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

Annie L. Mach
Congressional Research Service

Bernadette Fernandez
Congressional Research Service

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

Abstract

[Excerpt] 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 of the report provides details about the types of plans that are required to comply with the different reforms.

Keywords

private health insurance, Patient Protection and Affordable Care Act, ACA, market reform

Comments

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

Annie L. Mach

Analyst in Health Care Financing

Bernadette Fernandez

Specialist in Health Care Financing

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Summary

The Affordable Care Act (ACA, P.L. 111-148, as amended) establishes federal requirements that apply to private health insurance. The market reforms affect insurance offered to groups and individuals and impose requirements on sponsors of coverage (e.g., employers). In general, all of ACA's market reforms are currently effective; some became effective shortly after ACA was passed in 2010, while others are effective for plan years that begin on or after January 1, 2014.

While 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 means that, in general, insurers must accept every applicant for health coverage, as long as the applicant agrees to the terms and conditions of the coverage (e.g., premium). The requirement to offer the essential health benefits means that certain plans have to cover a specified package of benefits.

The applicability of the market reforms across types of plans is not uniform. Some of the reforms apply to all three segments of the private insurance market—nongroup, small group, and large group—while others may apply only to plans offered in the nongroup 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 applicability of the reforms also depends on whether a plan has “grandfathered” status. Under 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.

While the applicability of the market reforms 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 a nongroup plan offered through an exchange and a nongroup 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 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** of the report provides details about the types of plans that are required to comply with the different reforms.

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The 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 requirements. Certain reforms also require the participation of public agencies and officials, such as the Secretary of Health and Human Services (HHS), in order to facilitate administrative or operational elements of the insurance market.

This report first provides background information about the private health insurance market and then describes the market reforms included in ACA. The **Appendix** of the report provides additional information about how 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 Prior to ACA, large group plans typically had more than 50 workers, and small group plans had 50 or fewer workers. However, ACA implements specific definitions of large and small groups that affect the provisions discussed in this report. Prior to 2016, states can elect to define “small employers” as those that employ 100 or fewer employees or those that employ 50 or fewer. Beginning in 2016, small employers will be defined as those with 100 or fewer workers. The nongroup, or individual, 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 (15 U.S.C. §§1011 et seq.). Each state has a large, unique set of rules that apply to state-licensed insurance carriers and the plans they offer.³ Such 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), nature of insurance products (e.g., benefit mandates), and consumer protections (e.g., plan disclosure requirements), among others.

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 those groups bear the risk for covering medical expenses generated by the individuals covered under the self-insured plan.

³ State regulation of health insurance applies only to state-licensed entities. Since self-insured plans are financed directly by the plan sponsor, such plans are not subject to state law.

In addition to the state regulation of insurance, the federal government has established federal 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.⁴

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). In other words, while ACA establishes many federal rules, the states have primary responsibility for monitoring 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

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. While such market reforms may be new at the federal level, many of ACA's reforms had already been enacted in some form in some states, with great variation in scope and specificity across the states. In general, all of ACA's market reforms are currently effective.⁷ (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 applicability of reforms across types of plans is not uniform. Often reforms apply differently to health plans according to the market segment in which the plan is offered

Transitional Policy

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

Under the transitional policy, health insurance issuers offering non-grandfathered coverage in the nongroup and small group markets may choose to continue coverage that would otherwise be 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 would otherwise 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

⁴ Federal regulation applies to both traditional insurance and self-insured plans. For more information about federal regulation of health benefits provided through employment, see CRS Report RS22643, *Regulation of Health Benefits Under ERISA: An Outline*.

⁵ The March 5, 2014, extension guidance is available at <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/transition-to-compliant-policies-03-06-2015.pdf>. The original November 2013 guidance is available 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: <http://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner-letter-11-14-2013.PDF>.

