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 2011. The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) includes provisions that restructure the private health insurance market by (1) implementing market reforms that impose requirements on private health insurance plans and sponsors of health insurance (e.g., employers); (2) creating marketplaces, "exchanges," where individuals can shop for and purchase health plans that meet or exceed federal standards; (3) providing financial assistance to qualified individuals who purchase health plans through an exchange; (4) establishing an individual mandate that requires most individuals to either maintain health insurance coverage or pay a penalty; and (5) 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."

The ACA provisions build on and modify the existing structure of the PHI market. In the PHI market, most individuals receive coverage through the group market (i.e., from an employer or association). Prior to the passage of ACA, the group market had many protections for individuals, such as limiting pre-existing condition exclusions and prohibiting discrimination based on health status. However, access to coverage in the group market could be different depending on the size of the group. In general, the size and composition of a group can affect both an organization's decision to offer coverage and the cost of that coverage to an enrollee. As a result, smaller groups are less likely to offer coverage than larger groups, and members of smaller groups are less likely to enroll in the coverage than members of larger groups. Some individuals purchase nongroup, or individual, coverage in the PHI market. Prior to the passage of ACA, nongroup coverage typically provided fewer protections than group coverage. For example, subject to state law, insurers offering coverage in the nongroup market could deny coverage to applicants who had pre-existing conditions or a history of health problems.

The PHI market reform provisions in ACA affect health insurance offered to groups and individuals, impose requirements on sponsors of coverage, and, collectively, establish minimum requirements with respect to access to coverage, premiums, benefits, cost-sharing, and consumer protections. Some market reforms are already in effect, such as the requirement for certain health plans to provide dependent coverage up to age 26. Beginning in 2014, when more of the market reforms take effect, certain health plans will have to offer a somewhat standardized set of benefits, called the essential health benefits (EHB), and certain health plans will have to accept all individuals who apply for coverage, regardless of health status and pre-existing conditions.

ACA's new marketplaces, the exchanges, must be operational in every state in time for the first exchange open season, which begins October 1, 2013. Coverage under exchange plans will begin as early as January 1, 2014. In addition to individuals shopping for and obtaining nongroup health insurance coverage through exchanges, some individuals may be eligible to receive financial assistance for the cost of that coverage in the form of premium tax credits and cost-sharing subsidies. Small employers will be able to purchase coverage to offer to their employees through small business health options program (SHOP) exchanges; however, ACA limits the SHOPs to small employers with either 50 or fewer employees or 100 or fewer employees, at state option.

Another ACA requirement is that most individuals must either maintain health insurance coverage or pay a penalty. The "individual mandate" goes into effect in 2014. To comply with the mandate, most individuals will have to maintain "minimum essential coverage," which includes coverage

obtained through exchanges, employer-sponsored insurance, nongroup coverage, and coverage from a federal program such as Medicare and Medicaid. Certain individuals are exempt from the individual mandate penalty, such as those with qualifying religious exemptions and those whose household income is less than the filing threshold for federal income taxes for the applicable tax year.

Employers play an important role in providing coverage in the existing PHI market, and ACA includes two provisions that could influence an employer's decision to offer health benefits. First, certain small employers may be eligible to receive tax credits. To be eligible, small employers cannot have more than 25 full-time equivalent employees and must contribute a uniform percentage of at least 50% to their employees' health insurance coverage. The tax credit became available in 2010, and it is available for a total of six years. Second, beginning in 2014, ACA imposes penalties on employers with at least 50 full-time equivalent employees, if one or more of their full-time employees obtain a premium tax credit through an exchange. Individuals who meet certain requirements may be eligible for a premium tax credit if their employer does not offer health insurance coverage, or if their employer offers coverage that is "unaffordable" or does not provide "minimum value," as defined by ACA.

This report provides an overview of ACA provisions that affect the PHI market. In general, the ACA provisions build on or modify the existing structure of the PHI market, and a short background on the existing structure is included in the report. While this report provides a broad overview of the PHI provisions in ACA, the reader may be interested in more in-depth discussions on specific aspects of the law. **Appendix C** directs the reader to a collection of CRS reports that provide such in-depth analysis. Additionally, a table showing key policy staff for each provision is included at the end of the report.

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

The provisions have been gradually implemented since ACA was enacted (in 2010). In 2014 when most will be effective, nearly all individuals will be able to obtain private coverage regardless of pre-existing conditions or health status, and insurers will have limited ability to vary premiums based on an applicant's health status and other characteristics. To help accommodate individuals who will have access to private health insurance as a result of these (and other) provisions, individuals and small businesses will be able to shop for and purchase private coverage in new marketplaces, "exchanges." Additionally, some individuals will receive financial assistance toward coverage obtained in an exchange.

The market reform provisions attempt to increase access to private coverage for many individuals, including those who are sick. ACA also includes a "shared responsibility" requirement, which does not allow healthy individuals to wait to buy coverage until it is needed without incurring a penalty for doing so. Many argued that unless healthy individuals were encouraged to participate in the private market, insurance pools would become overrun with individuals who are high users of health care services, potentially creating financially unstable situations for insurers and enrollees.[1] Beginning in 2014, most individuals will be required to maintain health insurance coverage or otherwise pay a penalty, and employers will have new financial incentives to consider when determining whether to offer employer-based health insurance to employees.

This report begins with a short background on the existing structure of the private health insurance market. It is important to understand the features of the existing market as a way to understand public policies, such as ACA, that affect the market. Descriptions of ACA provisions follow; each provision is considered within the context of the existing structure of the market.[2] The report does not provide exhaustive information about each provision, but it includes references to Congressional Research Service (CRS) reports that contain detailed information and a table with contact information for key policy staff.

Background

Americans obtain health insurance coverage in different settings and through a variety of methods. While many receive coverage through publicly funded programs, such as Medicare and Medicaid, private health insurance is the predominate form of health coverage in the United States. In 2011, 65% of the population had private health insurance. Most individuals and families

[1] 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.

[2] ACA includes two provisions that establish temporary programs. Because these provisions are required to end by 2014, they are not discussed in the body of this report. Instead, these provisions, relating to the creation of an early retiree reinsurance program and establishing a pre-existing condition insurance plan, are discussed in **Appendix A**.

obtain private insurance through group coverage, such as employer-sponsored insurance (ESI); about 57% of the population had ESI in 2011. Some individuals and families may purchase private insurance on their own in the nongroup, or individual, market. Approximately 12% of the population had nongroup coverage in 2011.[3]

The private health insurance market in the United States is sometimes described as "patchwork." The patchwork nature of the market is reflected, in part, in that often an individual's ability to obtain and maintain comprehensive private coverage is different in each of the three market segments: large group, small group, and nongroup.[4] Additionally, access to comprehensive and affordable private insurance can be affected by factors such as state residency, health status, and employment status. Understanding the patchwork nature of the private market helps explain why not all individuals have the same opportunities, experiences, and outcomes in the market. For example, some types of private firms are more likely to offer group coverage to their employees (e.g., private firms that consider at least three-quarters of their workers "full-time"), and as follows, individuals who work at these firms (at least those who are full-time) may have more access to private coverage compared to individuals who work at firms that do not offer coverage.

