funds.

[41] One of the issuers must be nonprofit.

OPM can contract with a health insurance issuer to offer an MSP if the health insurance issuer agrees to a phase-in expansion. MSPs would have to be made available in 35 states by 2015, 43 states in 2016 and 2017, and all states by open enrollment in 2017.

In 2014, OPM contracted with the Blue Cross Blue Shield Association to offer over 150 MSPs in 30 states and the District of Columbia. For 2015, OPM has added a second group of insurers, an association of CO-OP programs, and the MSP program expanded to 5 additional states for a total of 36 states. The MSP program offers more than 200 plans on the exchanges for 2015.

State Options

Many of the provisions discussed to this point are required to be implemented under ACA. However, the ACA also includes provisions that states may choose to implement. The flexibility for states inherent in these *state option* provisions allows states to continue programs already in existence or create new programs that may be better-suited to their specific private insurance markets.

Basic Health Program

The ACA provides states an option to offer coverage to certain low-income individuals through a basic health program (BHP). Beginning in 2015,[42] states are able to establish a BHP, which is a health insurance program for individuals under the age of 65 who are not eligible for Medicaid or eligible to enroll in minimum essential coverage. A BHP is offered in lieu of these individuals obtaining coverage through an exchange. The BHP is available to individuals with household income between 133% FPL[43] and 200% FPL,[44] and the BHP coverage must be at least as comprehensive and affordable as what the individuals could have obtained through an exchange. A state that chooses to establish a BHP will receive some funds from the federal government to operate the program.[45]

As of the publication date of this report, CMS approved MinnesotaCare as the nation's first BHP, after Minnesota became the first state to win approval for this option under the ACA.

[42] As enacted, the ACA allowed states to establish a Basic Health Program (BHP) beginning in 2014; however, HHS released guidance stating that the program will not be operational and available as a state option until 2015. For more information, see *Questions and Answers: Medicaid and the Affordable Care Act*, available at http://medicaid.gov/State-Resource-Center/FAQ-Medicaid-and-CHIP-Affordable-Care-Act-ACA-Implementation/Downloads/ACA-FAQ-BHP.pdf.

[43] The ACA includes a five percentage point income disregard, so the effective limit is 138% FPL.

[44] The BHP would also be available to individuals who are not citizens of the United States but are lawfully present and barred from Medicaid because of duration of U.S. residency. These individuals are eligible for a BHP if they otherwise meet the eligibility criteria and have household income not greater than 138% FPL.

[45] The ACA requires the HHS Secretary to transfer funds to a state that establishes a BHP in an amount equal to 95% of the premium tax credits and the cost-sharing reductions that would have been provided to the state's BHP enrollees had they been able to obtain coverage through an exchange.

Waiver for State Innovation

The ACA allows a state to apply to the HHS Secretary for a waiver of specific requirements with respect to health insurance coverage within that state for plan years beginning on or after January 1, 2017. The state may apply to waive any or all of the following:

- requirements relating to the establishment of QHPs;
- requirement for the state to have an exchange;
- requirement to offer premium tax credits and cost-sharing reductions through an exchange;
- requirement for individuals to maintain coverage (individual mandate); and
- penalties imposed on employers whose employees receive premium tax credits.

For a state to obtain a waiver, the HHS Secretary and the Secretary of the Treasury need sufficient information from the state to determine that its proposed waiver will provide benefits that are at least as comprehensive as the EHBs; provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable as the cost-sharing provisions in the ACA; provide coverage to at least a comparable number of residents as the provisions of the ACA that affect private health insurance would provide; and not increase the federal deficit.

Health Care Choice Compacts

The ACA allows two or more states to create a health care choice compact. The compact would allow the states to enter into an agreement whereby one or more QHPs could be offered in the nongroup market in all states in the compact. In this arrangement, a QHP would only be subject to the laws and regulations of the state in which the plan was issued; however, the issuer of such QHP would be subject to other rules and requirements (e.g., market conduct rules, consumer protection rules) imposed by the state(s) in which the consumer resides. Additionally, the issuer would either be required to be licensed in each state in the compact or to submit to each state's standards for offering insurance, and the issuer would have to notify all consumers that it may not comply with their state's rules.

A state must have a law that specifically authorizes it to enter into a compact. The HHS Secretary may approve a compact if the agreement meets certain requirements. The ACA directed the HHS Secretary to promulgate regulations on this provision no later than July 31, 2013; as of the publication date of this report, the regulations have not been promulgated. Approved compacts cannot go into effect before January 1, 2016.

