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

(name redacted)
Analyst in Health Care Financing

(name redacted)
Analyst in Health Care Financing

April 5, 2016

Congressional Research Service
7-....
www.crs.gov
R43854

CRS REPORT
Prepared for Members and
Committees of Congress

Summary

Private health insurance is the predominant form of health insurance coverage in the United States, covering about two-thirds of Americans in 2014. The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) builds on and modifies existing sources of private health insurance coverage—the non-group (individual), small-group, and large-group markets. The ACA 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

- implementing market reforms that impose requirements on insurers and sponsors of health insurance (e.g., employers);
- creating health insurance exchanges (*marketplaces*) in which individuals and small businesses can shop for and purchase private health plans that meet or exceed federal standards;
- providing financial assistance to qualified individuals and small employers who purchase health plans through an exchange;
- establishing an individual mandate, which requires most individuals to either maintain health insurance coverage or pay a penalty;
- creating three risk mitigation programs to help health insurance issuers adjust to the reformed private health insurance landscape;
- assessing penalties on certain employers that either do not provide health insurance or provide health insurance that does not meet certain criteria; and
- including some state-option provisions, which states may choose to implement.

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

Contents

Introduction ... 1
Private Health Insurance Market Reforms ... 2
Exchanges (Marketplaces) ... 5
    Premium Tax Credits ... 6
    Cost-Sharing Subsidies ... 7
    Small Business Health Insurance Tax Credits ... 7
Individual Mandate ... 8
Risk Mitigation Programs ... 8
    Reinsurance ... 9
    Risk Corridors ... 10
    Risk Adjustment ... 10
Employer Shared Responsibility ... 11
Consumer Operated and Oriented Plan Program ... 11
Multi-State Plan Program ... 12
State Options ... 12
    Basic Health Program ... 13
    State Innovation Waivers ... 13
    Health Care Choice Compacts ... 14
Related CRS Reports ... 14

Tables

Table 1. Patient Protection and Affordable Care Act (ACA) Private Health Insurance Market Reforms ... 4

Contacts

Author Contact Information ... 15

Introduction

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 predominant form of health coverage in the United States. In 2014, about 66.6% of the U.S. population had private health insurance.[1] The private market is often described as having three segments: non-group (or individual), small group, and large group.[2] Most individuals and families obtain private insurance through small- or large-group coverage, such as employer-sponsored insurance; some individuals and families purchase private insurance on their own in the non-group 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 an overall goal of the ACA—to increase access to health insurance coverage.

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). In addition, some individuals can receive financial assistance toward coverage obtained in an exchange.

The ACA's individual mandate 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 consist primarily of individuals who are high users of health care services, potentially creating financially unstable situations for insurers and enrollees.[3]

The ACA created three risk mitigation programs—reinsurance, risk corridors, and risk adjustment—to help health insurance issuers adjust to the reformed private health insurance landscape, particularly the new entrants to the market and the changes to how issuers set premiums. Reinsurance and risk corridors are temporary programs, providing issuers assistance from 2014 through 2016. The risk adjustment program, which also began in 2014, is permanent, designed to help issuers address the ongoing issue of adverse selection.[4]

---

[1] State Health Access Data Assistance Center (SHADAC) analysis of the American Community Survey (ACS) Public Use Microdata Sample (PUMS) files, at http://datacenter.shadac.org/rank/6/coverage-type-by-age#1/28,5/80/11/false/location.

[2] As of January 1, 2016, for purposes of determining the segment in which employers are eligible to purchase insurance, federal law defines a large employer as one with more than 50 employees and a small employer as one with 50 or fewer employees. Federal law gives states the option to define a large employer as one with more than 100 employees and a small employer as one with 100 or fewer employees.

[3] Health insurance aims to minimize the potential financial risk associated with the 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.

[4] For information about adverse selection, see the section "Risk Adjustment" in this report.

The ACA provides financial incentives to 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 (often called the employer mandate). 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 employees.

The ACA also includes some provisions that states may choose to implement. For example, states have the option of creating a Basic Health Program to provide state-designed assistance to lower-income individuals in lieu of those individuals obtaining coverage through an exchange. State-option provisions give states some flexibility to continue existing programs or create new programs better suited to their specific health insurance markets.

This report provides an overview of many of the ACA provisions that affect the private health insurance market. More detailed information about these provisions can be found in other Congressional Research Service (CRS) reports. For a list of related reports, see the "Related CRS Reports" section below.

