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Private Health Insurance Market Reforms in the Patient Protection and Affordable Care Act (ACA)

(name redacted)

Specialist in Health Care Financing

(name redacted)

Specialist in Health Care Financing

February 10, 2016

Congressional Research Service

7-....

www.crs.gov

R42069

Summary

The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) establishes federal requirements that apply to private health insurance. Its market reforms affect insurance offered to groups and individuals and impose requirements on sponsors of coverage (e.g., employers). In general, all of the ACA's market reforms are currently effective; some became effective shortly after the ACA was passed in 2010, and others became effective for plan years beginning in 2014.

Although some of the market reforms had previously been enacted in some states, many of the reforms are new at the federal level. Collectively, the reforms create federal minimum requirements with respect to access to coverage, premiums, benefits, cost sharing, and consumer protections. For example, the requirement to offer health plans on a guaranteed-issue basis generally means that insurers must accept every applicant for health coverage, as long as the applicant agrees to the terms and conditions of the coverage (e.g., the premium). The ACA's requirement to offer the essential health benefits means that certain plans must cover a specified package of benefits.

The market reforms do not apply uniformly to all types of plans. Some reforms apply to all three segments of the private insurance market—individual, small group, and large group—whereas others may apply only to plans offered in the individual and small-group markets. In the group market, the reforms do not always apply to both fully insured plans (plans offered by state-licensed carriers that are purchased by employers or other sponsors) and self-insured entities (groups that set aside funds to pay for health benefits directly). The reforms' applicability also depends on whether a plan has *grandfathered* status. Under the ACA, an existing health plan in which a person was enrolled on the date of ACA enactment was grandfathered; the plan can maintain its grandfathered status as long as it meets certain requirements. Grandfathered health plans are exempt from the majority of ACA market reforms.

Although the market reforms' applicability is not necessarily uniform across plan types, it is uniform for plans offered inside and outside health insurance exchanges. Every state has an exchange, and individuals and small employers can use the exchanges to shop for and obtain health insurance coverage. The same market reforms apply to an individual plan offered through an exchange and to an individual plan offered in the market outside of an exchange. Some types of plans do not have to comply with any of the market reforms. For example, retiree-only health plans are not required to comply with federal health insurance requirements, including the ACA's market reforms.

This report provides background information about the private health insurance market, including market segments and regulation. It then describes each ACA market reform. The reforms are grouped under the following categories: obtaining coverage, keeping coverage, cost of purchasing coverage, covered services, cost-sharing limits, consumer assistance and other health care protections, and plan requirements related to health care providers. The **Appendix** provides details about the types of plans that are required to comply with the different reforms.

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The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) includes reforms of the health insurance market that impose requirements on private health insurance plans.¹ Such reforms relate to the offer, issuance, generosity, and pricing of health plans, among other issues. Certain reforms also require the participation of public agencies and officials, such as the Secretary of Health and Human Services (HHS), to facilitate administrative or operational elements of the insurance market.

This report first provides background information about the private health insurance market. It then describes the market reforms included in the ACA. The **Appendix** provides additional information about how the ACA market reforms apply to different market segments and types of health plans.

Background

Health Insurance Markets

The private health insurance market is often characterized as having three segments—the large-group, small-group, and individual markets. Insurance sold in the large- and small-group markets refers to plans offered through a plan sponsor, typically an employer.² A small employer is defined as one with 50 or fewer employees, but states may elect to define a small employer as one with 100 or fewer employees. The individual, or non-group, market refers to insurance policies offered to individuals and families buying insurance on their own (i.e., not through a plan sponsor).

State and Federal Regulation

States are the primary regulators of the business of health insurance, as codified by the 1945 McCarran-Ferguson Act.³ Each state has a unique set of rules that apply to state-licensed insurance carriers and the plans they offer.⁴ These rules are broad in scope and address a variety of issues, such as the legal structure and organization of insurance issuers (e.g., licensing requirements); business practices (e.g., marketing rules); market conduct (e.g., capital and reserve standards); the nature of insurance products (e.g., benefit mandates); and consumer protections (e.g., plan disclosure requirements), among others.

In addition to state regulation, the federal government has established standards applicable to health coverage and imposes requirements on state-licensed insurance carriers and sponsors of health benefits (e.g., employers). The federal regulation of health coverage is particularly salient with respect to health benefits provided through employment.

¹ For simplicity's sake, the term *plan* is used generically in this report. It applies to different types of health coverage provided to groups (e.g., employees of a single firm) and individuals.

² The reference to group markets technically applies to health plans offered by state-licensed insurance carriers and purchased by employers and other plan sponsors. However, health insurance coverage provided through a group may also be sponsored through *self-insurance*. Groups that self-insure set aside funds to pay for health benefits directly, and they bear the risk of covering medical expenses generated by the individuals covered under the self-insured plan.

³ 15 U.S.C. §§1011 et seq.

⁴ State regulation of health insurance applies only to state-licensed entities. Because self-insured plans are financed directly by the plan sponsor, such plans are not subject to state law.

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, P.L. 104-191). In other words, although the ACA establishes many federal rules, the states have primary responsibility for monitoring both compliance with and enforcement of such 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.

ACA Market Reforms

The ACA establishes federal requirements that apply to private health insurance. The reforms affect insurance offered to groups and individuals; impose requirements on sponsors of coverage; and, collectively, establish a federal floor with respect to access to coverage, premiums, benefits, cost sharing, and consumer protections. Although such market reforms may be new at the federal level, many of the ACA's reforms had already been enacted in some form in several states, with great variation in scope and specificity across the states. In general, all ACA market reforms are currently effective. (See the text box, "Transitional Policy," for a discussion about why some plans may not have to comply with applicable ACA market reforms until 2017.)