Risk Mitigation Programs

As part of a larger set of private health insurance market reforms, beginning in 2014, the ACA requires private health insurance issuers to provide coverage to individuals regardless of health status, medical history, and preexisting conditions. Some individuals are eligible to receive premium tax credits and cost-sharing subsidies through an exchange (marketplace), which can increase the attractiveness of coverage by reducing its cost. The individual mandate is also in effect, which requires most individuals to maintain coverage or otherwise pay a penalty.

All the new health insurance market reforms and the expanded market of individuals seeking to purchase insurance contribute to the uncertainty insurers face as they try to price their insurance products in the first few years of the ACA's implementation. Additional questions insurers face include: Will young and healthy uninsured individuals purchase insurance? Have individuals who were previously uninsured been delaying necessary health care, and how much will their health care utilization (and costs) change when they have insurance? How many employers will send their employees to the exchanges to acquire insurance? How will competitors in the market price their products?

The ACA establishes *three* programs to help mitigate the financial risk insurers face as a result of the insurance market reforms. The *risk adjustment program* is a permanent program that began in 2014 and is intended to mitigate the effects of adverse selection both inside and outside of the new exchanges. Adverse selection occurs when individuals who expect or plan for high use of health services enroll in more generous and often more expensive health plans and, simultaneously, individuals who expect or plan for low use of health services enroll in more modest plans (both in terms of price and benefits) or choose not to enroll in coverage. Adverse selection can thus lead to insurers *enrolling* either a large number of high-cost individuals or a disproportionate number of low-cost individuals, depending on plan offerings. Risk adjustment is an adjustment to plan *payments* to reflect the higher cost of enrolling a relatively sicker group of enrollees or the lower cost of enrolling a relatively healthier group of enrollees.

The ACA also establishes two temporary programs to help mitigate other types of plan risks. The *reinsurance program* is a temporary program (2014-2016) designed to compensate plans for the cost of individual enrollees who have excessively high medical expenses, such as those who may have delayed receiving needed health care. The *risk corridor program* is a temporary program (2014-2016) designed to mitigate excessive losses (or gains) that result from errors in estimating premiums as the new market reforms get under way. See **Table 3** for more information about the risk programs.

Table 3. Description of the Patient Protection and Affordable Care Act (ACA) Risk Mitigation Programs

	Reinsurance	Risk Corridors	Risk Adjustment
Goal	Offset a plan's risk associated with high-cost enrollees.	Protect against inaccurate rate setting.	Protect against adverse selection.[a]
Objective	Provide funding to plans that incur high costs for individual enrollees.	Limit the issuers' losses (and gains).	Transfer funds from lowest-risk plans to highest-risk plans.

	Reinsurance	Risk Corridors	Risk Adjustment
Description	Reinsurance typically is thought of as insurance for insurers. When issuing policies, an insurer faces the risk that the premiums[b] it collects will not be sufficient to cover its expenses and generate profit. Reinsurance shifts the risk of covering high expenses from the primary insurer to a reinsurer. The ACA requires all health insurance issuers and third-party administrators of group health plans (including self-insured plans) to contribute to a reinsurance program administered by a nonprofit reinsurance entity. The contribution rate for 2015 is $44 per covered life.	Risk corridors refer to a mechanism that adjusts payments[c] to health 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. Likewise, if a plan's expenses are at least a certain percentage below the target, the plan's payment is decreased. Under the ACA, HHS must make payments to a QHP issuer that experiences losses greater than 3% of the issuer's projections, whereas a QHP issuer whose gains are greater than 3% of its projections must remit payments to HHS.	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. Plans with enrollment of less-than-average risk will pay an assessment to the state. States will provide payments to plans with higher-than-average risk.
	Non-grandfathered individual market plans (inside and outside of exchanges) are eligible for payments from the reinsurance program.	All QHPs in the individual and small group markets (inside and outside of exchanges) must participate in the risk corridor.	All non-grandfathered individual and small group market plans (inside and outside the exchanges) are subject to risk adjustment.
Time Frame	Three years (2014-2016)	Three years (2014-2016)	Permanent; began after end of benefit year 2014

Source: CRS analysis of the ACA and its implementing regulations.

Notes: HHS = Department of Health and Human Services. QHP = qualified health plan.

a. Adverse selection occurs when individuals who expect or plan for high use of health services tend to enroll in more generous (and consequently more expensive) health plans.

b. Premiums refer, in general, to payments from an insured individual to the issuer.

c. In this table, payments are between the insurer and HHS Secretary, either to or from.

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