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, these *market reforms* establish federal minimum requirements regarding access to coverage, premiums, 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]

The market reforms do not apply uniformly to all types of private health plans. The application of some reforms varies by market segment—non-group, small group, or large group. Some reforms apply to all three market segments, but many focus specifically on the non-group 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 provide some parity with the large-group market, which may already have many of these features. The application of group market reforms also varies by whether the group sponsor (e.g., employer) is fully insured or self-insured.[7] In addition, certain types of private plans are exempt from complying with some or all of the market reforms. See the text box for more details.

---

[5] Cost sharing is the share of costs an insured individual pays for services; the term 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] States are the primary regulators of the business of health insurance, as codified by the 1945 McCarran-Ferguson Act (15 U.S.C. §§1011 et seq.). The ACA follows the model of federalism that has been employed in prior federal health insurance reform efforts (e.g., Health Insurance Portability and Accountability Act of 1996). As such, although the ACA establishes many federal rules, the states have primary responsibility for monitoring compliance with and enforcement of these rules. In addition, states may impose additional requirements on insurance carriers and the health plans they offer, provided that the state requirements neither conflict with federal law nor prevent the implementation of federal market reforms.

[7] A fully insured plan is one in which an entity (e.g., employer or association) purchases health insurance from an issuer and the issuer assumes the risk of providing health benefits to the entity's enrolled members. A self-insured plan is one in which an entity provides coverage for its members directly by setting aside funds and paying for health benefits. Under self-insurance, the entity bears the risk of covering medical expenses, and self-insured plans are not (continued...)

Exemptions from ACA Market Reforms

Certain types of private plans are exempt from all or some of the ACA market reforms. Exempt plans include *grandfathered* plans, which are plans that were in existence (either in the group or non-group market) and in which at least one person was enrolled on the ACA's enactment date (March 23, 2010). As long as a plan maintains its grandfathered status, the plan has to comply with some but not all ACA market reforms.[8]

Plans affected by the transitional policy announced by the Centers for Medicare & Medicaid Services are also exempt from many ACA market reforms.[9] Under the transitional policy, state insurance commissioners may choose whether to enforce compliance with specified ACA market reforms for health insurance issuers offering non-grandfathered coverage in the non-group and small-group markets. Presumably, if state insurance commissioners choose not to enforce compliance, then issuers may renew coverage that is not compliant with ACA market reforms. Coverage renewed for a plan year beginning before or on October 1, 2017,[10] does not have to comply with certain ACA market reforms, provided the coverage meets specified conditions.

In addition, retiree-only health plans and plans that only cover excepted benefits are exempt from the ACA market reforms. A *retiree-only* health plan is one with fewer than two enrollees who are current employees. The term *excepted benefits* is defined in statute and includes accident-only coverage, disease-specific coverage, and stand-alone dental and vision coverage.[11]

When market reforms were implemented under the ACA, some of them were new to certain insurance markets; others had been in place in some capacity due to either state or federal laws. For example, guaranteed issue requires 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 non-group markets.[12] 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 non-group and group plans (except those that are self-insured) offer coverage on a guaranteed-issue basis.

Table 1 provides a brief overview of the market reforms in the ACA.

(...continued)

subject to state insurance regulations.

[8] For more details about *grandfathered* plans, see Center for Consumer Information & Insurance Oversight (CCIIO), "Grandfathered Plans," at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Grandfathered-Plans.html.

[9] Gary Cohen, *Extended Transition to Affordable Care Act-Compliant Policies*, CCIIO, March 5, 2014, at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/transition-to-compliant-policies-03-06-2015.pdf.

[10] Kevin Counihan, *Extended Transition to Affordable Care Act-Compliant Policies*, CCIIO, February 29, 2016, at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/final-transition-bulletin-2-29-16.pdf.

[11] The term *excepted benefits* is defined in §2791 of the Public Health Service (PHS) Act, §733 of the Employee Retirement Income Security Act (ERISA), and §9832 of the Internal Revenue Code (IRC).

[12] 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.

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

ACA Provision	Brief Description
Obtaining Coverage	
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.
Keeping Coverage	
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.
Costs Associated with Coverage	
Rate Review	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 adjust premiums based only on certain ACA-specified factors.
Single Risk Pool	Applicable health insurance issuers must consider all enrollees in plans offered by the issuer to be members of a single risk pool.
Covered Services	
Coverage of Preventive Health Services Without 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.
Coverage of Essential Health Benefits (EHB)	Applicable plans must cover the EHB.[a]
Cost-Sharing Limits	
Prohibition on Lifetime Limits	Applicable plans are prohibited from imposing lifetime limits on the dollar value of the EHB.
Prohibition on Annual Limits	Applicable plans are prohibited from imposing annual limits on the dollar value of the EHB.
Limits for Annual Out-of-Pocket Spending	Applicable plans must comply with annual limits on out-of-pocket spending.
Minimum Actuarial Value Requirements	Applicable plans must meet one of four levels of generosity based on actuarial value (categorized as metal tiers—bronze, silver, gold, or platinum).[b]
Consumer Assistance and Other Patient Protections	

ACA Provision	Brief Description
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.
Nondiscrimination Regarding Clinical Trial Participation	Applicable plans cannot prohibit enrollees from participating in approved clinical trials.
Plan Requirements Related to Health Care Providers	
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.
Reporting Requirements Regarding Quality of Care	Applicable plans must annually submit reports to the HHS Secretary and enrollees that address plan quality.

