Private Health Insurance Provisions of S. 1679

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Summary

This report summarizes key provisions affecting private health insurance in S. 1679, the Affordable Health Choices Act, as ordered reported by the Senate Committee on Health, Education, Labor and Pensions (HELP) on July 15, 2009.

Title I of the bill focuses on reducing the number of uninsured, restructuring the private health insurance market, setting minimum standards for health benefits, and providing financial assistance to certain individuals and, in some cases, small employers. In general, the Senate HELP bill would require individuals to maintain health insurance and employers to either provide insurance or pay a fee in lieu of coverage, with some exceptions. Several insurance market reforms would be made, such as modified community rating and guaranteed issue and renewal. Both the individual and employer mandates would be linked to qualifying health insurance coverage. Qualifying coverage would include (1) coverage under a qualified health plan (QHP) obtained through the newly created American Health Benefits Gateways; (2) new group or individual coverage that meets or exceeds minimum qualifying coverage; (3) grandfathered employment-based plans; (4) grandfathered nongroup plans; and (5) other coverage, such as Medicare and Medicaid. The Gateways would offer private plans alongside a community health insurance option. Based on income, certain individuals could qualify for subsidies toward their premium costs; these subsidies would be available only through a Gateway. Currently existing plans could be grandfathered indefinitely, if the plan had not been altered to a significant extent. Most of these provisions would be effective one year after enactment, or on the date on which a state has an operating Gateway. A state would be required to have an operating Gateway within four years of enactment, or the Secretary of Health and Human Services would establish one in the state as a federal fallback.

A Gateway would not be an insurer; it would provide eligible individuals and small businesses with access to insurers' plans in a comparable way. A Gateway would consist of a selection of private plans as well as a community health insurance option. A community health insurance option is a public plan created by the Secretary of Health and Human Services that generally meets the requirements that apply to all private Gateway plans. Eligible individuals for a Gateway plan could purchase the community health insurance option or a private health insurance plan. Individuals would be eligible to enroll in a Gateway plan only if they were not eligible for certain other coverage, including coverage through an employer, Medicare, and Medicaid, among others. The community health insurance option established by the Secretary of Health and Human Services (HHS) would offer the essential benefits package plus any state mandated benefits. For the community health insurance option, the Secretary would be required to negotiate with medical providers to set payment rates, subject to limits. Credits to limit the amount of money certain individuals would pay for premiums would be available only within a Gateway.

New plans could also be sold in both the individual and group market outside of the Gateway, but only those new plans that meet the minimum requirements would satisfy the mandates for individuals and employers.

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Overview of S. 1679

This report summarizes the key provisions affecting private health insurance in Title I of S. 1679, the Affordable Health Choices Act, as ordered reported by the Senate Committee on Health, Education, Labor and Pensions (HELP) on July 15, 2009. Title I of the bill focuses on reducing the number of uninsured, restructuring the private health insurance market, setting minimum standards for health benefits, and providing financial assistance to certain individuals and, in some cases, small employers. In general, the bill includes the following:

- Individuals would be required to maintain health insurance, and employers with more than 25 employees would be required to either provide insurance or pay a fee, with some exceptions.
- Several market reforms would be made, such as modified community rating and guaranteed issue and insurance renewal.
- Both the individual and employer mandates would be linked to qualifying health insurance coverage. Qualifying coverage would include
  - qualified health plans offered through a Gateway, and employment-based and nongroup plans not offered through a Gateway that meet specified criteria, including meeting required minimum standards and the market reforms established in the bill;
  - grandfathered employment-based plans;
  - grandfathered nongroup plans; and
  - other coverage, such as Medicare and Medicaid.
- States could either establish a Gateway (referred to as an establishing state) or request that the Secretary of Health and Human Services establish a Gateway in the state (referred to as a participating state). In the case of a state that was not an establishing or participating state at the end of four years after enactment, the Secretary would establish and operate a Gateway in that state, deeming the state as a participating state. Gateways would offer private plans alongside a community health insurance option.
- Certain individuals with incomes below 400% of the federal poverty level could qualify for subsidies toward their premium costs; these subsidies would be available only through the Gateways.
- Currently existing plans offered by employers as well as plans offered in the individual market (the nongroup market) could be grandfathered indefinitely, but only if no substantial changes were made to benefits and cost-sharing.
- New plans could also be sold in both the individual and group market outside of the Gateway, but only those new plans that meet the minimum requirements would satisfy the mandates for individuals and employers.
- Most of these provisions would be effective one year after enactment, or on the date on which a state becomes a participating or establishing state.