Individuals who have group coverage typically obtain this coverage as part of a compensation package received through his/her own employment or a family member's employment. Health insurance coverage provided by larger employers or associations has several attributes. The coverage is usually comprehensive and subsidized by the sponsor of the group plan (e.g., the employer). An individual's access to this coverage depends on access to the group, but it does not typically depend on the individual's health status or demographic characteristics, such as age.

Coverage offered by smaller employers does not always share the same attributes as coverage offered by larger employers. One reason is because of how risk is managed.[5] In group insurance, risk is spread among all members of the group. Individuals contribute to a common pool ("risk pool") and contributions from low-risk individuals subsidize the medical costs of higher-risk individuals. The larger the pool, the less likely that costs associated with higher-risk individuals will result in catastrophic financial loss for the entire group. As follows, the smaller the pool the more likely even one individual's use of health care services can adversely affect the entire pool. This means a smaller pool is riskier for an insurer to cover, which can result in the insurer increasing the costs of coverage (either premiums or cost-sharing or both) and/or limiting the benefit package. As a result, small employers may find it difficult to obtain affordable and comprehensive insurance to offer to their employees.

There are additional reasons why smaller employers, as compared to large employers, may find providing health insurance coverage to employees less enticing. For example, the per capita administrative costs for providing coverage might be higher for smaller employers, as there are

[3] The health insurance estimates are from the U.S. Census Bureau's American Community Survey (ACS), 2011. Data are available through American FactFinder, at http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml. The percentages include individuals who may have more than one form of insurance.

[4] What constitutes "large" and "small" in the private market varies. Often, for the purpose of state and federal laws, a large employer has more than 50 employees, and a small employer has up to 50 employees. The definitions of "small" and "large" also vary under ACA, but most often ACA defines small as either up to 50 or up to 100 employees.

[5] Risk—the potential for loss—is an underlying concept of insurance. Individuals obtain health insurance to protect themselves against the risk of financial loss in the event of a medical event. To learn more about how risk is managed in the health insurance market, see CRS Report RL32237, *Health Insurance: A Primer*, by Bernadette Fernandez.

fewer employees for the administrative costs to be spread among.[6] The result of these and other issues facing smaller employers is that smaller firms are less likely to offer coverage (**Table 1**).

Table 1. Percentage of Private Sector Firms that Offer Health Insurance, by Firm Size, 2011

Firm Size	Number of Firms	Percent That Offer Health Insurance
Less than 10 employees	3,809,084	28.3%
10-24 employees	748,434	58.4%
25-99 employees	510,114	78.1%
100-999 employees	452,731	93.3%
1000 or more employees	991,162	99.5%

Source: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2011 Medical Expenditure Panel Survey – Insurance Component (MEPS-IC).

Note: Firm size is classified by the number of any type of employee – including full-time, part-time, temporary, and seasonal employees.

In the nongroup market, risk is not typically pooled in the same way as it is in either the large or small group market. Insurers often decide whether to offer coverage and the terms of that coverage are based on an individual's risk profile (e.g., health status, medical history, pre-existing conditions) rather than on a group's risk profile. Without the stabilizing influence of pooling risk, it can be more difficult for insurers to offer coverage to high-risk individuals. To the extent permitted by law, insurers employ methods, such as excluding coverage for pre-existing conditions and charging higher premiums to individuals based on health status, to address the risk associated with covering high-risk individuals. The use of these tools may not adversely affect individuals with good risk profiles, such as young and healthy individuals. However, an individual with a complex health status (e.g., diabetes) or certain demographic characteristics (e.g., advanced age) can have trouble obtaining and maintaining affordable nongroup coverage that does not exclude benefits and services because of health status or pre-existing conditions.

The various laws that govern private insurance markets influence the characteristics of each market segment. States are the primary regulators of insurance; therefore, they have the authority to impose their own set of requirements on state-licensed carriers in each market. The scope of state laws varies across states, but often state laws and regulations focus on improving access to coverage and/or certain benefits and reducing the cost of coverage. For example, some states have required plans to offer certain benefits, such as infertility treatments and some states have imposed rules on how insurers can vary premiums based on health status and demographic characteristics. The federal government has also passed laws (even prior to ACA) that affect how coverage can be offered and obtained in the private market, and these laws are also often implemented differently across market segments.[7]

[6] Dawn M. Gencarelli, *Health Insurance Coverage for Small Employers*, National Health Policy Forum, April 19, 2005.

[7] For example, federal statutory language on private health insurance can be found in the Employee Retirement Income Security Act (ERISA), the Health Insurance Portability and Accountability Act (HIPAA), and the Public Health Service Act (PHSA).

ACA Provisions Affecting the Private Health Insurance Market

Private Health Insurance Market Reforms

A number of ACA provisions focus on changing how insurers and sponsors of insurance (e.g., employers) offer coverage. Some of the reforms are already in effect; others will become effective in 2014. Collectively, the market reforms establish federal minimum requirements with respect to access to coverage, premiums, benefits, cost-sharing, and consumer protections, while generally giving states the authority to enforce the reforms and the ability to expand on the reforms. Many of the reforms focus specifically on the small group and nongroup insurance markets to address perceived failures in the 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 new to certain insurance markets; others have been in place in some capacity due to either state or federal laws or both. For example, guaranteed issue is the requirement that a plan 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.[8] 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. ACA extends these efforts by requiring, beginning in 2014, that all non-grandfathered nongroup and group plans (except those that are self-insured)[9] offer coverage on a guaranteed issue basis (see the shaded **box**).

ACA & 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 ACA enactment (March 23, 2010) were considered "grandfathered" under ACA.

Individuals enrolled in grandfathered plans may re-enroll in the plan, and family members may join a grandfathered plan, if such enrollment is permitted under the terms of the plan that were in effect on the date of ACA enactment. If the grandfathered plan is a group plan, new members of the group may choose to enroll in the plan.

Grandfathered plans have a unique status under ACA, and they may lose their status if they apply certain changes to benefits, cost-sharing, employer contributions, and access to coverage. As long as a plan maintains its grandfathered status, the plan has to comply with some, but not all ACA provisions. 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)*, by Bernadette Fernandez.

Table 2 provides a brief overview of the market reforms in ACA that are effective prior to 2014, and **Table 3** describes the market reforms effective in 2014. Together, these tables describe the

[8] 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.

[9] 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 plan sponsor purchases health coverage and the carrier assumes the risk of providing health benefits to the sponsor's enrolled members. A self-insured plans 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 such plans are not subject to state insurance regulations.

major market reforms included in 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 Patient Protection and Affordable Care Act (ACA)*, by Annie L. Mach and Bernadette Fernandez.

