Congressional Research Service

MEMORANDUM September 24, 2010

To: Senator John Cornyn
Attention: Stephanie Carlton

From: Jennifer Staman, Legislative Attorney, 7-2610

Subject: **Legal Analysis of Section 1311(e)(1)(B) of the Patient Protection and Affordable Care Act and State-Sponsored Public Health Plans**

You have requested an updated memorandum[1] concerning the effect of section 1311(e)(1)(B) of the Patient Protection and Affordable Care Act (PPACA).[2] Specifically, you have asked whether this section would allow a state, through its governor or other state official, to disallow private plans from participating in a state's health benefit exchange, and whether this language could effectively be used to allow some type of state-sponsored health plan (i.e., a public health plan) to be the only insurance option offered.[3] As discussed below, there is no specific language in PPACA that would prohibit an exchange from denying certification to every private plan that applies if the exchange were to determine that every plan is not in the "interest of plan participants." However, it appears that the Secretary of Health and Human Services[4] could use its authority to affect whether such a scenario would be permissible. Further, certain requirements of PPACA can prevent a state's public health plan from being the only plan in a state's exchange.

Background

PPACA specifies that by January 1, 2014, each state must establish an American Health Benefit Exchange ("exchange") that is either a state governmental agency or a nonprofit entity, in order to provide health coverage to qualified individuals and/or employers.[5] In general, if a state does not elect to establish an exchange, or if the Secretary determines that a state will not have an operational exchange by January 1, 2014 or has not taken certain specified actions, the Secretary must establish and operate an exchange within the state.[6] Each state exchange must, among other things, facilitate the purchase of "qualified"

[1] This memorandum is an update to a memorandum provided to your office on December 8, 2009, and July 14, 2010, addressing similar issues.

[2] P.L. 111-148 (2010). PPACA was amended by the Health Care Education and Reconciliation Act of 2010, P.L. 111-152 (2010). (HCERA). These Acts will be collectively referred to in this memorandum as "PPACA."

[3] Examples of public plans that you have provided to us include the Basic Health Program offered in the State of Washington, a state-only Medicaid plan offered to higher-income populations or a high risk pool program administered by a third party.

[4] The Secretary of Health and Human Services will hereinafter be referred to as the Secretary.

[5] P.L. 111-148, §§ 1311(b)(1), 1311(d)(1).

[6] P.L. 111-148, § 1321(c).

health plans. Qualified health plans are defined by PPACA as health plans that are, among other things, offered by a "health insurance issuer" that "is licensed and in good standing to offer health insurance coverage in each State in which such issuer offers health insurance coverage…."[7] An exchange is prohibited from making available any health plan that is not a qualified plan.[8]

PPACA requires the Secretary to promulgate regulations establishing criteria for the certification of health plans as qualified plans.[9] The exchange, in turn, must implement procedures for the certification, recertification, and decertification of health plans as qualified plans, consistent with guidelines developed by the Secretary.[10] Under section 1311(e)(1) of PPACA, an exchange may certify a health plan as a qualified health plan if (A) the health plan meets the standards for certification as set forth in regulations promulgated by the Secretary and (B), the exchange determines "that making available such health plan through such exchange is in the interests of qualified individuals and qualified employers in the State or States in which such exchange operates…." An exception to subsection (B) prevents an exchange from excluding a health plan (i) on the basis that a plan is a fee-for-service plan; (ii) by imposing premium price controls; or (iii) on the basis that the plan provides treatments necessary to prevent patients' deaths in circumstances the exchange determines are inappropriate or too costly.