The reforms do not apply uniformly to all types of plans. Often, reforms apply differently to health plans according to the market segment in which the plan is offered and whether the plan has grandfathered status.⁷ Furthermore, the reforms do not apply to certain types of plans (this is true of other federal health reforms as well). For example, retiree-only

Transitional Policy

On March 5, 2014, the Centers for Medicare & Medicaid Services (CMS) extended a transitional policy that was first described in guidance issued by CMS in November 2013.⁵

Under the transitional policy, health insurance issuers offering non-grandfathered coverage in the individual and small-group markets may choose to continue coverage that otherwise would be cancelled. Pursuant to the policy, state insurance commissioners may choose whether to enforce compliance with specified ACA market reforms. Presumably, if state insurance commissioners choose not to enforce compliance, then issuers may renew coverage for enrollees who otherwise would receive cancellation notices.

Pursuant to the extended policy, coverage renewed for a plan year between January 1, 2014, and October 1, 2016, does not have to comply with certain ACA market reforms, provided the coverage meets specified conditions.⁶

⁵ For the March 5, 2014, extension guidance, see letter from Gary Cohen, Director of the Center for Consumer Information and Insurance Oversight, "Insurance Standards Bulletin Series—Extension of Transitional Policy through October 1, 2016: Extended Transition to Affordable Care Act-Compliant Policies," March 5, 2014, at <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/transition-to-compliant-policies-03-06-2015.pdf>. For the original November 2013 guidance, see letter from Gary Cohen, Director of the Center for Consumer Information and Insurance Oversight, to Insurance Commissioners, November 14, 2013, at <http://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner-letter-11-14-2013.PDF>.

⁶ The market reforms with which the coverage does not have to comply and the conditions the coverage must meet are described in the November 2013 guidance: letter from Gary Cohen, Director of the Center for Consumer Information and Insurance Oversight, to Insurance Commissioners, November 14, 2013, at <http://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner-letter-11-14-2013.PDF>.

⁷ A *grandfathered* health plan refers to an existing plan in which at least one individual has been enrolled since enactment of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) on March 23, 2010. To maintain grandfathered status, a plan must avoid certain changes to employer contributions, access to coverage, benefits, and cost sharing (e.g., any increase in coinsurance requirement). For more information about grandfathered status, see CRS Report R41166, *Grandfathered Health Plans Under the Patient Protection and Affordable Care Act* (continued...)

health plans are not required to comply with federal health insurance requirements, including the ACA's market reforms.⁸ For information as to the specific types of plans (i.e., a grandfathered plan in the large-group market) to which a reform applies, see the **Appendix**.

Descriptions of the market reforms are grouped under the following categories: obtaining coverage, keeping coverage, cost of purchasing coverage, covered services, cost-sharing limits, consumer assistance and other health care protections, and plan requirements related to health care providers.

Obtaining Coverage

Guaranteed Issue

Certain types of coverage must be offered on a guaranteed-issue basis.⁹ In general, *guaranteed issue* in health insurance is the requirement that a plan accept every applicant for health coverage, as long as the applicant agrees to the terms and conditions of the insurance offer (e.g., the premium). With regard to plans offered in the group market, guaranteed issue generally means that a plan sponsor (e.g., an employer) must be able to purchase a group health plan any time during a year.¹⁰ Individual plans are allowed to restrict enrollment to open and special enrollment periods.¹¹

Plans that otherwise would be required to offer coverage on a guaranteed-issue basis are allowed to deny coverage to individuals and employers in certain circumstances.¹² Those circumstances include when a plan demonstrates that it does not have the network capacity to deliver services to additional enrollees or the financial capacity to offer additional coverage.

Nondiscrimination Based on Health Status

Plans are prohibited from basing eligibility or coverage on health status-related factors.¹³ Such factors include health status, medical condition (including both physical and mental illness), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), disability, and any other health status-related factor determined appropriate by the HHS Secretary. However, plans

(...continued)

(ACA), by (name redacted)

⁸ The federal exemption for retiree-only health plans is not new. Retiree-only health plans have been exempt from federal health insurance requirements since enactment of the Health Insurance Portability and Accountability Act of 1996 (HIPAA; P.L. 104-191). For additional information about these issues, see the Appendix in CRS Report R41166, *Grandfathered Health Plans Under the Patient Protection and Affordable Care Act (ACA)*, by (name redacted).

⁹ 42 U.S.C. §300gg-1.

¹⁰ Regulations provide an exception for plans offered in the small-group market. The plans may limit enrollment to an annual period from November 15 through December 15 of each year if the plan sponsor does not comply with provisions relating to employer-contribution or group-participation rules, pursuant to state law.

¹¹ The annual open enrollment periods in the individual market are the same inside and outside ACA health insurance exchanges. The dates for the annual open enrollment period are issued in regulations, and the period typically runs from October through January. Qualifying events for special enrollment periods are defined in §603 of the Employee Retirement Income Security Act (ERISA; P.L. 93-406) and in 45 C.F.R. §155.420(d).

¹² 45 C.F.R. §147.104(c) and (d).