Overview of Report

This report begins by providing background information on key aspects of the private insurance market as it exists currently. This information is useful in setting the stage for understanding how and where S. 1679 would reform health insurance. This report summarizes key provisions affecting private health insurance in Title I[1] of the Affordable Health Choices Act, as ordered reported by the Senate Committee on Health, Education, Labor and Pensions (HELP) on July 15, 2009.

Although the description that follows segments the private health insurance provisions into various categories, these provisions are interrelated and interdependent. For example, the bill includes a number of provisions to alter how current private health insurance markets function, primarily for individuals who purchase coverage directly from an insurer or through a small employer. S. 1679 would require that insurers not exclude potential enrollees or charge them premiums based on preexisting health conditions. In a system where individuals voluntarily choose whether to obtain health insurance, however, individuals may choose to enroll only when they become sick, known as "adverse selection," which can lead to higher premiums and greater uninsurance. When permitted, insurers often guard against adverse selection by adopting policies such as excluding preexisting conditions. If reform eliminates many of the tools insurers use to guard against adverse selection then, instead, America's Health Insurance Plans (AHIP), the association that represents health insurers, has stated that individuals must be required to purchase coverage, so that not just the sick enroll.[2]

Furthermore, some individuals currently forgo health insurance because they cannot afford the premiums. If individuals are required to obtain health insurance, one could argue that adequate premium subsidies must be provided by the government and/or employers to make practical the individual mandate to obtain health insurance, which is in turn arguably necessary to make the market reforms possible. In addition, premium subsidies toward plans with high cost-sharing (i.e., deductible, copayments, and coinsurance) may provide individuals with health insurance that they cannot afford to use. So, while the descriptions below discuss various provisions separately, the removal of one from the bill could be deleterious to the implementation of the others.

The private health insurance provisions are presented under the following topics, with the primary CRS contact listed for each:

- Individual and employer mandate: the requirement on individuals to maintain health insurance and on employers to either provide health insurance or pay a fee.
  [(name redacted), 7-....]

[1] This report does not discuss quality, wellness, and other titles of the bill, which are addressed in CRS Report R40831, *Public Health, Workforce, Quality, and Other Provisions in the Affordable Health Choices Act (S. 1679)*, coordinated by (name redacted) and (name redacted).

[2] AHIP, "Health Plans Propose Guaranteed Coverage for Pre-Existing Conditions and Individual Coverage Mandate," November 19, 2008, available at http://www.ahip.org/content/pressrelease.aspx?docid=25068. See also Blue Cross Blue Shield Association, "BCBSA Announces Support for Individual Mandate Coupled with a Requirement for Insurers to Offer Coverage to All," November 19, 2008, at http://www.bcbs.com/news/bcbsa/bcbsa-announces-support-for.html.

- Private health insurance market reforms.
  [(name redacted), 7-....]
- Gateway [Chris Peterson, 7-....], through which the following two items can only be offered:
  - Community Health Insurance Options.
    [Paulette Morgan, 7-....]
  - Premium subsidies.
    [Chris Peterson, 7-....]

Background

Americans obtain health insurance in different settings and through a variety of methods. People may get health coverage in the private sector or through a publicly funded program, such as Medicare or Medicaid. In 2008, 60% of the U.S. population had employment-based health insurance. Employers choosing to offer health coverage may either purchase insurance or choose to self-fund health benefits for their employees. Other individuals obtained coverage on their own in the nongroup market. However, there is no federal law that either requires individuals to have health insurance or requires employers to offer health insurance. Approximately 46 million individuals (15% of the U.S. population) were estimated to be uninsured in 2008.[3]

Individuals and employers choosing to purchase health insurance in the private market fit into one of the three segments of the market, depending on their situation—the large group (large employer) market, the small group market, and the nongroup market.[4]

More than 95% of large employers offer coverage.[5] Large employers are generally able to obtain lower premiums for a given health insurance package than small employers and individuals seeking nongroup coverage. This is partly because larger employers enjoy economies of scale and a larger "risk pool" of enrollees, which makes the expected costs of care more predictable. Employers generally offer large subsidies toward health insurance, thus making it more attractive for both the healthier and the sicker workers to enter the pool. So, not only is the risk pool larger in size, but it is more diverse. States have experimented with ways to create a single site where individuals and small employers could compare different insurance plans, obtain coverage, and sometimes pool risk. Although most of these past experiments failed (e.g., California's PacAdvantage[6]), other states have learned from these experiences and have fashioned potentially

[3] CRS Report 96-891, *Health Insurance Coverage: Characteristics of the Insured and Uninsured in 2008,* by (name red acted).