⁷ The reforms that go into effect in 2014 are generally effective for plan or policy years that begin on or after January 1, 2014. In other words, when a plan or policy is renewed in 2014 it must become compliant with all ACA market reforms that are effective in 2014 (but it does not necessarily have to comply with the reforms on January 1, 2014).

and whether the plan has grandfathered status.⁸ However, the reforms do not apply to certain types of plans (this is true of other federal health reforms as well). For example, retiree-only health plans are not required to comply with federal health insurance requirements, including ACA's market reforms.⁹ In the text of this report the term "plan" is used generally; 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**.

In this report, 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.

Obtaining Coverage

Guaranteed Issue

ACA requires certain types of coverage to be offered on a guaranteed issue basis.¹⁰ 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 (such as the premium). Nongroup plans that must be offered on a guaranteed issue basis are allowed to restrict enrollment to open and special enrollment periods.¹¹ With regard to plans offered in the group market, in general "guaranteed issue" means that a plan sponsor (e.g., an employer) must be able to purchase a group health plan any time during a year.¹²

Regulations allow plans that would otherwise be required to offer coverage on a guaranteed issue basis to deny coverage to individuals and employers in certain circumstances.¹³ Those circumstances include when a plan demonstrates that it does not have the network capacity to deliver services to additional enrollees and when the plan demonstrates that it does not have the financial capacity to offer additional coverage.

⁸ A grandfathered health plan refers to an existing plan in which at least one individual has been enrolled since enactment of ACA (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 co-insurance requirement). For more information about grandfathered status, see CRS Report R41166, *Grandfathered Health Plans Under the Patient Protection and Affordable Care Act (ACA)*, by Bernadette Fernandez.

⁹ The federal exemption for retiree-only health plans is not a new exemption. Retiree-only health plans have been exempt from federal health insurance requirements since enactment of the Health Insurance Portability and Accountability Act of 1996. 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 Bernadette Fernandez.

¹⁰ 42 U.S.C. §300gg-1.

¹¹ The annual open enrollment periods in the nongroup market are the same inside and outside ACA health insurance exchanges. For policy years beginning on or after January 1, 2014, the open enrollment period is October 1, 2013, through March 31, 2014. The 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 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.

¹³ 45 C.F.R. §147.104(c) and (d).

Nondiscrimination Based on Health Status

ACA prohibits plans from basing eligibility or coverage on health status-related factors.¹⁴ 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 Secretary of HHS. ACA allows, however, for the offering of premium discounts or rewards based on enrollee participation in wellness programs, in keeping with prior federal law.¹⁵

Extension of Dependent Coverage

ACA requires that if a plan offers dependent coverage, the plan must make such coverage available to a child under age 26.¹⁶ ACA does not require plans to offer dependent coverage; if a plan chooses not to provide such coverage, nothing in this statute requires them to do so. The age requirement affects only plans that choose to offer dependent coverage. Plans that *offer* dependent coverage must make coverage available for both married and unmarried adult children under age 26, but not for the adult child's children or spouse.

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 total hourly or annual salary of the employee.¹⁷ Eligibility rules cannot be permitted to discriminate in favor of higher-wage employees. The Departments (HHS, Labor, and 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.¹⁸

Waiting Period Limitation

ACA prohibits plans from establishing waiting periods greater than 90 days.¹⁹ A “waiting period” refers to the time period 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 coverage complies with this provision.

¹⁴ 42 U.S.C. §300gg-4.

¹⁵ The Health Insurance Portability and Accountability Act of 1996 (HIPAA) allows group plans to establish premium discounts or rebates or modify cost-sharing requirements in return for adherence to a wellness program. If a reward is provided based solely on participation in a wellness program, 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 reward is 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 ACA, the reward must be capped at 30% of the cost of the employee-only coverage under the plan, but the Secretaries of HHS, Labor, and the Treasury would have the discretion to increase the reward up to 50% of the cost of coverage if the increase is determined to be appropriate.

¹⁶ 42 U.S.C. §300gg-14.

¹⁷ 42 U.S.C. §300gg-16.

¹⁸ Internal Revenue Service (IRS) Notice 2011-1.