¹³ 42 U.S.C. §300gg-4.

may offer premium discounts or rewards based on enrollee participation in wellness programs, in keeping with prior federal law.¹⁴

Extension of Dependent Coverage

If a plan offers dependent coverage, the plan must make such coverage available to a child under the age of 26.¹⁵ Plans that offer dependent coverage must make coverage available for both married and unmarried adult children under the age of 26 but not for the adult child's children or spouse (although a plan may voluntarily choose to cover these individuals).

Prohibition of Discrimination Based on Salary

The sponsors of health plans (e.g., employers) are prohibited from establishing eligibility criteria for any full-time employee that are based on the employee's total hourly or annual salary.¹⁶ Eligibility rules are not permitted to discriminate in favor of higher-wage employees.

The Departments of HHS, Labor, and the Treasury have determined that compliance with this requirement is not required until after regulations are issued. As of the date of this report, regulations have not been issued.¹⁷

Waiting Period Limitation

Plans are prohibited from establishing waiting periods longer than 90 days.¹⁸ A *waiting period* refers to the time that must pass before coverage for an individual who is eligible to enroll under the terms of the plan can become effective. In general, if an individual can elect coverage that becomes effective within 90 days, the plan complies with this provision.

Keeping Coverage

Guaranteed Renewability

Guaranteed renewability in health insurance is a plan's requirement to renew individual coverage at the option of the policyholder or to renew group coverage at the option of the plan sponsor. Most plans offered in the individual and small-group markets must renew coverage at the option of the enrollee or plan sponsor; however, plans may discontinue coverage under certain circumstances.¹⁹ For example, a plan may discontinue coverage if the individual or plan sponsor

¹⁴ HIPAA allows group plans to establish premium discounts or rebates or to modify cost-sharing requirements in return for adherence to a wellness program. If a wellness program provides a reward based solely on participation, or if it does not provide a reward, the program complies with HIPAA without having to satisfy any additional standards, as long as the program is made available to all similarly situated individuals. If a program provides a reward based on an individual meeting a certain standard relating to a health factor, then the program must meet additional requirements specified in HIPAA regulations. Under the ACA, the reward must be capped at 30% of the cost of employee-only coverage under the plan. However, the Secretaries of Health and Human Services (HHS), Labor, and the Treasury have the discretion to increase the reward up to 50% of the cost of coverage if the increase is determined to be appropriate.

¹⁵ 42 U.S.C. §300gg-14.

¹⁶ 42 U.S.C. §300gg-16.

¹⁷ Internal Revenue Service (IRS), "Affordable Care Act Nondiscrimination Provisions Applicable to Insured Group Health Plans," Internal Revenue Notice 2011-1, January 10, 2011.

¹⁸ 42 U.S.C. §300gg-7.

¹⁹ 42 U.S.C. §300gg-4.

fails to pay premiums or if an individual or plan sponsor performs an act that constitutes fraud in connection with the coverage.²⁰

Prohibition on Rescissions

The practice of *rescission* refers to the retroactive cancellation of medical coverage after an enrollee has become sick or injured. In general, rescissions are prohibited, but they are permitted in cases where the covered individual committed fraud or made an intentional misrepresentation of material fact as prohibited by the terms of the plan.²¹ A cancellation of coverage in this case requires that a plan provide at least 30 calendar days advance notice to the enrollee.²²

Costs Associated with Coverage

Rating Restrictions

Plans must use adjusted (or modified) community rating rules to determine premiums.²³ Adjusted community rating rules prohibit plans from pricing health insurance products based on health factors but allow plans to price products based on other key characteristics, such as age. The rating rules restrict premium variation to the four factors described below.

Self-Only or Family Enrollment. In most states, plans can vary premiums based on whether an individual or an individual and any number of his/her dependents enroll in the plan. However, under certain circumstances,²⁴ the state is allowed to require that premiums for family coverage are determined using state-established uniform family tiers.²⁵ For example, such a state may allow plans to vary premiums based on self-only coverage, self plus one coverage, and family coverage.

Geographic Rating Area. States are allowed to establish one or more geographic rating areas within the state for the purposes of this provision. The rating areas must be based on one of the following geographic boundaries: (1) counties, (2) three-digit zip codes,²⁶ or (3) metropolitan statistical areas (MSAs) and non-MSAs.²⁷ If a state does not establish rating areas or if the Centers for Medicare & Medicaid Services (CMS) determines that a state's proposed rating areas are inadequate,²⁸ then the default is one rating area for each MSA in the state and one rating area comprising all non-MSAs in the state.

²⁰ 45 C.F.R. §147.106.

²¹ 42 U.S.C. §300gg-12.

²² 45 C.F.R. §147.128.

²³ 42 U.S.C. §300gg.

²⁴ This practice is allowed if a state does not permit rating variation for age and tobacco.

²⁵ As of the date of this report, only two states—New York and Vermont—prohibit plans from using tobacco and age to vary rates. Both states allow plans to vary premiums using state-established uniform family tiers.

²⁶ A three-digit zip code refers to the first three digits of a five-digit zip code. A three-digit zip code represents a larger geographical area than a five-digit zip code, as all five-digit zip codes that share the same first three numbers are included in the three-digit zip code.

²⁷ The Office of Management and Budget establishes delineations for various statistical areas, including metropolitan statistical areas (MSAs). The most recent delineations are available at Executive Office of the President, Office of Management and Budget, "Revised Delineations of Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas, And Guidance on Uses of the Delineations of These Areas," OMB Bulletin No. 13-01, February 28, 2013, at <http://www.whitehouse.gov/sites/default/files/omb/bulletins/2013/b-13-01.pdf>.