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

Notes: More specific information, including how the reforms apply to each segment of the private market, is in CRS Report R42069, *Private Health Insurance Market Reforms in the Patient Protection and Affordable Care Act (ACA)*.

a. The ACA does not explicitly define the essential health benefits (EHB); rather, it lists 10 broad categories from which benefits and services must be included and requires the Secretary of Health and Human Services to further define the EHB. For more details, see CRS Report R44163, *The Patient Protection and Affordable Care Act's Essential Health Benefits (EHB)*.

b. Actuarial value (AV) is a summary measure of a plan's generosity, expressed as the percentage of total medical expenses that are estimated to be paid by the issuer for a standard population and set of allowed charges. In other words, AV reflects the relative share of cost sharing that may be imposed.

Exchanges (Marketplaces)

By January 1, 2014, every state had to establish a health insurance exchange. The ACA exchanges are marketplaces in which individuals and small businesses can shop for and purchase private health insurance coverage.

Exchanges are intended to simplify the experience of providing and obtaining coverage. They are not intended to supplant the private market outside of exchanges. Plans offered through an exchange must be, for the most part, qualified health plans (QHPs). In general, to be a QHP, a plan has to offer the essential health benefit (EHB) package and meet certain standards related to marketing, choice of providers, and plan networks.[13]

To facilitate the purchase of private insurance, the exchanges have two parts. One is the *individual exchange*,[14] in which individuals can buy non-group insurance for themselves and their families. The other is the *small business health options program* (SHOP) exchange, designed to

[13] The standards are outlined in the *Code of Federal Regulations* at Title 45, Subtitle A, Subchapter B, Part 156, Subparts C and D.

[14] The term *individual exchange* is used for purposes of this report. It is not defined in exchange-related statute or regulations.

assist qualified small employers and their employees with insurance purchases. For SHOP exchange eligibility in 2016 and beyond, a small employer is one with 50 or fewer employees, but states may elect to define a small employer as one with 100 or fewer employees. In 2017, a state will have the option to allow large employers to use the SHOP exchange, regardless of how the state defines large employer.

Individuals purchasing non-group coverage through an exchange may be eligible to receive financial assistance in the form of premium tax credits and cost-sharing reductions. Small employers purchasing small-group coverage through a SHOP exchange may be eligible for small business health insurance tax credits.

Premium Tax Credits

Premium tax credits are generally available to lower-income individuals who are part of a tax-filing unit and who purchase non-group coverage through an exchange. To be eligible, individuals must have household income[15] at or above 100% of the federal poverty level (FPL) but not more than 400% FPL.[16] (For 2016, the corresponding income range is $11,880-$47,520 for a single individual and $24,300-$97,200 for a family of four, provided the individuals live in the 48 contiguous states.)[17]

Premium tax credit eligibility is also contingent on an individual's eligibility for other minimum essential coverage.[18] Individuals who are eligible for minimum essential coverage are generally ineligible for premium tax credits, because the credits are directed at individuals who do not have access to coverage outside the non-group market. An exception is individuals who are eligible for employer-sponsored insurance that is not considered affordable or adequate.[19] If an individual's offer of employer-sponsored insurance is considered unaffordable or inadequate, the individual may purchase non-group coverage through an exchange with the assistance of a premium tax credit (provided the individual is otherwise eligible for the credit).[20]

The premium tax credits 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

---

[15] In this instance, household income is modified adjust gross income. For more information, see CRS Report R43861, *The Use of Modified Adjusted Gross Income (MAGI) in Federal Health Programs*.

[16] There are exceptions to the lower-bound income threshold at 100% federal poverty level (FPL). One exception is for lawfully present aliens with income below 100% FPL, who are *not* eligible for Medicaid for the first five years that they are lawfully present. The ACA established Section 36B(c)(1)(B) of the IRC to allow such lawfully present aliens to still be eligible for premium credits. For details, see CRS Report R44425, *Eligibility and Determination of Health Insurance Premium Tax Credits and Cost-Sharing Subsidies: In Brief*.