¹⁹ 42 U.S.C. §300gg-7.

Keeping Coverage

Guaranteed Renewability

“Guaranteed renewability” in health insurance is the requirement on a plan to renew individual coverage at the option of the policyholder, or renew group coverage at the option of the plan sponsor. Under ACA, most plans offered in the nongroup and small group markets must renew coverage at the option of the enrollee or plan sponsor; however, plans may discontinue coverage under certain circumstances.²⁰ For example, a plan may discontinue coverage if the individual or plan sponsor fails to pay premiums or if an individual or plan sponsor performs an act that constitutes fraud in connection with the coverage.²¹

Prohibition on Rescissions

The practice of “rescission” refers to the retroactive cancellation of medical coverage after an enrollee has become sick or injured. ACA generally prohibits rescissions, except that rescissions will still be 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.²² A cancellation of coverage in this case requires that a plan provide at least 30 calendar days advanced notice to the enrollee.²³

Cost of Purchasing Coverage

Rating Restrictions

ACA imposes adjusted (or modified) community rating rules on the determination of premiums.²⁴ “Adjusted community rating” rules prohibit plans from pricing health insurance products based on health factors but allow it for other key characteristics such as age or gender. ACA’s 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, if a state does not permit rating variation for age and tobacco, the state is allowed to require that premiums for family coverage are determined by 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.

²⁰ 42 U.S.C. §300gg-4.

²¹ 45 C.F.R. §147.106.

²² 42 U.S.C. §300gg-12.

²³ 45 C.F.R. §147.128.

²⁴ 42 U.S.C. §300gg.

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.

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 and 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.

Tobacco use. Plans are allowed to charge a tobacco user up to 1.5 times the premium that the plan will 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 means that a plan will not be allowed to charge an older individual more than three times the premium that the plan will charge a 21-year-old. Regulations require that each state use a uniform age rating curve to specify the rates across all adult age bands, and they require each state to 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

Figure 1 shows the federally established age rating curve. In states that choose to use this curve, a plan cannot set a premium for a child (age 0-20) that is more than 63.5% of a premium for a 21-year-old, and a premium for an individual age 64 and older cannot be more than three times that of a premium for a 21-year-old.

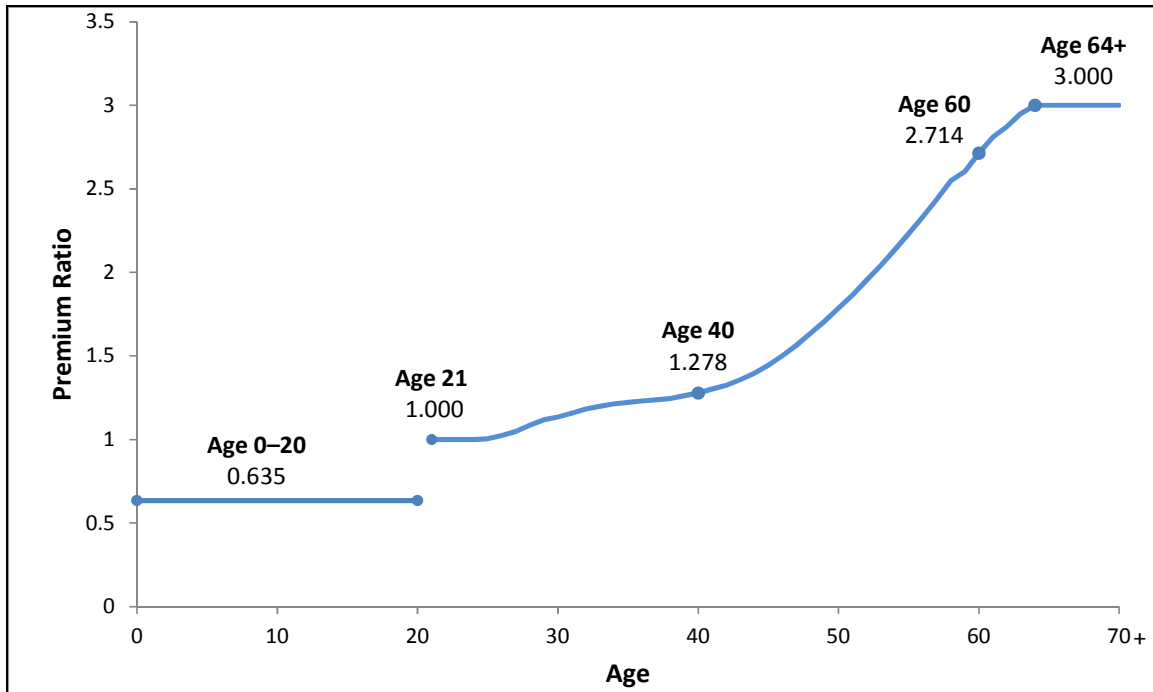
²⁶ A three-digit zip code refers to the first three digits of a five-digit zip code. A three-digit zip code represents a larger geographical area than a five-digit zip code, as all five-digit zip codes that share the same first three numbers are included in the three-digit zip code.