²⁸ A state's rating areas are presumed adequate if either of the following conditions are met: (1) the state established the (continued...)

Tobacco Use. Plans are allowed to charge a tobacco user up to 1.5 times the premium that they charge an individual who does not use tobacco.

Age. Plans can vary premiums by no more than a 3-to-1 ratio for adults aged 21 and older. This provision means that a plan may not charge an older individual more than three times the premium that the plan charges a 21-year-old individual. Each state must use a uniform age rating curve to specify the rates across all adult age bands, and each state must set a separate rate for all individuals aged 20 and younger. HHS created an age curve that states may choose to use, but some states have implemented standards other than the federal defaults.²⁹

Rate Review

The rate review program aims to ensure that proposed annual health insurance rate increases in the small-group and individual markets that meet or exceed a specified threshold are reviewed by a state or CMS to determine whether they are unreasonable.³⁰ States have the option to establish state-specific thresholds, and a 10% threshold is in effect in any states that do not establish state-specific thresholds.³¹

Plans subject to review are required to submit to CMS and the relevant state a justification for the proposed rate increase prior to its implementation, and CMS will publicly disclose the information.³² The rate review process does not establish federal authority to deny implementation of a proposed rate increase; it is a sunshine provision designed to publicly expose rate increases determined to be unreasonable.

Single Risk Pool

A risk pool is used to develop rates for coverage. A health insurance issuer must consider all enrollees in plans offered by the issuer to be members of a single risk pool.³³ More specifically, an issuer must consider all enrollees in individual plans offered by the issuer to be members of a single risk pool; the issuer must have a separate risk pool for all enrollees in small-group plans offered by the issuer. (However, states have the option to merge their individual and small-group markets; if a state does so, an issuer will have a single risk pool for all enrollees in its individual and small-group plans.) A result of the single risk pool requirement is that issuers must consider the medical claims experience of enrollees in all plans (individual and small-group, either separately or combined) offered by the issuer when developing rates.

(...continued)

rating areas for the entire state prior to January 1, 2013, or (2) the state establishes the rating areas after January 1, 2013, for the entire state and there are no more rating areas than the number of MSAs in the state plus one. A state that establishes its rating periods after January 1, 2013, may propose a greater number of rating areas to the Centers for Medicare & Medicaid Services (CMS), provided such rating areas are based on the geographic boundaries noted above.

²⁹ The HHS default standard age curve is available at CMS, Center for Consumer Information & Insurance Oversight (CCIIO), "Sub-regulatory Guidance Regarding Age Curves, Geographical Rating Areas and State Reporting," February 25, 2013, at <https://www.cms.gov/CCIIO/Resources/Files/Downloads/market-reforms-guidance-2-25-2013.pdf>. For information about states that have established their own age curves, see CMS, CCIIO, "Market Rating Reforms," at <http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-rating.html>.

³⁰ The rate review requirements do not apply to grandfathered health plans.

³¹ For information on state-specific thresholds, see CMS, Center for Consumer Information & Insurance Oversight, "State-Specific Threshold Proposals," at <http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/sst.html>.

³² 42 U.S.C. §300gg-94.

³³ 42 U.S.C. §18032.

Covered Services

Coverage of Essential Health Benefits

Plans must cover the essential health benefits (EHB).³⁴ The ACA does not explicitly list the benefits that comprise the EHB; rather, it lists 10 broad categories from which benefits and services must be included.³⁵ The HHS Secretary is tasked with further defining the EHB.

For 2014 through 2016, the Secretary asked each state to select a benchmark plan from four different types of plans. If the selected benchmark plan does not cover services and benefits from all 10 categories listed in statute, the state must supplement the benchmark plan (according to a process outlined by HHS) to ensure that all 10 statutorily required categories are represented. In general, plans that are required to offer the EHB must model their benefits package after the state's selected benchmark plan.³⁶

The EHB requirement does not prohibit states from maintaining or establishing state-mandated benefits. In fact, state-required benefits enacted on or before December 31, 2011, are considered part of the EHB for 2014 through 2016. However, any state that requires plans to cover benefits beyond the EHB and what was mandated by state law prior to 2012 must assume the total cost of providing those additional benefits.³⁷ In other words, states must defray the cost of any mandated benefits enacted after December 31, 2011.

Coverage of Preventive Health Services Without Cost Sharing

Plans are generally required to provide coverage for certain preventive health services without imposing cost sharing.³⁸ The preventive services include the following minimum requirements:³⁹

- evidence-based items or services that have in effect a rating of “A” or “B” from the United States Preventive Services Task Force (USPSTF);⁴⁰

³⁴ 42 U.S.C. §18022.

³⁵ 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. For more information about the essential health benefits (EHB), see CRS Report R44163, *The Patient Protection and Affordable Care Act's Essential Health Benefits (EHB)*, by (name redacted).

³⁶ Summaries of each state's selected benchmark plan are available at CMS, Center for Consumer Information & Insurance Oversight, “Information on Essential Health Benefits (EHB) Benchmark Plans,” at <http://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html>.

³⁷ Plans offered inside and outside an exchange must cover the EHB; however, states only have to defray the cost of additional benefits for qualified health plans, which are plans that must meet the certification standards to be offered through an exchange.

³⁸ 42 U.S.C. §300gg-13.

³⁹ The complete list of recommendations and guidelines required to be covered under regulations at 45 C.F.R. §147.130 is available at HealthCare.gov, “Health Benefits and Coverage: Preventive Health Services,” at <http://www.healthcare.gov/coverage/preventive-care-benefits/>.