[17] The guidelines that designate the FPL vary by family size and by whether the individual resides in the 48 contiguous states and the District of Columbia, Alaska, or Hawaii. For more details, see https://www.healthcare.gov/glossary/federal-poverty-level-FPL/.

[18] The definition of minimum essential coverage, found at 26 U.S.C. §5000A(f), includes most types of private (e.g., employer-sponsored insurance and non-group coverage) and public coverage (e.g., Medicare and Medicaid).

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

[20] This scenario could trigger a penalty for the employer under the ACA's shared responsibility provision. For more details, see the "Employer Shared Responsibility" section of this report.

factors. The amount a tax filer receives in credits must be reconciled when filing a federal tax return. Any additional credit amounts owed to the tax filer will be included in the filer's tax refund for that year, and any excess amount that was overpaid in premium credits to the tax filer will have to be repaid to the federal government as a tax payment.[21]

Cost-Sharing Subsidies

Some individuals are eligible to receive subsidized financial assistance for cost-sharing expenses—deductibles, coinsurance, and co-payments. In general, to qualify, individuals must be eligible for premium tax credits and enrolled in a non-group silver plan through an exchange.[22]

Cost-sharing assistance is provided in two forms, and both forms are based on income.[23] Some individuals may receive both types of cost-sharing subsidies if they meet applicable eligibility requirements. The first form reduces annual out-of-pocket limits for individuals with income between 100 % FPL and 250% FPL.[24] The second form, which also applies to individuals with income between 100% FPL and 250% FPL, involves reducing 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 deductibles, coinsurance, and co-payments.

Small Business Health Insurance Tax Credits

Certain small employers may be eligible for a tax credit, which reduces the cost of premiums, making small-group coverage more affordable for small employers. The 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.[25] To qualify for the credit, employers must cover at least 50% of the cost of each of their employees' self-only health insurance coverage.

The full credit covers up to 50% of the for-profit employer's contribution and 35% of the nonprofit employer's contribution to employees' health insurance premiums.[26] As of 2014, the credit is generally available only to an employer that obtains coverage through a SHOP exchange, and it is only available for two consecutive tax years. In other words, if a qualified employer first obtains coverage through a SHOP exchange in 2016, the credit would be available to the employer only in 2016 and 2017.

---

[21] The ACA limits the amount of required repayments for some individuals who receive the credits. For details, see CRS Report R43945, *Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA) in 2015*.

[22] Health plans offered in the non-group and small-group markets must tailor cost sharing to comply with one of four levels of AV. Each level of plan generosity is designated according to a precious metal and corresponds to an AV. The silver level corresponds to a 70% AV.

[23] For more information, see CRS Report R43945, *Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA) in 2015*.

[24] In 2016, the annual out-of-pocket limit is $6,850 for a self-only plan and $13,700 for a family plan.

[25] For information about determining the number of full-time equivalent (FTE) employees and calculating average wages, see Internal Revenue Service (IRS), "Small Business Health Care Tax Credit Questions and Answers: Determining FTES and Average Annual Wages" at https://www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit-Questions-and-Answers:-Determining-FTEs-and-Average-Annual-Wages.

[26] The amount of credit an employer receives is based on a sliding scale. As the number of an employer's FTE employees and the employer's average taxable wages increase, the amount of the credit decreases. Ibid.

Individual Mandate

Since January 1, 2014, the ACA has required that most individuals maintain health insurance coverage or pay a penalty for noncompliance. To comply with the individual mandate, individuals need to obtain *minimum essential coverage*, which includes most types of private (e.g., employer-sponsored insurance and non-group coverage) and public coverage (e.g., Medicare and Medicaid). Certain individuals are exempt from the individual mandate or its associated penalty.[27] The exemptions as outlined in statute and regulations include religious conscience, membership in a health care sharing ministry, and membership in an Indian tribe. Individuals who are incarcerated, cannot afford coverage, and not lawfully present in the United States may also be exempt.[28]

Those individuals who do not comply with and are not exempt from the mandate may be required to pay a penalty for each month of noncompliance. The penalty is calculated as the greater of either

- a percentage of *applicable income*, defined as the amount by which a taxpayer's household income exceeds the applicable tax filing threshold for the tax year; or
- a flat dollar amount assessed on each taxpayer and any dependents.

As of 2016, the annual penalty is the greater of 2.5% of applicable income or $695 (the $695 will be adjusted for inflation in subsequent years).