[4] Health insurance can be provided to groups of people that are drawn together by an employer or other organization, such as a trade union. Small groups typically refer to firms with between 2 and 50 workers, although some self-employed individuals are considered "groups of one" for health insurance purposes in some states. Consumers who are not associated with a group can obtain health coverage by purchasing it directly in the nongroup (or individual) market.

[5] Where the firm has 50 or more workers, 96.5% of private-sector employers offered health insurance in 2008. Where the firm has fewer than 50 workers, 43.2% of private-sector employers offered health insurance in 2008. "Table II.A.2(2008) Percent of private-sector establishments that offer health insurance by firm size and State: United States, 2008," Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends, 2008 Medical Expenditure Panel Survey-Insurance Component (MEPS-IC), http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2008/tiaa2.pdf.

[6] PacAdvantage was created as part of the small business health insurance reforms enacted in California in 1992, as a (continued...)

more sustainable models (e.g., Massachusetts's Connector[7]). There are private-sector companies that also serve the role of making various health insurance plans easier to compare for individuals and small groups (e.g., eHealthInsurance), available in most, but not all, states because of variation in states' regulations.

Less than half of all small employers (less than 50 employees) offer health insurance coverage;[8] such employers cite cost as the primary reason for not offering health benefits. One of the main reasons is a small group's limited ability to spread risk across a small pool. Insurers generally consider small firms to be less stable than larger pools, as one or two employees moving in or out of the pool (or developing an illness) would have a greater impact on the risk pool than they would in large firms. Other factors that affect a small employer's ability to provide health insurance include certain disadvantages small firms have in comparison with their larger counterparts: small groups are more likely to be medically underwritten, have relatively little market power to negotiate benefits and rates with insurance carriers, and generally lack economies of scale. Allowing these firms to purchase insurance through a larger pool, such as an Association, Gateway or an Exchange, could lower premiums for those with high-cost employees.

Depending on the applicable state laws, individuals who purchase health insurance in the nongroup market may be rejected or face premiums that reflect their health status, which can make premiums lower for the healthy but higher for the sick. Even when these individuals obtain coverage, there may be exclusions for certain conditions. Reforms affecting premiums ratings would likely increase premiums for some while lowering premiums for others, depending on their age, health, behaviors, and other factors.

States are the primary regulators of the private health insurance market, though some federal regulation applies, mostly affecting employer-sponsored health insurance (ESI).[9] The Health Insurance Portability and Accountability Act (HIPAA) requires that coverage sold to small groups (2-50 employees) must be sold on a guaranteed issue basis. That is, the issuer must accept every small employer that applies for coverage. All states require issuers to offer policies to firms with 2-50 workers on a guaranteed issue basis, in compliance with HIPAA. As of January 2009, in the small group market, 13 states also require issuers to offer policies on a guaranteed issue basis to the self-employed "groups of one." And as of December 2008, in the individual market, 15 states require issuers to offer some or all of their insurance products on a guaranteed issue basis to non-HIPAA eligible individuals.

(...continued)

state-established health insurance pool to help cover small-business employees in California. PacAdvantage was created to allow small businesses to band together and negotiate lower insurance premiums for their employees, but it did little to make insurance more affordable. Over time, employers whose workers had the lowest health risks exited the pool for plans with cheaper premiums, leaving the program with the highest-risk members and driving up costs. See, for example, Rick Curtis and Ed Neuschler, "What Health Insurance Exchanges or Choice Pools Can and Can't Do About Risks and Costs," Institute for Health Policy Solutions, p. 1.

[7] See http://www.mahealthconnector.org.

[8] See footnote 5.

[9] Federal law mandates compliance if an employer chooses to offer health benefits, such as compliance with plan fiduciary standards, procedures for appealing denied benefit claims, rules for health care continuation coverage, limitations on exclusions from coverage based on preexisting conditions, and a few benefit requirements such as minimum hospital stay requirements for mothers following the birth of a child.