²⁷ OMB establishes delineations for various statistical areas, including MSAs. The most recent delineations are available at <http://www.whitehouse.gov/sites/default/files/omb/bulletins/2013/b-13-01.pdf>.

²⁸ A state's rating areas will be presumed adequate if either of the following conditions are met: the state established the rating areas for the entire state prior to January 1, 2013, or the state establishes the rating areas after January 1, 2013, for the entire states 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 CMS, provided such rating areas are based on the geographic boundaries noted above.

²⁹ For information about states that have established their own age curves, see <http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-rating.html>.

Figure 1. Age Rating Curve, as Established by HHS
For Plan Years Beginning in 2014



Source: 77 Federal Register 70584, November 26, 2012.

Notes: In implementing the ACA’s rating restriction requirements, states may use a different uniform age curve, provided it prohibits plans from varying premiums based on age by more than a 3 to 1 ratio.

Rate Review

The intent of the rate review program is to ensure that all proposed 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 Plans subject to review are required to submit to the HHS and the relevant state a justification for the proposed rate increase prior to implementation of the premium, and HHS will publicly disclose the information.³¹

For the first year of the rate review program (plan years beginning on or after September 1, 2011), a proposed rate increase was considered unreasonable if the increase was 10% or more (over a 12-month period beginning on September 1). Since then, states have had the option to establish state-specific thresholds; the 10% threshold remains in effect in any states that do not establish state-specific thresholds.³² Note that ACA’s rate review process does not establish federal authority to deny implementation of a proposed rate increase. (This is a “sunshine” provision designed to publicly expose rate increases determined to be unreasonable.)

³⁰ ACA does not apply the rate review requirements to grandfathered health plans.

³¹ 42 U.S.C. §300gg-94.

³² For information on state-specific thresholds, see <http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/sst.html>.

Covered Services

Coverage of Essential Health Benefits

ACA requires plans to cover the essential health benefits (EHB).³³ ACA does not explicitly list the benefits that comprise EHBs; rather, it lists 10 broad categories from which benefits and services must be included.³⁴ ACA requires the Secretary to further define the EHB. In response, the Secretary outlined a process for defining the EHB for at least 2014 and 2015; the Secretary may revisit how the EHB are defined for the 2016 plan year and beyond.

For 2014 and 2015, the Secretary asked each state to select a benchmark plan from four different types of plans.

- the largest plan by enrollment in any of the three largest small group insurance products in the state's small group market;
- any of the largest three state employee health benefit plans by enrollment;
- any of the largest three national Federal Employees Health Benefit (FEHBP) plan options by enrollment; or
- the largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the state.

If the selected benchmark plan did not cover services and benefits from all 10 categories listed in statute, a state is required to 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.³⁵

ACA requirement for plans to cover the EHB does not prohibit states from maintaining or establishing state-mandated benefits. In fact, the Secretary of HHS has determined that state-required benefits enacted on or before December 31, 2011, are considered part of the EHB for at least 2014 and 2015. However, any state that requires plans to cover benefits beyond EHBs and what was mandated by state law prior to 2012 must assume the total cost of providing those additional benefits.³⁶ In other words, states have to defray the cost of any mandated benefits enacted after December 31, 2011.