Potential Statutory Interpretation of Section 1311(e)(1)(B) of PPACA

When interpreting the meaning of legislative language, courts will often use general principles of statutory construction commonly referred to as "canons" for drawing inferences about language. Perhaps the most common "canon of construction" is the plain meaning rule, which assumes that the legislative body meant what it said when it adopted the language in the statute. Phrased another way, if the meaning of the statutory language is "plain," the court will simply apply that meaning and end its inquiry.[11] As the United States Supreme Court stated in *Connecticut National Bank v. Germain*:

> [I]n interpreting a statute a court should always turn first to one, cardinal canon before all others. We have stated time and again that courts must presume that a legislature says in a statute what it means and means in a statute what it says there .... When the words of a statute are unambiguous, then, this first canon is also the last: judicial inquiry is complete.[12]

Applying the plain meaning canon to the language in section 1311(e)(1)(B) of PPACA, it appears that each state exchange has discretion to make a determination as to whether making a particular health plan available to individuals and employers is in the individuals' and employers' interest. An exchange may then certify a plan as a qualified health plan, so long as the other requirements for certification, as set forth in regulations, are met. PPACA does not provide a state with criteria for making this determination. While the language of PPACA seems clear that a health plan may not be excluded from certification because the plan is a fee-for-service plan, by an exchange's use of price controls, or because certain treatments offered by the plan are determined to be inappropriate or too costly, there is no additional

[7] P.L. 111-148, § 1301(a)(1)(C).

[8] P.L. 111-148, § 1311(d)(2).

[9] Under section 1311 of PPACA, the Secretary must establish criteria for the certification of health plans as qualified plans, which includes marketing, health care provider, and administrative requirements.

[10] P.L. 111-148, § 1311(d)(4)(A).

[11] *See* Hartford Underwriters Insurance Co. v. Union Planters Bank, N.A., 530 U.S. 1 (2000); *see also* Robinson v. Shell Oil Co., 519 U.S. 337 (1997); Connecticut National Bank v. Germain, 503 U.S. 249 (1992); Mallard v. United States District Court for the Southern District of Iowa, 490 U.S. 296, 300 (1989).

[12] Connecticut National Bank, 503 U.S. at 253–54 (citations and quotation marks omitted).

language requiring a state to certify a certain number of plans or stating how many plans must be found to be in the interest of individuals and employers. Further, there is no language that forces an exchange to make available any particular plan except for multi-state plans, which are discussed below. Presumably, unless regulations dictate otherwise, the exchange could have the ability to make a determination that any or all of the private health plans seeking certification are not in the interest of qualified individuals and employers.

On the other hand, it should be noted that in analyzing a statute's text, courts are generally guided by the basic principle that a statute should be read as a harmonious whole, with its separate parts being interpreted within their broader statutory context.[13] Taking a more holistic view of the establishment of exchanges under PPACA, there are requirements for exchanges that evidence the creation of a marketplace for obtaining health coverage. For example, exchanges must maintain a website through which individuals can view standardized comparative information on plans.[14] PPACA also requires exchanges to establish a grant program for navigators, which are responsible for conducting public education activities regarding the availability of qualified health plans, distributing fair and impartial information on enrollment in plans and subsidies, and facilitating enrollment in a qualified plan, among other things.[15] If a court were to determine whether the language of section 1311(e)(1)(B) of PPACA allows a state official to reject all private plans from being certified to participate in an exchange, it could reject this argument based on the idea when evaluating PPACA as a whole, exchanges should have the ability to offer a variety of plans with different benefit levels.

Factors Affecting a Rejection of Certification for Every Private Plan under a State Exchange

Certain factors may affect or prevent a state from rejecting each private plan that applies to be certified under a state's exchange. For example, a governor or other state official may or may not have the authority to make this determination for the exchange. As noted above, a state exchange must be a state agency or a nonprofit entity. The extent of authority vested in the governor and other individuals to control the exchange and make decisions on its behalf may depend on the state's implementing legislation and would have to be determined on a state-by-state basis.

Certain fraud and abuse provisions found in PPACA may also serve as a check on an exchange's ability to prevent all private plans from participating in the exchange. If an exchange's decision not to certify a plan was not on the basis that it was not in the interest of individuals or employers, but, in actuality, to keep all private plans out of the exchange, it is possible that the Secretary could find the exchange engaged in misconduct. Section 1313 of PPACA allows the Secretary to investigate the affairs of an exchange, examine its property and records, and may require reports in relation to activities undertaken by the exchange. Exchanges must cooperate in these investigations. This section also allows the Secretary to rescind payments due to the state until the state takes corrective action. Further, the Secretary must provide for the efficient and nondiscriminatory administration of exchange activities and must implement any measure or procedure that the Secretary determines is appropriate to reduce fraud and abuse and has the authority to implement under the Title of PPACA containing the exchange provisions, or any other