Table 2. ACA Private Health Insurance Market Reforms Effective Prior to 2014

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 age 26
Prohibition of Discrimination Based on Salary	Applicable plans are prohibited from establishing eligibility criteria for full-time employees based on salary
Maintaining Health Insurance	
Prohibition on Rescissions	Applicable plans are prohibited from rescinding coverage except in cases of fraud or intentional misrepresentation
Cost of Purchasing Health Insurance	
Review of "Unreasonable" Rate Increases	Applicable plans must submit a justification for an "unreasonable" rate increase to the HHS Secretary and the relevant state prior to implementation of the increase
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 Pre-existing Health Conditions – Children	Applicable plans are not allowed to exclude benefits based on pre-existing conditions for children under age 19[a]
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)[b]
Restricted Annual Limits	Applicable plans are restricted from imposing annual limits that fall below a specified dollar threshold on the dollar value of the EHB[c]
Other Consumer Protections	
Medical Loss Ratio (MLR) 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
HHS Internet Portal	HHS is required to establish an Internet portal which will allow the public to easily search for health insurance options
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

Source: CRS analysis of ACA and its implementing regulations.

a. Beginning in 2014, applicable plans will not be able to exclude benefits based on pre-existing conditions for anyone, regardless of age.

b. The essential health benefits (EHB) are certain benefits that all non-grandfathered health plans offered in the nongroup and small group markets will have to cover beginning in 2014. For more information about the EHB, see the "Essential Health Benefits (EHB) Package" section of this report.

c. Beginning in 2014, ACA prohibits annual limits on the dollar value of EHBs.

Table 3. ACA Private Health Insurance Market Reforms Effective in 2014

ACA Provision	Brief Description
Obtaining Health Insurance	
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 greater than 90 days
Maintaining Health Insurance	
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	
Rating restrictions	Applicable plans can only adjust premiums based on certain ACA-specified factors
Covered Benefits	
Coverage of Pre-existing Health Conditions – All Ages	Applicable plans are prohibited from excluding coverage for pre-existing health conditions for all individuals
Limits on Cost-sharing	
Prohibition on Annual Limits	Applicable plans are prohibited from imposing annual limits on the dollar value of the essential health benefits (EHB)[a]
Other Consumer Protections	
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: CRS analysis of ACA and its implementing regulations.

a. The essential health benefits (EHB) are certain benefits that all non-grandfathered health plans offered in the nongroup and small group markets will have to cover beginning in 2014. For more information about the EHB, see the "Essential Health Benefits (EHB) Package" section of this report.

Essential Health Benefits (EHB) Package

Both state and federal governments have the authority to require private plans to comply with certain rules and regulations, such as offering certain benefits and services. ACA includes a

provision that expands federal requirements with regard to covered benefits and cost-sharing structures.[10] Beginning in 2014, ACA requires that all non-grandfathered plans offered in the nongroup and small group markets (both inside and outside exchanges) offer the EHB package. The EHB package consists of three parts: coverage of the EHB, compliance with specific cost-sharing limitations, and having an actuarial value that corresponds to one of the metal tiers (described below).

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

The EHB package includes limits on enrollees' cost-sharing requirements. ACA specifies that the limits work in three ways: (1) prohibition on applying deductibles to preventive health services; (2) prohibition on deductibles, in small group health plans, that are greater than $2,000 for self-only coverage, or $4,000 for any other coverage in 2014 (annually adjusted thereafter); and (3) prohibition on annual out-of-pocket limits that exceed existing limits in the tax code.[13]

Additionally, plans offering the EHB package must meet one of four levels of generosity based on actuarial value. Actuarial value is a summary measure of a plan's generosity, expressed as a percentage of medical expenses estimated to be paid by the issuer for a standard population and set of allowed charges. 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.

[10] It should be noted that ACA includes two additional provisions that relate to whether and how private health plans can offer certain benefits and services. These additional provisions, relating to coverage of abortion services and the offer of wellness programs, are described in **Appendix B**.

[11] 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.

[12] This approach is described in the final rule, "Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation," 78 *Federal Register* 12834, February 25, 2013.

[13] The "existing limits" are those that are applicable to high-deductible health plans (HDHPs) that qualify to be paired with health savings accounts (HSAs). In general, an HDHP is an insurance policy with low premiums and a high deductible (the amount that must be paid by an enrollee before the insurer begins to pay for covered services). In 2013, the cost-sharing limit for HSA-qualified HDHPs is $6,250 for single coverage and $12,500 for family coverage. Given that these existing limits are updated annually and this ACA provision does not become effective until 2014, the existing limits in 2014 will likely be different than the 2013 levels.

Exchanges

ACA requires the establishment of a health insurance exchange in every state.[14] ACA exchanges are marketplaces where individuals and small businesses can shop for and purchase private health insurance coverage.[15] To facilitate the purchase of insurance by these groups, ACA requires the exchanges to have two parts: one where individuals can buy nongroup insurance for themselves (and their families), 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.[16]

ACA & Actuarial Value

Actuarial value is a summary measure of a plan's generosity, expressed as a percentage of medical expenses estimated to be paid by the issuer for a standard population and set of allowed charges. In other words, actuarial value reflects the relative share 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.

It is important to note, 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. Also, actuarial value does not take into account aspects of health insurance coverage that may be important to individuals. In particular, actuarial value 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.

Exchanges are intended to simplify the experience of providing and obtaining coverage in the nongroup and small group markets. They are not intended to supplant the private market outside of exchanges, and individuals and small businesses cannot be compelled to obtain coverage through an exchange. Plans offered in exchanges are generally subject to ACA market reforms and will typically have to offer the essential health benefits (EHB) package. The open enrollment period for exchanges begins October 1, 2013 with coverage beginning in January 2014. Certain individuals purchasing nongroup coverage through an exchange will be eligible to receive financial assistance in the forms of premium tax credits and cost-sharing subsidies.[17]

The Congressional Budget Office (CBO) estimates that in 2014, 7 million nonelderly individuals will obtain coverage through an exchange, and by 2022 that number will increase to 26 million.[18] The following sections briefly describe some features of exchanges. For more detailed information, see CRS Report R42663, *Health Insurance Exchanges Under the Patient Protection and Affordable Care Act (ACA)*, by Bernadette Fernandez and Annie L. Mach.

[14] It should be noted that HHS is currently referring to health insurance exchanges as health insurance *marketplaces*.

[15] Individuals who approach exchanges could also be potentially screened for eligibility for public programs such as Medicaid and the State Children's Health Insurance Program (CHIP). For more information see the "Eligibility and Enrollment" section in CRS Report R42663, *Health Insurance Exchanges Under the Patient Protection and Affordable Care Act (ACA)*, by Bernadette Fernandez and Annie L. Mach.