³³ 42 U.S.C. §18022.

³⁴ 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.

³⁵ Summaries of each state's selected benchmark plan are available at <http://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html>.

³⁶ 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 (QHP), which are plans that must meet the certification standards to be offered through an exchange.

No Cost-Sharing for Preventive Health Services

Plans are required to provide coverage for certain preventive health services without imposing cost-sharing.³⁷ The preventive services include the following minimum requirements:³⁸

- evidence-based items or services that have in effect a rating of “A” or “B” from the United States Preventive Services Task Force (USPSTF);³⁹
- immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC);⁴⁰
- 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);⁴¹ and
- additional preventive care and screenings for women not described by the USPSTF, as provided in comprehensive guidelines supported by HRSA.⁴²

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, ACA negates the November 2009 USPSTF recommendation that women receive routine screening mammograms beginning at age 50. As a result, plans are required to cover screening mammograms beginning at age 40, based on the prior USPSTF recommendation.

A plan that has a network of providers is not required to provide coverage for a recommended preventive service that 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.

³⁷ 42 U.S.C. §300gg-13.

³⁸ The complete list of recommendations and guidelines required to be covered under the regulations is available at <http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html>.

³⁹ The USPSTF is currently sponsored by the Agency for Healthcare Research and Quality (AHRQ), as an independent panel of private-sector experts in prevention and primary care issues. For more background, see <http://www.ahrq.gov/clinic/uspstfab.htm>.

⁴⁰ The Advisory Committee on Immunization Practices consists of 15 experts in fields associated with immunization who have been selected by the Secretary of HHS to provide advice and guidance to the Secretary and the CDC on the control of vaccine-preventable diseases. The committee develops recommendations for the routine administration of vaccines to children and adults in the civilian population; recommendations include age for vaccine administration, number of doses and dosing interval, and precautions and contraindications. For more information, see <http://www.cdc.gov/vaccines/acip/index.html>.

⁴¹ HRSA is the primary federal agency within the Department of Health and Human Services for improving access to health care services for people who are uninsured, isolated, or medically vulnerable. For background information, see <http://www.hrsa.gov/about/index.html>.

⁴² HRSA published its guidelines related to women’s preventive services in August 2011; the guidelines are found at <http://www.hrsa.gov/womensguidelines/>. These guidelines include, among other services, coverage for all FDA approved contraceptive methods and sterilization procedures. The requirement to cover these services has been a source of controversy; for more details, see CRS Report WSLG689, *History and Current Status for Enforcement of ACA’s Contraceptive Coverage Requirement*, by Cynthia Brougher.

Coverage of Preexisting Health Conditions

ACA prohibits plans from excluding coverage for preexisting health conditions.⁴³ In other words, plans may not exclude benefits based on health conditions for any individuals. A “preexisting health condition” is a medical condition that was present before the date of enrollment for health coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

Cost-Sharing Limits

Deductible Limits

ACA generally prohibits plans offered in the small group market from having deductibles that are greater than \$2,000 for self-only coverage and \$4,000 for any other coverage in 2014 (and annually adjusted thereafter).⁴⁴ However, regulations allow plans to make adjustments to deductibles, including exceeding the specified limits, to maintain a given level of coverage based on actuarial value (AV).⁴⁵ Additionally, ACA prohibits plans from imposing any deductible applicable to preventive health services.