Taxpayers are required to include any payable penalty for themselves and their dependents in their federal income tax return for the taxable year.[29] Taxpayers who fail to pay the penalty will be notified by the Internal Revenue Service (IRS). The IRS can attempt to collect any unpaid funds by reducing the amount of a taxpayer's refund for that year or future years. However, individuals who fail to pay the penalty will not be subject to any criminal prosecution or additional penalty for such failure. The Secretary of the Treasury cannot file a lien against or a levy on any taxpayer's property for failing to pay the penalty.

The individual mandate is often described as working in conjunction with certain ACA market reforms, including guaranteed issue and renewability, nondiscrimination based on health status, coverage of preexisting health conditions, and rating restrictions (see **Table 1**). These reforms are intended to improve access to coverage for sick individuals or those at high risk of becoming ill. The individual mandate works in tandem with these reforms by encouraging healthy individuals to participate in the market so that insurers' risk pools are not entirely composed of individuals who are at high risk of using health care services.

Risk Mitigation Programs

An insurer calculates and charges a premium in order to finance the health coverage it provides. The premium reflects several components, including the expected cost of claims for health care

[27] The ACA provides that certain exemptions are from the individual mandate, whereas other exemptions are not from the mandate but from the penalty. The practical effects are the same whether an individual is exempt from the mandate or the penalty—the individual will not be subject to a penalty for not maintaining minimum essential coverage.

[28] For a detailed list of exemptions and who may qualify for them, see IRS, "Individual Shared Responsibility Provision—Exemptions: Claiming or Reporting," at https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/ACA-Individual-Shared-Responsibility-Provision-Exemptions.

[29] Those individuals who file joint returns are jointly liable for the penalty.

use during a plan year. To accurately estimate this expected cost and set appropriate premium levels, it is useful for an insurer to have information about the population it covers (i.e., to have information about the *risk* it is taking on).

ACA provisions—particularly the market reforms and the financial assistance available through exchanges—have expanded access to the non-group and small-group markets and limited the methods insurers can use to manage risk. As a result, insurers face increased uncertainty about who will enroll in their plans and the risk levels of those enrollees. For example, individuals who were previously uninsured may apply for coverage on a guaranteed-issue basis, and insurers must accept these applicants despite having little information about their health status and pent-up demand for services.

The increased uncertainty about enrollees and their risk levels makes it more difficult for insurers to accurately set premiums. The ACA establishes three risk programs to address different aspects of this uncertainty and help mitigate the financial risks associated with it. The reinsurance program and the risk corridors program are temporary programs designed to assist insurers in 2014 through 2016. The risk adjustment program is a permanent program that began in 2014.

Reinsurance

The *transitional reinsurance program* is a temporary program (2014-2016) designed to compensate insurers for a portion of the cost of particularly high-cost enrollees in the non-group market, both inside and outside the exchanges.

Prior to the ACA, little information was available on health care usage and demand for the previously uninsured, as well as any pent-up demand due to the lack of health insurance. Accordingly, insurers would likely raise premiums to the extent possible to protect themselves against the potential high cost associated with delayed care.

However, some of the new ACA market reforms limit the degree to which insurers can vary premiums. The transitional reinsurance program is designed to mitigate the financial risk associated with individuals who had delayed needed health care while they were uninsured. This temporary program assumes that any care that was delayed due to a lack of insurance would be provided in the early years of the program. All insurers and third-party administrators[30] of group health plans (including self-insured plans) must contribute to a reinsurance program.[31] Non-grandfathered non-group plans (offered inside and outside of exchanges) are eligible for transitional reinsurance payments to help offset the medical claims associated with high-cost enrollees.[32]

---

[30] Third-party administrators typically handle the administrative duties of offering a health plan, such as member services, premium collection, and utilization review; however, third-party administrators do not underwrite risk.

[31] The contribution rate for the 2016 benefit year is $27 per covered life. For more information about contributions to the reinsurance program, see CCIIO, "The Transitional Reinsurance Program – Reinsurance Contributions," at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/The-Transitional-Reinsurance-Program/Reinsurance-Contributions.html.

[32] For a summary of reinsurance payments made for the 2014 benefit year, see Centers for Medicare & Medicaid Services (CMS), *Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit Year*, revised September 17, 2015, at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RI-RA-Report-REVISED-9-17-15.pdf.

Risk Corridors

The *risk corridors program* is another temporary program (2014-2016) designed to mitigate the risk that insurers faced in setting premiums for QHPs in the non-group and small-group markets, both inside and outside the exchanges. Insurers were faced with many questions in regard to rate setting in this new and unfamiliar market, such as whether young, healthy individuals would sign up for insurance. The insurers' assumptions about the answers to these questions can have an impact on the premiums they set. But if the insurers' assumptions are wrong, they may end up underestimating or overestimating the premiums necessary to pay for their enrollees' claims.