[16] Before 2016, states will have the option to define "small employers" either as those with 100 or fewer employees or 50 or fewer employees. Beginning in 2016, small employers will be defined as those with 100 or fewer employees. Beginning in 2017, states may allow large employers to obtain coverage through an exchange (but will not be required to do so).

[17] See the "Premium Tax Credits" and "Cost-Sharing Subsidies" sections of this report for more information.

[18] Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2013 to 2023*, February 2013, http://www.cbo.gov/sites/default/files/cbofiles/attachments/43907-BudgetOutlook.pdf.

Exchange Establishment

A state can choose to run its own exchange (state-based exchange) or—if it chooses not to run its own exchange or the federal government determines that it is not ready to run its own exchange—the state will have a federal exchange in one of two forms. The state will either partner with the federal government, allowing the state to manage certain aspects of its exchange while the federal government has authority over the exchange (partnership exchange); or the state will have an exchange that is wholly established and administered by the federal government (federally facilitated exchange).

States interested in running a state-based exchange in 2014 were required to declare their intentions by December 14, 2012. To date, HHS has granted conditional approval[19] for 18 state-based exchanges.[20] States interested in having a partnership exchange in 2014 had until February 15, 2013 to declare their intentions; HHS has conditionally approved seven partnership exchanges.[21] Federal grant funding is available to states to assist in planning and establishing exchanges, and states are able to apply for the grants through 2014. All exchanges, state-based and federal, must be self-sustaining beginning in 2015.

Coverage Offered Through an Exchange

ACA requires that plans offered through an exchange are, for the most part, qualified health plans (QHPs). In general, to be certified a QHP, a plan has to offer the EHB package and meet certain standards related to marketing, choice of providers, and plan networks. State-based exchanges will certify plans as QHPs for their exchanges. In federally facilitated exchanges (including partnerships), the federal government will certify QHPs.

ACA allows for some additional types of QHPs—multi-state plans (MSPs), consumer operated and oriented plans (CO-OPs), and child-only QHPs. In general, these plans have to meet many of the same standards as QHPs. Additionally, ACA allows exchanges to offer at least two types of plan that are not required to meet most QHP standards—stand-alone dental plans and catastrophic plans. **Table 4** briefly describes each type of plan that can be offered through an exchange. Unless otherwise noted, the plans may be offered in both the nongroup and small group markets.

[19] HHS may also "conditionally approve" state-based exchanges (77 *Federal Register* 18310, March 27, 2012). In its "Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges," HHS says it will "utilize conditional approval for state-based exchanges and partnership states where exchange establishment is not complete at the time of Blueprint submission." http://cciio.cms.gov/resources/files/hie-blueprint-081312.pdf.

[20] The following states and DC have received conditional approval to establish a state-based exchange: CA, CO, CT, HI, ID, KY, MD, MA, MN, NV, NM, NY, OR, RI, UT, VT, WA. For more information, see http://cciio.cms.gov/resources/factsheets/state-marketplaces.html.

[21] HHS has conditionally approved partnership exchanges in AR, DE, IL, IA, MI, NH, and WV. For more information, see http://cciio.cms.gov/resources/factsheets/state-marketplaces.html.

Table 4. Types of Health Plans that Can Be Offered Through Exchanges

Type of Plan	Brief Description	Availability to Individuals Eligible for Exchanges
Qualified Health Plans (QHPs)	QHPs are plans that meet certain requirements related to offering the essential health benefits (EHB) package,[a] marketing, choice of providers, plan networks, and other features. An issuer of a QHP must be licensed in a state in which it offers coverage, must agree to offer at least one silver plan and one gold plan, and must comply with all applicable exchange regulations. State-based exchanges will certify QHPs; the federal government will certify QHPs for federally facilitated exchanges and partnership exchanges.	Generally available to all individuals[b]
Multi-state Plans (MSPs)	MSPs are nationally available QHPs that are overseen by the Office of Personnel Management (OPM). In general, MSPs must meet the requirements of QHPs, including being licensed in a state and offering the EHB, as well as other criteria required by OPM. Any MSP deemed certified by OPM will eventually be offered through every exchange, and OPM must offer at least two MSPs in every exchange.[c]	Generally available to all individuals
Consumer Operated and Oriented Plans (CO-OPs)	Plans offered by a CO-OP loan recipient may be deemed eligible to be offered as a QHP in an exchange by the Centers for Medicare & Medicaid Services (CMS).[d] To be deemed a CO-OP QHP, the plans must meet QHP certification requirements, state-specific exchange standards, and all CO-OP program requirements. In general, CO-OP QHPs must be offered at the silver and gold metal tiers in every exchange that serves the geographic regions in which the CO-OP loan recipient is licensed and intends to provide health insurance coverage.	Generally available to all individuals
Child-only QHPs	Issuers that offer a QHP through an exchange must also offer that plan as a "child-only" plan at the same level of coverage (bronze, silver, gold, or platinum)	Available to individuals less than 21 years of age
Stand-alone Dental Plans	Exchanges must allow issuers to offer stand-alone dental plans if the plans cover pediatric oral services (as specified in the EHB) and if the issuer and plan generally meet the criteria to be certified as a QHP. The dental plans may be offered separate from or in conjunction with a QHP, at issuers' discretion.	Generally available to all individuals
Catastrophic Plans	Issuers may choose to offer catastrophic plans through exchanges. Catastrophic plans can have actuarial values less than what is required to meet any of the metal tiers (bronze, silver, gold, platinum) but they must include coverage for the EHB and meet certain additional requirements.	Available to individuals under 30 years of age, and certain individuals exempt from the individual mandate. Catastrophic plans are only available in the nongroup market.

Source: CRS analysis of ACA and its implementing regulations.

Notes: For more information about coverage available through exchanges, see CRS Report R42663, *Health Insurance Exchanges Under the Patient Protection and Affordable Care Act (ACA)*, by Bernadette Fernandez and Annie L. Mach.

HHS has recently indicated that state-based exchanges may also allow issuers that are Medicaid managed care organizations to offer QHPs in exchanges on a limited-enrollment basis to certain populations. These QHPs would serve as "bridge" plans for individuals who transition from Medicaid and CHIP coverage to an exchange. HHS plans to release additional guidance on these plans. For more information, see Department of Health and Human Services, *Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid*, December 10, 2012.

a. The essential health benefits (EHB) package is described in the "Essential Health Benefits (EHB) Package" section of this report.

b. It should be noted that issuers may offer QHPs outside the exchange as well; if they do, they must agree to charge the same premium for a QHP offered inside and outside the exchange.

c. ACA allows MSPs to phase-in coverage. An MSP must offer coverage in 60% of states the first year it contracts with OPM, 70% of states the second year, 85% of states the third year, and in all states thereafter.

d. Under the CO-OP program, the federal government provides loans to eligible nonprofit entities to help them establish and administer health insurance plans. Prior to 2013, some entities received CO-OP loans, but much of the remaining funding for the CO-OP program has since been rescinded. For more information, see the "Consumer Operated and Oriented Plan (CO-OP) Program" section of this report.