Limits for Annual Out-of-Pocket Spending

ACA places annual limits on out-of-pocket spending. The limits apply only to in-network coverage of the essential health benefits (EHB).⁴⁶ In 2014, the limits cannot exceed existing limits specified in the tax code applicable to certain high-deductible health plans: \$6,350 for self-only coverage and \$12,700 for coverage other than self-only.⁴⁷

The Departments (HHS, Labor, and Treasury) have provided that group plans that utilize more than one service provider to administer benefits may allow separate out-of-pocket limits. For example, if a group plan utilizes one service provider to administer major medical coverage and another to administer a separate pharmacy benefit, the major medical coverage may have the maximum out-of-pocket limit (\$6,350 or \$12,700) and the pharmacy benefit may also have the maximum out-of-pocket limit. This option is available only for the first plan year that begins on or after January 1, 2014, and it is not an option for nongroup plans.⁴⁸

⁴³ 42 U.S.C. §300gg-3.

⁴⁴ 42 U.S.C. §18022.

⁴⁵ For more information about actuarial value and levels of coverage under ACA, see “Minimum Actuarial Value Requirements” in this report.

⁴⁶ 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 EHBs. 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.

⁴⁷ 42 U.S.C. §18022.

⁴⁸ For more information, see the Department of Labor’s Frequently Asked Questions Part XVIII: <http://www.dol.gov/ebsa/faqs/faq-aca18.html>.

Minimum Actuarial Value Requirements

ACA requires plans to tailor cost-sharing to comply with one of four levels of actuarial value.⁴⁹ 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.⁵⁰ 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 the enrollee.⁵¹

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

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

Prohibition of Lifetime Limits and Annual Limits

Prior to 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 individual was enrolled in the plan (lifetime limits) or during a plan year (annual limits).⁵² Under ACA, both lifetime and annual limits are prohibited; the limits apply specifically to essential health benefits (EHB).⁵³ 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 Secretary of HHS, in consultation with the states, is required to establish an Internet portal for the public to easily access affordable and comprehensive coverage options.⁵⁴ The portal is

⁴⁹ 42 U.S.C. §18022.

⁵⁰ While 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.

⁵¹ While actuarial value is calculated based on costs for an entire population, it does not mean that every person enrolled in the same plan will have the same expenses, because 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.

⁵² 42 U.S.C. §300gg-11.

⁵³ Certain types of plans—grandfathered plans, self-insured plans, and plans offered in the large group market—must comply with these requirements but do not have to offer the EHBs. 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 requirements.

⁵⁴ 42 U.S.C. §18003.

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

The ACA required the Secretaries (HHS, Labor, and Treasury) to develop standards for plans with respect to providing their enrollees with a summary of benefits and coverage (SBC) and to periodically review and update the standards.⁵⁵ **Table 1** summarizes the standards for the SBC.

Table 1. Summary of Benefits and Coverage Document Requirements

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. • Contact information including a phone number and Internet web address for consumer information.
Other requirements	<ul style="list-style-type: none"> • Must be presented in a culturally and linguistically appropriate manner utilizing 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.

ACA requires that each plan provide a SBC to individuals at the time of application, prior to the time of enrollment or reenrollment, and when the insurance policy is issued. The SBC can be 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. Any entity that willfully fails to provide the information required is subject to a fine of not more than \$1,000 for each such failure, defined as each enrollee that did not receive the required information. ACA also requires that plans provide a uniform glossary of terms commonly used in health insurance coverage (e.g., coinsurance) to enrollees upon request.⁵⁶

⁵⁵ 42 U.S.C. §300gg-15.

⁵⁶ HHS created the uniform glossary that plans must provide upon request; for more information, see [http://www.cms.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/Summary-of-Benefits-and-\(continued...\)](http://www.cms.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/Summary-of-Benefits-and-(continued...))

Medical Loss Ratio (MLR)

Under ACA, health plans are required to submit to the Secretary of HHS a report concerning the percentage of premium revenue spent on medical claims (“medical loss ratio,” or MLR).⁵⁷ 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%.⁵⁸ States are permitted to increase the percentages, and the Secretary of HHS may adjust the state percentage for the individual market if it is determined that the application of a minimum MLR of 80% would destabilize the individual market within the state.⁵⁹ 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.⁶⁰

Appeals Process

ACA requires that plans implement an effective appeals process for coverage determinations and claims.⁶¹ The process at a minimum must

- have an internal claims appeals process;
- provide notice to enrollees of available internal and external appeals processes, and the availability of any applicable assistance; and
- allow an enrollee to review their file, present evidence and testimony, and to 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 law⁶² and will update their processes in accordance with any standards established by the Secretary of Labor. Individual health plans will comply with internal claims and appeals procedures set forth under applicable law and updated by the Secretary of HHS.