Under the program, payments between an insurer and the Department of Health and Human Services (HHS) are adjusted according to a formula based on each insurer's actual, allowed expenses in relation to a target amount. HHS is to make payments to an insurer that experiences losses greater than 3% of the insurer's projections, whereas an insurer whose gains are greater than 3% of its projections is to remit payments to HHS.[33]

The risk corridors program assumes that insurers will be better able to estimate premiums under the new market reforms after three years.

Risk Adjustment

The *risk adjustment program* is a permanent program (which began in 2014) intended to mitigate the effects of adverse selection in the non-group and small-group markets, both inside and outside the exchanges. *Adverse selection* is a function of the asymmetry of information between insurers and individuals. Individuals know more about their relative need for coverage than insurers. Individuals who expect or plan for high use of health services tend to seek out coverage and enroll in more generous (and consequently more expensive) plans, whereas individuals who do not expect to use many or any health services may not obtain coverage and, if they do, they tend to enroll in less generous (and less expensive) plans. The relative generosity of the insurance plan will thus attract higher- or lower-spending enrollees. Risk adjustment more accurately compensates insurers for the higher cost of sicker enrollees who tend to enroll in more generous plans, and it more accurately compensates insurers for the lower cost of healthier enrollees who tend to enroll in less-generous plans.

Under the risk adjustment program, the relative risk for each enrollee is based on demographic and health history information.[34] Those individual risk scores are used to calculate an adjusted average risk score for each insurer's book of business (i.e., non-group and small-group markets). These adjusted average scores are compared with a market average, and the HHS Secretary

[33] Although the corridors for determining payments to insurers or charges are symmetrical (i.e., funds move when losses or gains are greater than 3%), the errors that insurers make in estimating their premiums are not necessarily symmetrical. On October 1, 2015, the Secretary of Health and Human Services (HHS) announced that charges from insurers that had overestimated their premiums ($362 million) fall short of the amount needed to pay insurers that had underestimated their premiums ($2.87 billion). Because of provisions limiting the funds available to make risk corridor payments to, essentially, the amounts available through the risk corridor charges, the Secretary would be able to pay only $0.126 per $1.00 owed to insurers that had underestimated their premiums. See CMS, "Risk Corridors Payment Proration Rate for 2014," October 1, 2015, at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RiskCorridorsPaymentProrationRatefor2014.pdf.

[34] For more information, see John Kautter, Gregory Pope, and Patricia Keenan, "Affordable Care Act Risk Adjustment: Overview, Context, and Challenges," *Medicare & Medicaid Research Review*, vol. 4, no. 3 (2014).

calculates transfer payments between insurers based on the relative risks of their enrollment as compared with the market average.[35]

All non-grandfathered non-group and small-group market plans (offered inside and outside the exchanges) are subject to risk adjustment. Because adverse selection is a phenomenon that is always present, risk adjustment is a permanent risk mitigation program.

Employer Shared Responsibility

Certain employers are subject to a shared responsibility provision (often called the employer mandate). This provision does not explicitly mandate that an employer offer employees health insurance; instead, it has the potential to impose penalties on employers that do not provide affordable and adequate coverage to full-time employees (and those employees' dependents).[36] The provision applies to large employers—those with 50 or more FTE employees.[37]

A large employer is subject to a penalty only if one of its full-time employees obtains coverage through an exchange and receives a premium tax credit.[38] If a large employer offers its full-time employees coverage that is considered affordable and adequate, the employer may not be subject to a penalty because its employees are not eligible to receive premium tax credits. However, if a large employer does not offer coverage or if the coverage offered does not comply with the affordability or adequacy requirements, then the employer may be subject to a penalty because its full-time employees may be eligible to receive premium tax credits. 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 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.[39]

Consumer Operated and Oriented Plan Program

The Consumer Operated and Oriented Plan (CO-OP) program is intended to foster nonprofit, member-run health insurance issuers. The program was included in the ACA to increase the competitiveness of state health insurance markets and improve choice in the markets. The HHS Secretary must use funds appropriated to the CO-OP program to finance low-interest start-up and solvency loans for organizations applying to become qualified nonprofit issuers of health plans.

Awarded entities (referred to as CO-OPs) 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

---

[35] CMS, *Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit year*, revised September 17, 2015, at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RI-RA-Report-REVISED-9-17-15.pdf.

[36] For purposes of the employer shared responsibility provision, the term *dependent* means an employee's child under the age of 26 and does not include the employee's spouse.

[37] In general, both full-time and part-time employees are included in the calculation to determine the number of FTEs the employer has for purposes of determining whether the employer mandate applies to the employer, but the calculation does not include certain seasonal employees. For more details, see CRS Report R43981, *The Affordable Care Act's (ACA) Employer Shared Responsibility Determination and the Potential ACA Employer Penalty*.