[13] As the Supreme Court has noted, "[i]t is a fundamental canon of statutory construction that the words of a statute must be read in their context and with a view to their place in the overall statutory scheme… A court must therefore interpret the statute 'as a symmetrical and coherent regulatory scheme,' and 'fit, if possible, all parts into an harmonious whole.'" FDA v. Brown & Williamson Tobacco Corp., 529 U.S. 120, 133 (2000).

[14] P.L. 111-148, § 1311(d)(4).

[15] P.L. 111-148, § 1311(i).

Act.[16] Thus, if a state is found to not be properly following the requirement for certifying qualified health plans, a state could be subject to repercussions.

In addition, the Secretary must, as soon as practicable after the date of enactment of the Act, issue regulations setting standards for meeting certain requirements regarding the exchange.[17] Regulations must be promulgated for, among other things, the establishment and operation of the exchange; the offering of qualified plans through the exchange and their certification; and other requirements as the Secretary determines appropriate. Given this broad authority to issue regulations with regard to a state exchange, it seems plausible the Secretary could promulgate regulations that could affect the scenario at issue. Regulations could clarify or give guidance as to what is in the interest of qualified individuals and employers for purposes of the certification requirements. Regulations could also provide criteria that the state must take into account in making its determination as to whether a qualified health plan may be certified. Thus, if the Secretary promulgates this type of regulation, an exchange's ability to determine whether plans are in the interest of individuals and employers may be subject to additional requirements.

Issues with a "Public Plan" as the Only Qualified Health Plan in an Exchange

Aside from the factors affecting a rejection of certification for health plans under a state exchange, other provisions of PPACA present issues for any state seeking to make a public plan the only health plan in an exchange. As noted above, an exchange is required to provide qualified health benefit plans to qualified individuals and employers. As specified in section 1301 of PPACA, a "qualified health plan" is a health plan that is offered by a "health insurance issuer" that is, among other things, licensed and in good standing to offer health insurance coverage in each state in which such issuer offers health insurance coverage. A "health insurance issuer" as defined by PPACA is:

> an insurance company, insurance service, or insurance organization which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 514(b)(2) of ERISA).[18] Such term does not include a group health plan (e.g., a self-insured plan).[19]

The definition of "health insurance issuer" does not explicitly address whether an issuer must be a privately-owned entity. In other words, the provision does not seem to allow or prevent a state-owned or a state-sponsored health plan from being an issuer. While states have commonly established health insurance pools or programs for constituents as an alternative to, or in the absence of, affordable health coverage in the private insurance market, these programs are not generally established as an insurance company and may not be subject to the state licensing and other requirements that private health insurance entities are subject to (e.g., solvency requirements and benefit mandates).[20] While it may be

[16] P.L. 111-148, § 1313(a)(5).

[17] P.L. 111-148, § 1321(a). To date, these regulations have not been issued.

[18] Under section 514(a) of ERISA, state laws that relate to employee benefit plans are preempted. However, one exception to ERISA's preemptive scheme is section 514(b)(2) of ERISA, under which states may enforce any "law ... which regulates insurance, banking, or securities." 29 U.S.C. § 1144(b)(2). This provision is commonly referred to as the savings clause, in that it saves these types of state laws from being preempted by ERISA. The Supreme Court has determined that a state law is considered to be "regulating insurance" if it is "specifically directed toward" the insurance industry and "substantially affects the risk pooling arrangement between the insurer and insured." *See* Kentucky Association of Health Plans, Inc. v. Miller, 538 U.S. 329, 334, 338 (2003). For a discussion of ERISA preemption and the savings clause, see CRS Report RL34443, *Summary of the Employee Retirement Income Security Act (ERISA)*, by Patrick Purcell and Jennifer Staman.

[19] 42 U.S.C. § 300gg-91.