⁴⁰ The United States Preventive Services Task Force is currently sponsored by the Agency for Healthcare Research and Quality as an independent panel of private-sector experts in prevention and primary care issues. For more background, see <http://www.uspreventiveservicestaskforce.org/>.

- immunizations that have in effect a recommendation for routine use from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC);⁴¹
- evidence-informed preventive care and screenings (for infants, children, and adolescents) provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA);⁴² and
- additional preventive care and screenings for women not described by the USPSTF, as provided in comprehensive guidelines supported by HRSA.⁴³

Additional services not recommended by the USPSTF may be offered but are not required.

For the purposes of this provision and others in federal law, the ACA negated the November 2009 USPSTF recommendation that women receive routine screening mammograms to detect breast cancer beginning at the age of 50. Plans have instead been required to cover screening mammograms beginning at the age of 40, based on the prior (2002) USPSTF recommendation. The USPSTF published a draft revision in April 2015 that reiterated the recommendation in January 2016.⁴⁴ In the interim, Congress included a provision in FY2016 Omnibus appropriations clarifying that for the purposes of any law that references USPSTF recommendations, the mammography screening recommendation from 2002 shall be used, though January 1, 2018.⁴⁵ As a result, for 2016 and 2017, the coverage requirement continues to apply for women beginning at age 40.

A plan with a network of providers is not required to provide coverage for an otherwise required preventive service if it is delivered by an out-of-network provider, and the plan may impose cost-sharing requirements for a recommended preventive service delivered out of network. Additionally, if a recommended preventive service does not specify the frequency, method, treatment, or setting for the service, then the plan can determine coverage limitations by relying on established techniques and relevant evidence.

Coverage of Preexisting Health Conditions

The ACA prohibits plans from excluding coverage for preexisting health conditions.⁴⁶ In other words, plans may not exclude benefits based on health conditions for any individual. A *preexisting health condition* is a medical condition that was present before the date of enrollment

⁴¹ The Advisory Committee on Immunization Practices (ACIP) is a group of medical and public health experts that develop recommendations on use of vaccines in the U.S. civilian population. For more information, see CDC, “Advisory Committee on Immunization Practices,” at <http://www.cdc.gov/vaccines/acip/index.html>.

⁴² The Health Resources and Services Administration (HRSA) is the primary federal agency within the Department of HHS for improving access to health care services for people who are uninsured, isolated, or medically vulnerable. For background information, see HHS, HRSA, “About HRSA,” at <http://www.hrsa.gov/about/index.html>.

⁴³ HRSA published its guidelines related to women’s preventive services in August 2011, at HHS, HRSA, “Women’s Preventive Services Guidelines,” at <http://www.hrsa.gov/womensguidelines/>. These guidelines include, among other services, coverage for all Food and Drug Administration-approved contraceptive methods and sterilization procedures. The requirement to cover contraceptive services has been a source of controversy and the subject of several challenges in the courts, including the Supreme Court. See CRS In Focus IF10169, *The Affordable Care Act’s Contraceptive Coverage Requirement: History of Regulations for Religious Objections*, by (name redacted)

⁴⁴ USPSTF, “Breast Cancer: Screening,” January 2016, at <http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/breast-cancer-screening>.

⁴⁵ FY2016 Omnibus appropriation, P.L. 114-113, December 18, 2015.

⁴⁶ 42 U.S.C. §300gg-3.

for health coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

Cost-Sharing Limits

Limits for Annual Out-of-Pocket Spending

Plans must comply with annual limits on out-of-pocket spending.⁴⁷ The limits apply only to in-network coverage of the EHB.⁴⁸ In 2016, the limits cannot exceed \$6,850 for self-only coverage and \$13,700 for coverage other than self only.

The self-only limit applies to each individual, regardless of whether the individual is enrolled in self-only coverage or coverage other than self only. For instance, if an individual is enrolled in a family plan and incurs \$8,000 in cost sharing, the plan is responsible for covering the individual's costs above \$6,850.⁴⁹

Minimum Actuarial Value Requirements

Plans must tailor cost sharing to comply with one of four levels of actuarial value.⁵⁰ *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.⁵¹ In other words, AV reflects the relative share of cost sharing that may be imposed. On average, the lower the AV, the greater the cost sharing for enrollees overall.⁵²

Each level of plan generosity is designated according to a precious metal and corresponds to an actuarial value:

- Bronze: 60% AV
- Silver: 70% AV
- Gold: 80% AV
- Platinum: 90% AV

Prohibition of Lifetime Limits and Annual Limits

Prior to the ACA, plans were generally able to set lifetime and annual limits—dollar limits on how much the plan would spend for covered health benefits either during the entire period an

⁴⁷ 42 U.S.C. §18022.

⁴⁸ Certain types of plans—self-insured plans and plans offered in the large-group market—must comply with this requirement but do not have to offer the EHB. HHS has indicated that such plans must use a permissible definition of EHB (including any state-selected EHB benchmark plans) to determine whether they comply with the requirement.

⁴⁹ For additional information about this requirement, see Department of Labor, “Frequently Asked Questions About the Affordable Care Act (XXVII),” May 26, 2015, at <http://www.dol.gov/ebsa/pdf/faq-aca27.pdf>.

⁵⁰ 42 U.S.C. §18022.