Premium Tax Credits

Certain individuals who obtain coverage through an exchange will be eligible to receive health insurance premium tax credits. Premium tax credits are generally available to individuals who

- purchase nongroup coverage through an exchange;
- have household income[22] between 100% and 400% of the federal poverty level (FPL);[23]
- are not eligible for minimum essential coverage;[24] and
- are U.S. citizens (or legally residing in the United States).

To receive a premium tax credit, individuals also must be part of a tax-filing unit, as the credits are administered through federal income tax returns.

While 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 who is otherwise eligible for a premium tax credit, but has an offer of ESI, may be eligible for premium tax credits for exchange coverage if the ESI is unaffordable or does not meet a certain minimum value.[25] If this were the

[22] In this instance, household income is "modified adjust gross income" (MAGI). For more information about MAGI and ACA, see CRS Report R41997, *Definition of Income for Certain Medicaid Provisions and Premium Credits in ACA*, coordinated by Janemarie Mulvey.

[23] Lawfully present immigrants with income below 100% of FPL, who are ineligible for Medicaid for the first five years that they are present, 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% of FPL.

[24] According to law, minimum essential coverage includes Medicare Part A; Medicaid; the State Children's Health Insurance Program (CHIP); Tricare; Tricare for Life; a health care program administered by the Department of Veterans Affairs; the Peace Corps program; a local, state, or federal government plan; any plan established by an Indian tribal government; any plan offered in the individual, small group, or large group market; a grandfathered health plan; and any other health benefits coverage (such as a state high risk pool) as recognized by the HHS Secretary in coordination with the Treasury Secretary.

[25] "Affordable" in this context means that the individual's required contribution toward the plan premium for self-only coverage does not exceed 9.5% of their household income. "Minimum value" in this context means that the plan pays (continued...)

case, the individual could purchase nongroup coverage through an exchange with the assistance of a premium tax credit.[26]

The premium tax credits are advanceable, refundable tax credits. This means that tax filers do not have to wait until the end of the tax year to receive the credits (advance payments will go directly to the issuer of coverage), and tax filers may claim the full credit amount regardless of their federal income tax liability (i.e., even filers with no federal income tax liability can claim the credit).The amount of the tax credit will vary from person to person: it depends on the household income of the tax filer (and dependents), the premium for the exchange plan in which the tax filer (and dependents) is (are) enrolled, and other factors. In certain instances, the credit amount may cover the entire premium and the tax filer pays nothing towards the premium. In other instances, the tax filer may be required to pay part of the premium.

The amount received in premium credits is based on the prior year's income tax returns. These amounts are reconciled in the next year when individuals file a tax return for the actual year in which they received a premium credit. If a tax filing unit's income changed during the year, they may have been eligible for higher or lower amounts of tax credits (depending on whether income decreased or increased). If it is determined that the tax filer should have received a higher amount, this additional credit would be included in their tax refund for the year. If it is determined that the tax filer should have received a lower amount, then the overpayment must be repaid to the federal government as a tax payment, subject to statutorily defined caps on the repayment.[27]

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)*, by Bernadette Fernandez and Thomas Gabe.

Cost-Sharing Subsidies

Under 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 coinsurance and co-payments. To be eligible, individuals must be eligible for premium tax credits and enrolled in a silver plan through an exchange.[28]

The cost-sharing subsidies work in two ways. As described earlier, ACA requires each metal tier plan offered through exchanges to have an annual limit on the total amount an enrollee is required to pay out of pocket for use of covered services (see "Essential Health Benefits (EHB) Package"). One way the subsidies work is to reduce the annual limit for individuals with income between 100% and 400% FPL. This form of cost-sharing assistance will reduce the annual limit by two-

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for at least 60%, on average, of covered health care expenses.

[26] In this scenario, the individual's employer could be subject to a penalty. See the "Employers" section of this report for more information.

[27] The caps have been modified a few times since ACA enactment, for more information see CRS Report R41137, *Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA)*, by Bernadette Fernandez and Thomas Gabe.

[28] 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)*, by Elayne J. Heisler.

thirds for qualifying individuals with income between 100% and 200% FPL, by one-half for those with income between 201% and 300% FPL, and by one-third for those with income between 301% and 400% FPL.

The second way that cost-sharing subsidies work is to reduce a plan's cost-sharing requirements to ensure that the plan covers a certain percentage of allowed health care expenses, on average, for the individual. This form of cost-sharing subsidy is available to individuals with income between 100% and 250% FPL, and it will directly affect cost-sharing requirements, such as coinsurance and copayments.

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)*, by Bernadette Fernandez and Thomas Gabe.

Consumer Operated and Oriented Plan (CO-OP) Program

Some have suggested that the creation of new non-profit consumer governed health insurance companies would benefit the private insurance market because the non-profit cooperatives would return profits directly to their members, or would invest in plan members via lower premiums, lower cost-sharing, expanded benefits, and innovations such as wellness programs, chronic disease management, and integrated care.[29] To facilitate the creation of new health insurance cooperatives, ACA creates the Consumer Operated and Oriented Plan (CO-OP) program.

The HHS Secretary is required to use funds appropriated to the CO-OP program to finance start-up loans and solvency loans for eligible non-profit 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.[30] All loans must be repaid with interest; the start-up loans must be repaid within five years and the solvency loans must be repaid within 15 years (from the date of disbursement).

The HHS Secretary began awarding loans to eligible non-profits in January 2012. As of the date of this report, 24 entities in 24 states have received loans.[31] On January 2, 2013, Congress passed the American Taxpayer Relief Act of 2012 (ATRA, P.L. 112-240), the most recent in a series of laws that rescinded funds from the CO-OP program.[32] ATRA rescinded most of the unobligated CO-OP funds; the only funds remaining for the program must be used to support the 24 entities that have already received CO-OP loans.[33]

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[29] Senator Kent Conrad, "FAQ about the Consumer-Owned and -Oriented Plan (CO-OP)," 2010, available at http://conrad.senate.gov/issues/statements/healthcare/090813_coop_QA.cfm.

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

[31] The list of entities that have received loans is available at http://cciio.cms.gov/Archive/Grants/new-loan-program.html.

[32] As enacted, ACA appropriated $6 billion of federal funds for the CO-OP program. 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 (P.L. 112-240) rescinded nearly all other unobligated CO-OP funds.

[33] ATRA directed the HHS Secretary to create a fund to be used to support all nonprofit insurance issuers who were awarded CO-OP program loans prior to the date of the law's enactment (January 2, 2013). The fund contains 10% of (continued...)

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 qualified health plans (QHPs) offered in the nongroup and small group markets; up to one-third of a CO-OP issuer's plan 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-OPs 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-OPs 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. Accordingly, CO-OPs will be offered in at least the nongroup market in every exchange that shares a geographic region with a CO-OP loan recipient.