(...continued)

Coverage-and-Uniform-Glossary.html.

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

⁵⁸ Until 2016, ACA allows states to define the small group market as employers who have up to and including 50 employees or up to and including 100 employees; in 2016, the small group market will be defined as employers who have up to and including 100 employees.

⁵⁹ To view a list of state requests for an MLR adjustment, see <http://cciio.cms.gov/programs/marketreforms/mlr/state-mlr-adj-requests.html>.

⁶⁰ For rebate information, see <http://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html>.

⁶¹ 42 U.S.C. §300gg-19.

⁶² Section 503 of ERISA, codified at 29 CFR §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, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and 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.

In order 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 (NAIC). 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 Secretary of HHS, and plans must comply with such a process.⁶³

Patient Protections

Plans are subject to three ACA requirements relating to the choice of health care professionals and one ACA requirement relating to benefits for emergency services.⁶⁴

Regarding the choice of health care professionals, 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. This same provision applies to pediatric care for any child who is a plan participant. 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.

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.

Nondiscrimination Regarding Clinical Trial Participation

ACA does not allow health plans to

- prohibit "qualified individuals" from participating in an approved clinical trial;
- 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.⁶⁵

ACA defines qualified individual, for purposes of this provision, as an individual who is eligible to participate in an approved clinical trial for treatment of cancer or other life-threatening disease or condition, and who 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.

⁶³ Department of Labor, Technical Release No. 2013-01, March 15, 2013.

⁶⁴ 42 U.S.C. §300gg-19a.

⁶⁵ 42 U.S.C. §300gg-8.

Plan Requirements Related to Health Care Providers

Single Risk Pool

A health insurance issuer must consider all enrollees in plans offered by the issuer to be members of a single risk pool.⁶⁶ More specifically, an issuer must consider all enrollees in nongroup 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, ACA gives states the option to merge its nongroup and small group markets; if a state does so, an issuer will have a single risk pool for all enrollees in its nongroup and small group plans.)

A risk pool is used to develop rates for coverage. A result of the single risk pool requirement is that issuers must consider the medical claims experience of enrollees in all plans (nongroup and small group separately, or combined) offered by the issuer when developing rates.

Nondiscrimination Regarding Health Care Providers

ACA imposes nondiscrimination requirements with respect to health care providers.⁶⁷ 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. 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 Secretary of HHS from establishing varying reimbursement rates for providers based on quality or performance measures.

Reporting Requirements Regarding Quality of Care

Beginning upon ACA enactment, and concluding no later than two years after enactment, the Secretary of HHS (Secretary) must develop quality reporting requirements for use by specified plans.⁶⁸ 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 either.

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: (1) improve health outcomes through the use of quality reporting, case management, care coordination, and chronic disease management; (2) implement activities to prevent hospital readmissions and to improve patient safety and reduce medical errors; and (3) implement

⁶⁶ 42 U.S.C. §18032.

⁶⁷ 42 U.S.C. §300gg-5.