⁵¹ Although actuarial value (AV) is a useful measure, it is only one component that addresses the value of any given benefit package. AV, by itself, does not address other important features of coverage, such as total (dollar) value, network adequacy, and premiums.

⁵² AV is calculated based on costs for an entire population, but not every person enrolled in the same plan will have the same expenses; in any given group, some people use relatively little care while others use a great deal. Given that actuarial value reflects cost sharing, such a measure may be useful to consumers when comparing different health plans.

individual was enrolled in the plan (lifetime limits) or during a plan year (annual limits). Under the ACA, both lifetime and annual limits are prohibited;⁵³ the limits apply specifically to the EHB.⁵⁴ Plans are permitted to place lifetime and annual limits on covered benefits that are not considered EHBs, to the extent that such limits are otherwise permitted by federal and state law.

Consumer Assistance and Other Patient Protections

Internet Portal to Assist Consumers in Identifying Coverage Options

The HHS Secretary, in consultation with the states, is required to establish an Internet portal for the public to easily access affordable and comprehensive coverage options.⁵⁵ The portal is required to provide, at minimum, information on the following coverage options: health plans offered in the private insurance market, Medicaid and the State Children's Health Insurance Program (CHIP), high-risk pools, and small-group health plans. The Internet portal, www.healthcare.gov, launched on July 1, 2010.

Summary of Benefits and Coverage

Plans are required to provide a summary of benefits and coverage (SBC) to individuals at the time of application, prior to the time of enrollment or reenrollment, and when the insurance policy is issued.⁵⁶ The SBC must meet certain requirements, as specified in statute and further developed by the Secretaries of HHS, Labor, and the Treasury.⁵⁷ The statutory requirements for the SBC are summarized in **Table 1**.⁵⁸

The SBC may be provided in paper or electronic form. Enrollees must be given notice of any material changes in benefits no later than 60 days prior to the date that the modifications would become effective. Plans also must provide a uniform glossary of terms commonly used in health insurance coverage (e.g., coinsurance) to enrollees upon request.⁵⁹

⁵³ 42 U.S.C. §300gg-11.

⁵⁴ See footnote 48.

⁵⁵ 42 U.S.C. §18003.

⁵⁶ 42 U.S.C. §300gg-15.

⁵⁷ The ACA requires the Secretaries of HHS, Labor, and the Treasury to develop standards for the summary of benefits and coverage (SBC) and to periodically review and update the standards.

⁵⁸ For more detailed information about the requirements for the SBC, see CMS, Center for Consumer Information & Insurance Oversight, "Summary of Benefits & Coverage & Uniform Glossary," at <https://www.cms.gov/ccio/programs-and-initiatives/consumer-support-and-information/summary-of-benefits-and-coverage-and-uniform-glossary.html>.

⁵⁹ *Ibid.* HHS created the uniform glossary that plans must provide upon request.

Table I. Statutory Requirements for the Summary of Benefits and Coverage (SBC)

Issue Area	Requirements
Prohibitions	<ul style="list-style-type: none"> • Cannot exceed four pages in length. • Cannot use smaller than 12-point font.
Required Description	<ul style="list-style-type: none"> • Coverage, including cost sharing for each of the essential health benefit categories. • Any exceptions, reductions, and limitations on coverage. • Renewability and continuation provisions. • Whether the plan covers minimum essential benefits. • Other benefits as identified by the Secretary of Health and Human Services. • Contact information, including a phone number and web address for consumer information.
Other Requirements	<ul style="list-style-type: none"> • Must be presented in a culturally and linguistically appropriate manner using language understandable by the average plan enrollee. • Must use uniform definitions of standard insurance and medical terms. • Must have a statement ensuring that not less than 60% of allowed costs are covered by the benefits. • Must have a statement that the document is a summary and should not be consulted to determine the governing contractual provisions.

Source: 42 U.S.C. §300gg-15.

Medical Loss Ratio

Health plans are required to submit to the HHS Secretary a report concerning the percentage of premium revenue spent on medical claims (*medical loss ratio*, or MLR).⁶⁰ The MLR calculation includes adjustments for health quality costs, taxes, regulatory fees, and other factors. The law requires plans in the individual and small-group markets to meet a minimum MLR of 80%; for large groups, the minimum MLR is 85%. States are permitted to increase the percentages, and the HHS Secretary may adjust the state percentage for the individual market if HHS determines that the application of a minimum MLR of 80% would destabilize the individual market within the state.⁶¹ Health plans whose MLR falls below the specified limit must provide rebates to policyholders on a pro rata basis. Any required rebates must be paid to policyholders by August of that year.⁶²

Appeals Process

The ACA requires that plans implement an effective appeals process for coverage determinations and claims.⁶³ At a minimum, the plans must

⁶⁰ 42 U.S.C. §300gg-18. For more information about the medical loss ratio (MLR), see CRS Report R42735, *Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act (ACA): Issues for Congress*, by (name redacted).

⁶¹ To view a list of state requests for an MLR adjustment, see CMS, Center for Consumer Information and Insurance Oversight, “Ensuring the Affordable Care Act Serves the American People,” at <http://cciio.cms.gov/programs/marketreforms/mlr/state-mlr-adj-requests.html>.

⁶² For rebate information, see CMS, Center for Consumer Information and Insurance Oversight, “Medical Loss Ratio Data and System Resources,” at <http://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html>.

⁶³ 42 U.S.C. §300gg-19.