Reforms Related to the Allocation of Risk

Beginning in 2014, ACA requires issuers to provide coverage to individuals regardless of health status, medical history, and pre-existing conditions (see **Table 3** for more details). Some individuals will be eligible to receive premium tax credits and cost-sharing subsidies through an exchange, which will increase the attractiveness of coverage by reducing its cost. Also, the individual mandate will be in effect, which requires most individuals to maintain coverage or otherwise pay a penalty.

These provisions are intended to increase the likelihood that individuals will obtain and maintain coverage, but these provisions could also increase the potential for adverse selection. Adverse selection occurs when a large number of individuals who expect or plan for high use of health services enroll in more generous and often more expensive health plans, while 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 lead to health plans that have risk pools with a large number of high-cost individuals.

ACA establishes three risk programs to help mitigate the potential for adverse selection in the private health insurance market both inside and outside exchanges. Two of the programs, reinsurance and risk corridors, are temporary programs that will be in effect for three years, 2014-2016. The programs are designed to stabilize the private market until the third program, risk adjustment, is fully developed. The risk adjustment program is a permanent program that begins after the 2014 benefit year. See **Table 5** for more information about the risk programs.

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any unobligated CO-OP funds, and the Act rescinded all other unobligated CO-OP funds.

Table 5. Description of Reinsurance, Risk Corridors, and Risk-Adjustment Provisions of ACA

	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 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. 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. HHS estimates that the contribution rate for 2014 will be $63 per covered life.	Risk corridors refer to a mechanism that adjusts payments 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 ACA, HHS must make payments to a QHP issuer that experiences losses that are greater than 3% of the issuer's "projections," while a QHP issuer whose gains are greater than 3% of the issuer's "projections" must remit charges 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, excluding self-insured plans) are subject to risk adjustment.
Objective	Provide funding to plans that incur high costs for enrollees	Limit issuer loss (and gains)	Transfer funds from lowest risk plans to highest risk plans
Goal	Offset a plan's risk associated with high-cost enrollees	Protect against inaccurate rate setting	Protect against adverse selection
Time Frame	Three years (2014-2016)	Three years (2014-2016)	Permanent; begins after end of benefit year 2014

Source: CRS analysis of ACA and its implementing regulations.

Individual Requirement to Maintain Coverage

Beginning in 2014, ACA requires that most individuals maintain health insurance coverage or pay a penalty for noncompliance with the requirement (this provision is often referred to as the "individual mandate"). To comply with the individual mandate, most individuals will need to obtain "minimum essential coverage," which can include employer-sponsored insurance, nongroup coverage, and coverage from federal programs such as Medicare and Medicaid.[34]

[34] According to law, minimum essential coverage includes Medicare Part A; Medicaid; the State Children's Health (continued...)

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 years exceeds 8% of household income;[35] those who receive a hardship exemption from the HHS Secretary; and those who are not lawfully present in the United States.

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" or a flat dollar amount assessed on each taxpayer and any dependents.[36] In 2014, the percentage of applicable income is 1.0% and the flat dollar amount is $95. The penalty increases in 2015 and again in 2016. In 2016 and thereafter, the percentage will be 2.5% and the flat dollar amount will be $695 (adjusted for inflation each year after 2016).

It should be noted that 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). Any individuals who are required to pay the penalty but fail to do so will receive a notice from the Internal Revenue Service (IRS). If they still do not pay the penalty, the IRS can attempt to collect the funds by reducing the amount of their tax refund in the future. However, individuals who fail to pay the penalty cannot be subject to any criminal prosecution or penalty for such failure. For example, the IRS cannot file a notice of lien or file a levy on any property for an individual that does not pay the penalty.

The individual mandate is often described as working in conjunction with certain ACA market reforms that will be in effect in 2014: guaranteed issue and renewability, nondiscrimination based on health status, coverage of pre-existing health conditions, and rating restrictions (**Table 3**). Collectively, these reforms require insurers to accept all applicants while concurrently restricting 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, many argue that a provision such as the individual mandate is necessary to encourage healthy individuals to participate in the market so that risk pools are not limited to individuals who are high users of health care services (e.g., individuals who have multiple medical conditions).

For more information about the individual mandate, see CRS Report R41331, *Individual Mandate and Related Information Requirements under ACA*, by Janemarie Mulvey and Hinda Chaikind.

Employers

Employers are integral to the provision of private health insurance in the existing market, and ACA includes two provisions that could directly influence an employer's decision to offer health

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Insurance Program (CHIP); Tricare; Tricare for Life; the veteran's health care program; the Peace Corps program; a local, state, or federal government plan; any plan established by an Indian tribal government; any plan offered in the individual, small group, or large group market; a grandfathered health plan; and any other health benefits coverage (such as a state high risk pool) as recognized by the HHS Secretary in coordination with the Treasury Secretary.

[35] After 2014, the 8% will be adjusted to reflect the excess rate of premium growth above the rate of income growth for the period.

[36] "Applicable income" is defined as the amount by which and individual's household income exceeds the applicable filing threshold for the applicable tax year.

benefits: requirements and penalties related to the offer of insurance, and small business tax credits. Both provisions intend to provide financial incentives for employers to offer health insurance to their employees.

Employer Requirements and Penalties Related to the Offer of Insurance

Beginning in 2014, ACA imposes penalties on certain "large" employers, whether or not they offer health insurance coverage, if a full-time employee receives a premium tax credit toward a plan offered through an exchange. ("Full-time" employees are those working 30 hours per week or more.) For this provision, large employers are those who employed, on average, 50 or more full-time equivalent (FTE) employees in the preceding calendar year.[37]

An employer will not pay a penalty for any part-time worker, even if the part-time employee receives a premium credit. For employers that *do offer* coverage, they will only have to pay a penalty if a full-time worker receives a premium tax credit, which means the worker's self-only coverage from the employer either exceeds 9.5% of household income, or the plan pays for less than 60%, on average, of covered health care expenses. For employers that *do not offer* coverage, they will only have to pay a penalty if a full-time employee receives a premium tax credit.

An employer, regardless of the offer of coverage, pays a penalty if any of its full-time employees obtain coverage through an exchange and receive a premium tax credit. The penalty amount is dependent on whether the employer offers coverage and the total number of full-time employees working for the employer.[38] For more information, see CRS Report R41159, *Potential Employer Penalties Under the Patient Protection and Affordable Care Act (ACA)*, by Janemarie Mulvey.

Small Business Tax Credit

ACA includes provisions whereby certain small employers can be eligible for a tax credit, provided they contribute a uniform percentage of at least 50% toward their employees' health insurance. The tax credit is available to both non-profit and for-profit employers, but it takes a different form depending on the employer's profit status. The intent of the credit is to encourage small employers to offer coverage for the first time or maintain their offer of coverage.