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

[39] For more information about calculating the penalty, see CRS Report R43981, *The Affordable Care Act's (ACA) Employer Shared Responsibility Determination and the Potential ACA Employer Penalty*.

state solvency requirements.[40] All loans must be repaid with interest; the start-up loans must be repaid within 5 years and the solvency loans must be repaid within 15 years (from the date of disbursement).

The ACA appropriated $6 billion of federal funds for the CO-OP program. Subsequent legislation rescinded $2.6 billion from the program, leaving it with $3.4 billion.[41] The American Taxpayer Relief Act of 2012 (P.L. 112-240) rescinded all but 10% of the CO-OP funds that were unobligated at the end of 2012. The remaining funds were to be used to support the entities that had already received CO-OP loans.

The Centers for Medicare & Medicaid Services (CMS) awarded loans to 24 CO-OPs.[42] One of the 24 was dropped from the program prior to offering health plans. Among the remaining 23 CO-OPs, 11 are offering health plans in 2016. The other 12 offered health plans at one time but are not currently offering health plans and are in various stages of shutting down. CMS awarded about $2.4 billion to the 23 CO-OPs that ever offered health plans.

Multi-State Plan Program

To increase the number of plan choices offered through the exchanges, the Office of Personnel Management (OPM) must contract with private health insurance issuers in each state to offer at least two health plans through exchanges in every state. [43] The health plans are known as multi-state plans (MSPs).

OPM administers the MSP contracts similar to how it administers the Federal Employee Health Benefits (FEHB) Program.[44] OPM negotiates plan benefits, monitors performance, and oversees compliance with ACA provisions.[45] In general, MSPs must comply with the same requirements as QHPs offered through exchanges, and MSP issuers must be licensed in each state and comply with state laws. Individuals who enroll in MSPs have the same access to financial assistance (e.g., premium tax credits) as individuals who enroll in other QHPs offered through the exchanges.

State Options

States may choose to implement certain ACA provisions. The flexibility inherent in these state-option provisions allows states to continue existing programs or create new programs that may be better suited to their specific health insurance markets.

---

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

[41] The Department of Defense and Full-Year Continuing Appropriations Act, 2011 (P.L. 112-10) reduced Consumer Operated and Oriented Plan (CO-OP) funding by $2.2 billion, and the Consolidated Appropriations Act, 2012 (P.L. 112-74) rescinded an additional $400 million from the program.

[42] CMS (under HHS) administers the CO-OP program.

[43] At least one of the contracts must be with a nonprofit issuer.

[44] For information about how the Office of Personnel Management (OPM) administers Federal Employee Health Benefits (FEHB) Program, see CRS Report R43922, *Federal Employees Health Benefits (FEHB) Program: An Overview*.

[45] For more information about how OPM administers the multi-state plan (MSP) program, see OPM, "Multi-State Plan Program and the Health Insurance Marketplace: Program Guidance," at https://www.opm.gov/healthcare-insurance/multi-state-plan-program/program-guidance/.

Basic Health Program

Since 2015,[46] states may opt to offer coverage to certain low-income individuals through a basic health program (BHP). A BHP is a health insurance program for individuals under the age of 65 with household incomes between 133% FPL and 200% FPL who are not eligible for Medicaid or otherwise eligible to enroll in other minimum essential coverage and available to individuals.[47] A BHP is offered in lieu of these individuals obtaining coverage through an exchange; however, 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 can receive funds from the federal government to operate the program.[48]

State Innovation Waivers

A state may apply for the waiver of any or all of the provisions listed below for plan years beginning on or after January 1, 2017.

- **Part I of Subtitle D of the ACA:** Requirements related to the establishment of QHPs.
- **Part II of Subtitle D of the ACA:** Requirements related to the establishment of health insurance exchanges.
- **Section 1402 of the ACA:** Provision of cost-sharing subsidies to eligible individuals who purchase non-group health insurance through a health insurance exchange.
- **Section 36B of the Internal Revenue Code (IRC):** Provision of premium tax credits to eligible individuals who purchase non-group health insurance through an exchange.
- **Section 4980H of the IRC:** Employer mandate for large employers.
- **Section 5000A of the IRC:** Individual mandate.