- have an internal claims appeals process;
- provide notice to enrollees regarding available internal and external appeals processes and the availability of any applicable assistance; and
- allow an enrollee to review his or her file, present evidence and testimony, and receive continued coverage pending the outcome.

To comply with the requirements for the internal claims appeals process, group plans are expected to initially incorporate the claims and appeals procedures previously established under federal law⁶⁴ and to update their processes in accordance with any standards established by the Secretary of Labor. Individual health plans must comply with internal claims and appeals procedures set forth under applicable law and updated by the Secretary of HHS.

To comply with the requirements for the external appeals process, plans must comply with a state's external review process, provided that process includes, at a minimum, the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners. If a state's review process does not meet the minimum requirements, the state must implement a process that meets the standards established by the HHS Secretary and plans must comply with such a process.⁶⁵

Patient Protections

Plans are subject to three requirements relating to the choice of health care professionals.

1. A plan that requires or allows an enrollee to designate a participating primary care provider is required to permit the designation of any participating primary care provider who is available to accept the individual.
2. This same provision applies to pediatric care for any child who is a plan participant.
3. A plan that provides coverage for obstetrical or gynecological care cannot require authorization or referral by the plan or any person (including a primary care provider) for a female enrollee who seeks obstetrical or gynecological care from an in-network health care professional who specializes in obstetrics or gynecology.

Plans also must comply with one requirement relating to benefits for emergency services.⁶⁶ If the plan covers services in an emergency department of a hospital, the plan is required to cover those services without the need for any prior authorization and without the imposition of coverage limitations, irrespective of the provider's contractual status with the plan. If the emergency services are provided out of network, the cost-sharing requirement will be the same as the cost sharing for an in-network provider.

⁶⁴ §503 of ERISA, codified at 29 C.F.R. §2560.530-1, requires that employee benefit plans provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied. This written notification, which must set forth the specific reasons for such denial, is to be written in a manner calculated to be understood by the participant. It also is to afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

⁶⁵ Department of Labor, "Extension of the Transition Period for the Temporary NAIC-similar State External Review Process under the Affordable Care Act," Technical Release No. 2013-01, March 15, 2013.

⁶⁶ 42 U.S.C. §300gg-19a.

Nondiscrimination Regarding Clinical Trial Participation

Health plans cannot

- prohibit *qualified individuals* from participating in an approved clinical trial;⁶⁷
- deny, limit, or place conditions on the coverage of routine patient costs associated with participation in an approved clinical trial; or
- discriminate against qualified individuals on the basis of their participation in approved clinical trials.⁶⁸

Plan Requirements Related to Health Care Providers

Nondiscrimination Regarding Health Care Providers

Plans are not allowed to discriminate, with respect to participation under the plan, against any health care provider who is acting within the scope of that provider's license or certification under applicable state law.⁶⁹ This provision does not require that a plan contract with any health care provider willing to abide by the plan's terms and conditions, and the provision cannot be read as preventing a plan or the HHS Secretary from establishing varying reimbursement rates for providers based on quality or performance measures.

Reporting Requirements Regarding Quality of Care

Beginning upon the ACA's enactment and concluding no later than two years after enactment, the HHS Secretary must develop quality reporting requirements for use by specified plans.⁷⁰ The Secretary must develop these requirements in consultation with experts in health care quality and other stakeholders. The Secretary is also required to publish regulations governing acceptable provider reimbursement structures not later than two years after ACA enactment. Not later than 180 days after these regulations are promulgated, the U.S. Government Accountability Office (GAO) is required to conduct a study regarding the impact of these activities on the quality and cost of health care. To date, the Secretary has not published the required regulations; therefore, the required GAO report has not been published.

Once the reporting requirements are implemented, plans will annually submit, to the Secretary and enrollees, a report addressing whether plan benefits and reimbursement structures do the following:

- improve health outcomes through the use of quality reporting, case management, care coordination, and chronic disease management;
- implement activities to prevent hospital readmissions and to improve patient safety and reduce medical errors; and
- implement wellness and health promotion activities.

⁶⁷ For purposes of this provision, a *qualified individual* is an individual who (1) is eligible to participate in an approved clinical trial for treatment of cancer or other life-threatening disease or condition and (2) either has a referring health care provider who has concluded that the individual's participation is appropriate or who provides medical and scientific information establishing that participation in a clinical trial would be appropriate.

⁶⁸ 42 U.S.C. §300gg-8.

⁶⁹ 42 U.S.C. §300gg-5.

⁷⁰ 42 U.S.C. §300gg-17.

The Secretary is required to make these reports available to the public and is permitted to impose penalties for noncompliance.

Wellness and health promotion activities include personalized wellness and prevention services, specifically efforts related to smoking cessation, weight management, stress management, physical fitness, nutrition, heart disease prevention, healthy lifestyle support, and diabetes prevention. These services may be made available by entities (e.g., health care providers) that conduct health risk assessments or provide ongoing face-to-face, telephonic, or web-based intervention efforts for program participants.⁷¹

⁷¹ With respect to gun rights, a wellness or promotion activity cannot require disclosure or collection of any information in relation to (1) the presence or storage of a lawfully possessed firearm or ammunition in the residence or on the property of an individual or (2) the lawful use, possession, or storage of a firearm or ammunition by an individual. A health plan issued in accordance with the law is prohibited from increasing premium rates; denying health insurance coverage; and reducing or withholding a discount, rebate, or reward offered for participation in a wellness program on the basis of or reliance on the lawful ownership, possession, use, or storage of a firearm or ammunition.