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

- The employer has 10 or fewer full-time equivalents (FTEs);[39]
- and the employer's average taxable wages are $25,000 or less.[40]

[37] 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.

[38] The penalty is limited to the total number of the employer's full-time employees minus 30. In other words, 30 full-time employees are not counted for the purpose of calculating the penalty.

[39] For the purpose of this provision, FTEs are calculated by dividing the total hours worked by all "employees" (see description below) during the tax year by 2,080 (with a maximum of 2,080 hours for any one employee).

[40] This is calculated by dividing the aggregate amount of wages paid to the "employees" during the year by the number of FTEs (and then rounding to the nearest $1,000).

The credit is phased out as the number of FTEs increases from 10 to 25 and as average employee compensation increases from $25,000 to $50,000. In calculating the number of FTEs, the term "employees" excludes: seasonal workers (working no more than 120 days during the year); a self-employed individual; a 2% shareholder in an S-corporation; a 5% owner of an eligible small business; and someone who is a relation or dependent of these people. Thus, for example, the business will not receive a credit for small business owners or their family members.

For four years, between 2010 and 2013, the *full* credit is available to employers (but subject to the explanation above, employers may only claim part of the credit). Beginning in 2014, the amount of the credit is increased, but it is only available to an employer for two consecutive tax years, and it is only available to employers who obtain coverage through a SHOP exchange. The increased tax credit begins the first year that an employer offers coverage through an exchange. Thus, the small business tax credit is potentially available for a total of six years—the initial credit availability from 2010 through 2013, plus the two-year credit period beginning as early as 2014.

For more information about the small business tax credit, see CRS Report R41158, *Summary of Small Business Health Insurance Tax Credit Under the Patient Protection and Affordable Care Act (ACA)*, by Janemarie Mulvey and Hinda Chaikind.

State Options

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

Basic Health Program

ACA provides states an option to offer coverage to certain low-income individuals through a basic health program (BHP). Beginning in 2015,[41] a state can choose to establish a BHP, which is a health insurance program for individuals under the age of 65 who are not eligible for Medicaid, and it is offered in lieu of these individuals obtaining coverage through an exchange. The BHP would be available to individuals with household income between 133%[42] and 200% FPL,[43] 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.[44]

[41] As enacted, ACA allowed states to establish a 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.

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

[43] The BHP would also be available to individuals who are not citizens of the United States, but are lawfully present and are 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.

[44] The HHS Secretary is required 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 (continued...)

The BHP in the ACA is modeled after Washington State's Basic Health (BH) plan,[45] a public-private venture that provides subsidized health insurance to certain low-income residents of the state.[46] The BHP provision was included in S. 1796 (111th Congress),[47] a predecessor to ACA. The inclusion of the provision seems to indicate that the BHP is an option for addressing the absence of federal financial assistance for certain populations of low-income individuals. As stated in the Senate Finance Committee report that accompanied S. 1796, "There is no existing Federal law providing direct on-going program financing to the states for health insurance coverage of low income individuals not eligible for Medicaid either under standard criteria or via waivers."[48]

Waiver for State Innovation

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 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 the penalties imposed on employers whose employees receive premium tax credits.

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

Health Care Choice Compacts

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 plans was issued; however, the issuer of such QHP would be subject to other rules and requirements (e.g., market conduct rules, consumer

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they been able to obtain coverage through an exchange.

[45] U.S. Congress, Senate Committee on Finance, *America's Healthy Future Act 2009*, report to accompany S. 1796, 111th Cong., 1st sess., October 19, 2009, Report 111-89 (Washington: GPO, 2009).

[46] For more information, see http://www.basichealth.hca.wa.gov/.

[47] S. 1796 never became law; however, some of the language included in the bill was incorporated into ACA.

[48] U.S. Congress, Senate Committee on Finance, *America's Healthy Future Act 2009*, report to accompany S. 1796, 111th Cong., 1st sess., October 19, 2009, Report 111-89 (Washington: GPO, 2009).

protection rules) imposed by the state(s) in which the purchaser resides. Additionally, the issuer would either be required to be licensed in each state in the compact or submit to each state's standards for offering insurance, and the issuer must notify all consumers that it may not comply with their state's rules.

A state must have a law that specifically authorizes the state to enter into a compact. The HHS Secretary may approve a compact if it meets certain requirements. The HHS Secretary must promulgate regulations on this provision no later than July 31, 2013; approved compacts cannot go into effect before January 1, 2016.

Appendix A. Temporary Programs

Many ACA provisions that attempt to improve access to coverage are not in place until 2014. To account for this, ACA establishes two temporary programs that are intended to make it easier for certain individuals to obtain coverage prior to implementation of ACA provisions that will ensure their access to coverage. Both temporary programs were implemented shortly after enactment and will end by 2014.

Early Retiree Reinsurance Program (ERRP)

There was some concern that early retirees (those who retire prior to age 65) did not have access to affordable health insurance options. Few employers offer health benefits to early retirees,[49] and individuals are generally not eligible for Medicare until age 65. Coverage in the nongroup market may not be accessible and affordable, depending on the individual's health and economic status.

Many ACA provisions improving access to coverage will be implemented in 2014 and could improve early retirees' coverage options. Until that time, ACA includes the early retiree reinsurance program (ERRP) as one way to address coverage for early retirees.[50] The purpose of the ERRP is to make retiree coverage more affordable for employers to offer and maintain to improve early retirees' access to coverage.

The ERRP program provides reimbursement to sponsors of participating employer-sponsored plans for a portion of the cost of providing health insurance coverage to early retirees (and to the eligible spouses, surviving spouses, and dependents of such retirees).[51] The HHS Secretary reimburses claims for up to 80% of the portion of the cost attributed to such claim that exceeds $15,000 but is not more than $90,000.[52] The reimbursement from the HHS Secretary can only be used to lower costs for the plan or to reduce premium contributions, co-pays, deductibles, co-insurance, or other out-of-pocket costs for plan enrollees.

The program became effective June 1, 2010, and is scheduled to end no later than January 1, 2014. However, the HHS Secretary stopped taking applications for the program on May 5, 2011. The HHS Secretary had authority to stop taking applications for the program based on availability of funding. The HHS Secretary was appropriated $5 billion to carry out the program, and as of February 2012, the ERRP program had provided about $4.7 billion in payments to more than 2,800 employers and other sponsors of retiree coverage.[53]

[49] Paul Fronstin and Nevin Adams, *Employment-Based Retiree Health Benefits: Trends in Access and Coverage, 1997-2010*, Employee Benefit Research Institute, No. 377, October 2012, http://www.ebri.org/pdf/briefspdf/EBRI_IB_10-2012_No377_RetHlth.pdf.

[50] §1102 of ACA.

[51] For this provision, early retirees are individuals aged 55 and older who are not eligible for Medicare and are not active employees of an employer who is maintaining and/or contributing to their employment-based plan.