⁶⁸ 42 U.S.C. §300gg-17.

wellness and health promotion activities. 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, and 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) who conduct health risk assessments or who provide ongoing face-to-face, telephonic, or web-based intervention efforts for program participants.⁶⁹

⁶⁹ 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 on 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 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.	yes	N.A.	yes	N.A.	yes
Nondiscrimination Based on Health Status	N.A.	N.A.	N.A.	yes	yes	yes	yes	yes
Extension of Dependent Coverage	yes	yes	yes	yes	yes	yes	yes	yes
Prohibition of Discrimination Based on Salary	N.A.	N.A.	N.A.	yes	N.A.	yes	N.A.	N.A.
Waiting Period Limitation	yes	yes	N.A.	yes	yes	yes	yes	N.A.
Keeping Coverage								
Guaranteed Renewability	N.A.	N.A.	N.A.	yes	N.A.	yes	N.A.	yes
Prohibition on Rescissions	yes	yes	yes	yes	yes	yes	yes	yes
Cost of Purchasing Coverage								
Rating Restrictions	N.A.	N.A.	N.A.	N.A.	N.A.	yes	N.A.	yes
Rate Review	N.A.	N.A.	N.A.	N.A. ^h	N.A.	yes	N.A.	yes
Covered Services								
Coverage of Essential Health Benefits	N.A.	N.A.	N.A.	N.A.	N.A.	yes	N.A.	yes
No Cost-sharing for Preventive Health Services	N.A.	N.A.	N.A.	yes	yes	yes	yes	yes
Coverage of Preexisting Health Conditions	yes	yes	N.A.	yes	yes	yes	yes	yes
Cost-Sharing Limits								
Deductible Limits	N.A.	N.A.	N.A.	N.A.	N.A.	yes	N.A.	N.A.
Limits for Annual Out-of-pocket Spending	N.A.	N.A.	N.A.	yes	yes	yes	yes	yes

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
Minimum Actuarial Value Requirements	N.A.	N.A.	N.A.	N.A.	N.A.	yes	N.A.	yes
Prohibition on Lifetime Limits	yes	yes	yes	yes	yes	yes	yes	yes
Prohibition on Annual Limits	yes	yes	N.A.	yes	yes	yes	yes	yes
Consumer Assistance and Other Patient Protections								
Summary of Benefits and Coverage	yes	yes	yes	yes	yes	yes	yes	yes
Medical Loss Ratio	yes	N.A.	yes	yes	N.A.	yes	N.A.	yes
Appeals Process	N.A.	N.A.	N.A.	yes	yes	yes	yes	yes
Patient Protections	N.A.	N.A.	N.A.	yes	yes	yes	yes	yes
Nondiscrimination Regarding Clinical Trial Participation	N.A.	N.A.	N.A.	yes	yes	yes	yes	yes
Plan Requirements Related to Health Care Providers								
Single Risk Pool	N.A.	N.A.	N.A.	N.A.	N.A.	yes	N.A.	yes
Nondiscrimination Regarding Health Care Providers	N.A.	N.A.	N.A.	yes	yes	yes	yes	yes
Reporting Requirements Regarding Quality of Care	N.A.	N.A.	N.A.	yes	yes	yes	yes	yes

Source: CRS Analysis of ACA and its implementing regulations.

Notes: N.A. indicates that the reform is not applicable to that type of health insurance plan. These market reforms do not apply to retiree-only health coverage (see footnote 9). 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.

- a. A grandfathered plan refers to an existing group health plan or a health insurance plan/policy in which at least one individual is 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, like 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 ACA, large groups were defined as groups with more than 50 workers. For plan years beginning before January 1, 2016, a state may elect to keep the previous definition of large groups, or change the definition to include those groups with more than 100 workers, applicable to ACA-created exchanges and market reforms. For plan years beginning on or after January 1, 2016, large groups must be defined as groups with more than 100 workers.
- d. Prior to 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 before January 1, 2016, a state may elect to keep the previous definition of small groups, or change the definition to include those groups with 100 or fewer workers, applicable to ACA-created exchanges and market reforms. For plan years beginning on or after January 1, 2016, small groups must be defined as groups with 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 nongroup) health insurance market.
- h. The final rule regarding rate review specified that this provision would apply only to nongroup and fully insured, small group coverage, and not to large groups.

Author Contact Information

Annie L. Mach
Analyst in Health Care Financing
amach@crs.loc.gov, 7-7825

Bernadette Fernandez
Specialist in Health Care Financing
bfernandez@crs.loc.gov, 7-0322