[20] For general information on various state health coverage strategies, see the Robert Wood Johnson Foundation, State Coverage

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possible that a state could establish some type of insurance arrangement that is subject to the same state insurance laws as private insurance companies, or perhaps deem an arrangement to be licensed, in good standing in the state, and compliant with state insurance laws, closer examination of a particular plan and the state laws affecting such a plan may be warranted. Additionally, as mentioned above, section 1321(a) of PPACA requires the Secretary to issue regulations regarding, among other things, the offering of qualified health plans through exchanges. Thus, it seems possible that the Secretary may address whether a public plan could be considered a qualified health plan in an exchange. [21] In addition, assuming that a state-owned or state-sponsored plan could be a qualified health plan in an exchange, it appears that beginning in 2014, eligible individuals could receive premium tax credits and cost sharing subsidies to help pay for health insurance coverage from the plan.[22]

Assuming a state's public plan could be deemed a qualified health plan, an exchange would still be required to offer multi-state qualified health plans. Under section 1334 of PPACA, the Director of the Office of Personnel Management (OPM) must enter into contracts with health insurance issuers to offer at least two multi-state qualified health plans to provide individual and small group coverage through each exchange in each state. At least one of these contracts must be with a non-profit entity. Any individual eligible to purchase insurance through the exchange may enroll in a multi-state plan and may be eligible for premium credits and cost-sharing assistance. For purposes of an exchange's certification procedures, multi-state plans that are offered a contract by OPM must be deemed to be certified by an exchange. A health insurance issuer offering a multi-state plan must, among other things, meet the requirements in every state's exchange, be licensed in each state, and subject to all requirements of state law not inconsistent with the requirements for multi-state plans, subject to a phase-in period. These plans must also meet other requirements as determined appropriate by the OPM Director, in consultation with the Secretary. There appears to be no authority in PPACA to prevent multi-state plans from being part of a state's exchange.

Lastly, it should be noted that if a state wanted to induce exchange-eligible individuals to receive health insurance coverage through a state's public plan as opposed to a private health insurer, PPACA provides certain options that states may consider. For example, a state may avoid having an exchange by applying for a waiver under section 1332 of PPACA. Beginning in 2017, PPACA will permit states to apply to the Secretary for a waiver of requirements relating to exchanges and other PPACA provisions.[23] The Secretary will only be permitted to grant a request for a waiver if the Secretary determined that the state plan will provide coverage that is at least as comprehensive as the coverage offered through exchanges, contain protections against excessive out-of-pocket spending, cover at least a comparable number of its

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Initiatives, available at http://www.statecoverage.org/.

[21] It should also be noted that there may be other reasons why a public plan may not be suitable as a qualified health plan in an exchange. For example, a public plan's eligibility requirements may be different from that of a qualified health plan. Exchanges must make available qualified health plans available to "qualified individuals," defined by PPACA as an individual seeking to enroll in a qualified health plan in the individual market offered through the Exchange, and reside in the state that established the exchange, subject to certain exceptions. Qualified health plans must also be made available to "qualified employers," as defined by PPACA. If a public plan serves a more limited population, this may also affect a public plan's ability to participate in an Exchange.

[22] It should be noted that the availability of premium tax credits may be affected by regulations issued by the Secretary of the Treasury. *See e.g.*, P.L. 111-148, § 1401(a), 26 U.S.C. § 36B(g). For a general description of premium credits and cost sharing subsidies available under PPACA, see CRS Report R40942, *Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (PPACA)*, by Hinda Chaikind, et al.

[23] A waiver under section 1332 of PPACA may extend for up to 5 years. This period may be extended if a state requests a continuation of the wavier, and this request is granted unless the Secretary denies the request, or informs the state of additional information needed to make a determination regarding the request. P.L. 111-148, § 1332(e).

residents as will be provided without the waiver, and not increase the federal deficit. The Secretary must also provide to states receiving waivers the aggregate amount of premium credits and cost-sharing subsidies that would have been paid to residents of the state in the absence of a waiver. However, it should be noted that the waiver option will not be available to states until plan years beginning January 1, 2017, and thus, a state may not be able to bypass the creation of an exchange when one is required to be established in 2014.