[52] Amounts are indexed for plan years starting on or after October 1, 2011.

[53] Department of Health and Human Services, *Early Retiree Reinsurance Program: Program Status Update, February 2012*, February 17, 2012, http://cciio.cms.gov/resources/files/Files2/02172012/errp_progress_report.pdf.

Pre-existing Condition Insurance Plan (PCIP)

High-risk pools are intended for individuals who cannot obtain or afford health insurance in the private market, primarily because of pre-existing health conditions.[54] States began establishing high-risk pools in the 1970s, and currently 34 states have state-established high-risk pools, and approximately 220,000 individuals are enrolled across the states.[55]

Prior to 2014, ACA's pre-existing condition insurance plan (PCIP) program is intended to supplement existing state-established high-risk pools.[56] Individuals who have been uninsured for at least six months, have been denied coverage because of a pre-existing condition, and are U.S. citizens (or legally residing in the U.S.) are eligible for coverage under a PCIP. Coverage offered in a PCIP must meet certain standards related to the amount enrollees pay toward premiums and cost-sharing requirements. ACA appropriated $5 billion of federal funds to subsidize the program's claims and administrative costs. ACA requires that the program end by 2014, at which time insurers will be prohibited from denying coverage because of an individual's pre-existing health conditions.

States can run the PCIP program or elect to have HHS operate the program in their states. HHS administers the PCIPs in 23 states and the District of Columbia, and 27 states administer their own PCIPs. As of December 31, 2012, approximately 103,160 individuals were enrolled in PCIPs across the states.[57] As of February 16, 2013, the federal government suspended acceptance of new enrollment applications for the PCIPs run by HHS; as of March 2, 2013, the federal government required state-administered PCIPs to also suspend acceptance of new enrollment applications. Both HHS-administered and state-administered PCIPs will continue to cover individuals enrolled prior to the suspension dates (until the program ends in 2014).[58]

[54] For more information about high-risk pools, see [Archived] CRS Report RL31745, *Health Insurance: State High Risk Pools*, by Bernadette Fernandez.

[55] Enrollment data current as of December 31, 2010; available at http://www.statehealthfacts.org/comparetable.jsp?ind=602&cat=7.

[56] For more information about the PCIP program, see [archived] CRS Report R41235, *Temporary Federal High Risk Health Insurance Pool Program*, by Bernadette Fernandez.

[57] Department of Health and Human Services, "State by State Enrollment in the Pre-Existing Condition Insurance Plan as of September 30, 2012," press release, November 16, 2012, http://www.healthcare.gov/news/factsheets/2012/11/pcip11162012a.html.

[58] For more information about the suspensions, see https://www.pcip.gov/.

Appendix B. Additional ACA Provisions Relating to Benefits and Services

Provisions Related to Abortion

ACA includes provisions that address coverage of abortion services by QHPs offered through exchanges. Under ACA, the issuer of a QHP will determine whether to provide coverage for elective abortions, or abortions for which federal funds appropriated for HHS are permitted,[59] or both. A plan issuer may also choose to not cover either type of abortion. In addition, ACA will permit a state to prohibit abortion coverage in exchange plans by enacting a law with such a prohibition.

Individuals who receive premium credits or cost-sharing subsidies toward purchasing coverage through an exchange will be permitted to purchase an exchange plan that includes coverage for elective abortions. However, to ensure that funds attributable to a premium or cost-sharing subsidy are not used to pay for elective abortion services, ACA prescribes payment and accounting requirements for plan enrollees and issuers.

ACA also provides for conscience protection and the preservation of certain state and federal abortion-related laws. The measure prohibits exchange plans from discriminating against any individual health care provider or health care facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortions. State laws concerning the prohibition or requirement of coverage or funding for abortions, and state laws involving abortion-related procedural requirements will not be preempted.[60]

Wellness Programs

In the existing private market, group health plans can provide certain incentives for enrollee participation in wellness programs. To do so, group health plans must comply with the wellness program provisions in the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191). HIPAA generally allows the provision of premium discounts, rebates, or reduced cost-sharing for enrollee participation in wellness programs. HIPAA generally divides wellness programs into two categories:

- "participatory wellness programs" that do not require an individual to satisfy a standard related to a health factor[61] as a condition for obtaining a reward (or do not offer a reward);

[59] In addressing the coverage of abortion services by qualified health plans offered through an exchange, ACA refers to the so-called "Hyde Amendment" to distinguish between two types of abortions: abortions for which federal funds appropriated for HHS may be used, and abortions for which such funds may not be used. Under the Hyde Amendment, funds appropriated for HHS may be used to pay for an abortion if a pregnancy is the result of an act of rape or incest, or if a woman's life would be endangered if an abortion were not performed. Such funds may not be used, however, for elective abortions.

[60] For more information about how ACA affects coverage of abortion, see CRS Report R41013, *Abortion and the Patient Protection and Affordable Care Act*, by Jon O. Shimabukuro.

[61] Under HIPAA, "health factors" are: health status, medical conditional (including both physical and mental illness), (continued...)

- and "health-contingent wellness programs" that require individuals to satisfy a standard related to a health factor in order to obtain a reward.

Participatory wellness programs are compliant with HIPAA as long as participation in the programs is made available to all similarly situated individuals, and HIPAA does not limit the financial incentives these programs can provide. However, health-contingent wellness programs must meet additional requirements to comply with HIPAA. Among these requirements, the reward for such a program cannot exceed 20% of the total cost of self-only coverage under the plan.

Beginning in 2014, ACA modifies this provision of HIPAA by allowing the reward for a health-contingent wellness program to be capped at 30% of the total cost of self-only coverage under the plan. Additionally, ACA gives the Secretaries of HHS, Labor, and the Treasury the discretion to increase the reward up to 50% of the cost of coverage if the increase is determined to be appropriate.

ACA also requires the Secretary of HHS, in consultation with the Secretaries of the Treasury and Labor, to establish a 10-state pilot program no later than July 1, 2014, in which participating states must apply the wellness program provisions to health insurers in the individual market.

(...continued)

claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of act of domestic violence), and disability.

Appendix C. Selected CRS Reports

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

CRS Report R42735, *Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act (ACA): Issues for Congress*

CRS Report R41220, *Preexisting Condition Exclusion Provisions for Children and Dependent Coverage under the Patient Protection and Affordable Care Act (ACA)*

CRS Report R41166, *Grandfathered Health Plans Under the Patient Protection and Affordable Care Act (ACA)*

CRS Report R42663, *Health Insurance Exchanges Under the Patient Protection and Affordable Care Act (ACA)*

CRS Report R41137, *Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA)*

CRS Report R41331, *Individual Mandate and Related Information Requirements under ACA*

CRS Report R41159, *Potential Employer Penalties Under the Patient Protection and Affordable Care Act (ACA)*

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