Appendix. Applicability of Market Reforms to Health Plans

Table A-1. Applicability of the ACA's Private Health Insurance Market Reforms to Health Plans

Provision	Grandfathered Plans ^a			New Plans (Non-grandfathered)				
	Group Market ^b			Large-Group Market ^c		Small-Group Market ^d		
	Fully Insured ^e	Self-Insured ^f	Individual Market ^g	Fully Insured	Self-Insured	Fully Insured	Self-Insured	Individual Market
Obtaining Coverage								
Guaranteed Issue	N.A.	N.A.	N.A.	√	N.A.	√	N.A.	√
Nondiscrimination Based on Health Status	N.A.	N.A.	N.A.	√	√	√	√	√
Extension of Dependent Coverage	√	√	√	√	√	√	√	√
Prohibition of Discrimination Based on Salary	N.A.	N.A.	N.A.	√	N.A.	√	N.A.	N.A.
Waiting Period Limitation	√	√	N.A.	√	√	√	√	N.A.
Keeping Coverage								
Guaranteed Renewability	N.A.	N.A.	N.A.	√	N.A.	√	N.A.	√
Prohibition on Rescissions	√	√	√	√	√	√	√	√
Costs Associated with Coverage								
Rating Restrictions	N.A.	N.A.	N.A.	N.A.	N.A.	√	N.A.	√
Rate Review	N.A.	N.A.	N.A.	N.A.	N.A.	√	N.A.	√
Single Risk Pool	N.A.	N.A.	N.A.	N.A.	N.A.	√	N.A.	√
Covered Services								
Coverage of Essential Health Benefits	N.A.	N.A.	N.A.	N.A.	N.A.	√	N.A.	√
Coverage of Preventive Health Services Without Cost Sharing	N.A.	N.A.	N.A.	√	√	√	√	√
Coverage of Preexisting Health Conditions	√	√	N.A.	√	√	√	√	√

Provision	Grandfathered Plans ^a			New Plans (Non-grandfathered)				
	Group Market ^b			Large-Group Market ^c		Small-Group Market ^d		
	Fully Insured ^e	Self-Insured ^f	Individual Market ^g	Fully Insured	Self-Insured	Fully Insured	Self-Insured	Individual Market
Cost-Sharing Limits								
Limits for Annual Out-of-Pocket Spending	N.A.	N.A.	N.A.	√	√	√	√	√
Minimum Actuarial Value Requirements	N.A.	N.A.	N.A.	N.A.	N.A.	√	N.A.	√
Prohibition on Lifetime Limits	√	√	√	√	√	√	√	√
Prohibition on Annual Limits	√	√	N.A.	√	√	√	√	√
Consumer Assistance and Other Patient Protections								
Summary of Benefits and Coverage	√	√	√	√	√	√	√	√
Medical Loss Ratio	√	N.A.	√	√	N.A.	√	N.A.	√
Appeals Process	N.A.	N.A.	N.A.	√	√	√	√	√
Patient Protections	N.A.	N.A.	N.A.	√	√	√	√	√
Nondiscrimination Regarding Clinical Trial Participation	N.A.	N.A.	N.A.	√	√	√	√	√
Plan Requirements Related to Health Care Providers								
Nondiscrimination Regarding Health Care Providers	N.A.	N.A.	N.A.	√	√	√	√	√
Reporting Requirements Regarding Quality of Care	N.A.	N.A.	N.A.	√	√	√	√	√

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

Notes: N.A. indicates that the reform is not applicable to that type of health insurance plan. The reform “Internet Portal to Assist Consumers in Identifying Coverage Options” is not included in this table because the reform does not apply to health plans. Other health insurance reforms are currently effective under federal law. This table lists only ACA market reforms; therefore, it is not intended to be a comprehensive listing of all federal health insurance requirements and standards.

- a. A *grandfathered* plan refers to an existing group health plan or a health insurance plan/policy in which at least one individual has been enrolled since March 23, 2010. To maintain grandfathered status, a plan must avoid certain changes to benefits, cost sharing, employer contributions, and access to coverage.

- b. Health insurance can be provided to a group of people that are drawn together by an employer or other organization, such as a trade union. Such groups are generally formed for some purpose other than obtaining insurance, such as employment. When insurance is provided to a group, it is referred to as *group coverage* or *group insurance*. In the group market, the entity that purchases health insurance on behalf of a group is referred to as the *plan sponsor*.
- c. Prior to the ACA, *large groups* were defined as groups with more than 50 workers. For plan years beginning on or after January 1, 2016, states may elect to define large groups as groups with more than 50 workers or more than 100 workers.
- d. Prior to the ACA, *small groups* were defined as groups with 2 to 50 workers, although some states also included self-employed individuals (groups of one) in the small-group market. For plan years beginning on or after January 1, 2016, states may elect to define small groups as groups with 50 or fewer workers or 100 or fewer workers.
- e. A *fully insured health plan* is one in which the plan sponsor purchases health coverage from a state-licensed insurance carrier; the carrier assumes the risk of paying the medical claims of the sponsor's enrolled members.
- f. *Self-insured plans* refer to health coverage that is provided directly by the organization seeking coverage for its members (e.g., a firm providing health benefits to its employees). Such organizations set aside funds and pay for health benefits directly. Under self-insurance, the organization bears the risk for covering medical claims.
- g. Consumers who are not associated with a group can obtain health coverage by purchasing it directly from an insurance carrier in the individual (or non-group) health insurance market.

Author Contact Information

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

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

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