Waiving some or all of the allowed provisions could result in the residents of the state not receiving the "premium tax credits, cost-sharing reductions, or small business credits under sections 36B of the Internal Revenue Code of 1986 or under part I of subtitle E [of ACA] ... for which they would otherwise be eligible."[49] If this occurs, the state is to receive the aggregate amount of subsidies that would have been available to the state's residents had the state not

[46] As enacted, the ACA allowed states to establish a basic health program (BHP) beginning in 2014; however, HHS released guidance stating that the program would not be operational and available as a state option until 2015. For more information, see *Questions and Answers: Medicaid and the Affordable Care Act*, February 2013, at https://www.medicaid.gov/state-resource-center/faq-medicaid-and-chip-affordable-care-act-implementation/downloads/aca-faq-bhp.pdf.

[47] The ACA includes a five percentage point income disregard, so the effective range is between 138% FPL and 200% FPL. The BHP is also 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.

[48] 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. For more information about the federal funding and other aspects of the BHP program, see Medicaid.gov, "Basic Health Program," at https://www.medicaid.gov/basic-health-program/basic-health-program.html.

[49] 42 U.S.C. §18052(a)(3).

received a state innovation waiver.[50] The state must use the funds for purposes of implementing the plan or program established under the waiver.

A state must submit its application for a state innovation waiver to the HHS Secretary, who must share the responsibility of reviewing the application with the Treasury Secretary, as appropriate.[51] Either Secretary may grant a request for a state innovation waiver if it is determined by the relevant Secretary that the state's plan or program meets the following criteria:

- Provides coverage that is at least as comprehensive as the EHB, as certified by the Office of the Actuary of CMS;
- Provides coverage and cost-sharing protections that are at least as affordable as the provisions of Title I of the ACA;
- Provides coverage to at least a comparable number of the state's residents as the provisions of Title I of the ACA would provide; and
- Does not increase the federal deficit.

Health Care Choice Compacts

Two or more states may 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 non-group 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. The issuer would be required either 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 its QHPs 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 could not go into effect before January 1, 2016.

Related CRS Reports

- CRS Report RL32237, *Health Insurance: A Primer*
- CRS Report R42069, *Private Health Insurance Market Reforms in the Patient Protection and Affordable Care Act (ACA)*

---

[50] Under the ACA, eligible small employers can receive small business health insurance tax credits to defray the cost of providing employees' health insurance. In general, these credits are available only to small employers that purchase coverage through a small business health options program (SHOP) exchange. It is unclear whether the subsidy amounts a state could receive under a state innovation waiver could include amounts that small employers would have received in small business health insurance tax credits. The statutory text quoted above refers to *small business credits*, but the following language does not identify the section of the ACA that provides for the credits (which is part II of subtitle E of Title I).

[51] The Treasury Secretary has the authority to approve the waiver of provisions in the IRC—premium tax credits, the employer mandate, and the individual mandate. The HHS Secretary has the authority to waive the remaining provisions.

- CRS Report R44163, *The Patient Protection and Affordable Care Act's Essential Health Benefits (EHB)*
- CRS Report R42735, *Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act (ACA): Issues for Congress*
- CRS Report R44065, *Overview of Health Insurance Exchanges*
- CRS Report R44425, *Eligibility and Determination of Health Insurance Premium Tax Credits and Cost-Sharing Subsidies: In Brief*
- CRS Report R41331, *Individual Mandate Under the ACA*
- CRS Report R43981, *The Affordable Care Act's (ACA) Employer Shared Responsibility Determination and the Potential ACA Employer Penalty*
- CRS Report R44414, *Consumer Operated and Oriented Plan (CO-OP) Program: Frequently Asked Questions*

Author Contact Information

(name redacted)
Analyst in Health Care Financing
[redacted]@crs.loc.gov, 7-....

(name redacted)
Analyst in Health Care Financing
[redacted]@crs.loc.gov, 7-....

EveryCRSReport.com

The Congressional Research Service (CRS) is a federal legislative branch agency, housed inside the Library of Congress, charged with providing the United States Congress non-partisan advice on issues that may come before Congress.

EveryCRSReport.com republishes CRS reports that are available to all Congressional staff. The reports are not classified, and Members of Congress routinely make individual reports available to the public.

Prior to our republication, we redacted names, phone numbers and email addresses of analysts who produced the reports. We also added this page to the report. We have not intentionally made any other changes to any report published on EveryCRSReport.com.

CRS reports, as a work of the United States government, are not subject to copyright protection in the United States. Any CRS report may be reproduced and distributed in its entirety without permission from CRS. However, as a CRS report may include copyrighted images or material from a third party, you may need to obtain permission of the copyright holder if you wish to copy or otherwise use copyrighted material.

Information in a CRS report should not be relied upon for purposes other than public understanding of information that has been provided by CRS to members of Congress in connection with CRS' institutional role.

EveryCRSReport.com is not a government website and is not affiliated with CRS. We do not claim copyright on any CRS report we have republished.