Most states currently impose premium rating rules on insurance carriers in the small group and individual markets. The spectrum of existing state rating limitations ranges from pure community rating to adjusted (or modified) community rating, to rate bands, to no restrictions. Under pure community rating, all enrollees in a plan pay the same premium, regardless of their health, age, or any other factor. Only two states (New Jersey and New York) use pure community rating in their nongroup markets, and only New York imposes pure community rating rules in the small group market. Adjusted community rating prohibits issuers from pricing health insurance policies based on health factors, but allows it for other key factors such as age or gender. Rate bands allow premium variation based on health, but such variation is limited according to a range specified by the state. Rate bands are typically expressed as a percentage above and below the index rate (i.e., the rate that would be charged to a standard population if the plan is prohibited from rating based on health factors).[10]

Federal law requires that group health plans and health insurance issuers offering group health coverage must limit the period of time when coverage for preexisting health conditions may be excluded.[11] As of January 2009, in the small group market, 21 states had preexisting condition exclusion rules that provided consumer protection above the federal standard.[12] And as of December 2008, in the individual market, 42 states limit the period of time when coverage for preexisting health conditions may be excluded for certain enrollees in that market.[13] In fact, while there are a handful of federal benefit mandates for health insurance that apply to group coverage, there are more than 2,000 benefit mandates imposed by the states.[14]

One issue receiving congressional attention is whether a publicly sponsored health insurance plan should be offered as part of the insurance market reform. Some proponents of a public option see it as potentially less expensive than private alternatives, as it would not need to generate profits or pay brokers to enroll individuals and might have lower administrative costs. Some proponents argue that offering a public plan could provide additional choice and may increase competition, since the public plan might require lower provider payments and thus charge lower premiums. Some opponents question whether these advantages would make the plan a fair competitor, or rather provide the government with an unfair advantage in setting prices, in authorizing

[10] If a state establishes a rate band of +/- 25%, then insurance carriers can vary premiums, based on health factors, up to 25% above and 25% below the index rate.

[11] Under HIPAA, a plan is allowed to look back only six months for a condition that was present before the start of coverage in a group health plan. Specifically, the law says that a preexisting condition exclusion can be imposed on a condition only if medical advice, diagnosis, care, or treatment was recommended or received during the six months prior to enrollment date in the plan. If an individual has a preexisting condition that can be excluded from plan coverage, then there is a limit to the preexisting condition exclusion period that can be applied. HIPAA limits the preexisting condition exclusion period for most people to 12 months (18 months for late enrollment). In addition, some people with a history of prior health coverage will be able to reduce the exclusion period even further using "creditable coverage" (prior group coverage that meets the statutory requirements).

[12] See "Small Group Health Insurance Market Pre-Existing Condition Exclusion Rules, 2009," at http://www.statehealthfacts.org/comparetable.jsp?ind=352&cat=7.

[13] See "Individual Market Portability Rules, 2008," at http://www.statehealthfacts.org/comparetable.jsp?ind=355&cat=7.

[14] Federal law requires, for example, that group health plans and insurers that cover maternity care also cover minimum hospital stays for the maternity care and offer reconstructive breast surgery if the plan covers mastectomies. States have adopted mandates, for example requiring coverage of certain benefits, such as mammograms, well-child care, and drug and alcohol abuse treatment. For additional information about state benefit mandates, see "Health Insurance Mandates in the States, 2009," at http://www.cahi.org/cahi_contents/resources/pdf/HealthInsuranceMandates2009.pdf.

legislation, or in future amendments. Ultimately, they fear that these advantages might drive private plans from the market.[15]

Individual and Employer Mandates

Individual Mandate

S. 1679 includes a mandate for most individuals to have health insurance, with penalties for noncompliance. Individuals would be required to maintain qualifying coverage, defined as coverage under a group health plan or heath insurance coverage that an individual is enrolled in on the date of enactment or coverage that meets or exceeds the criteria for minimum qualifying coverage, Parts A and B of Medicare, Medicare Advantage, Medicaid, CHIP, Tricare, certain veteran's health care program coverage, Federal Employees Health Benefits Program (FEHBP), state health benefits high-risk pools, coverage for the Peace Corps, and coverage under a qualified health plan. Most individuals who do not maintain qualifying coverage for themselves and their dependents could be required to pay an annual amount established by the Secretary of Labor of no more than $750 per person (with a limit of no more than four times the penalty in total for the taxpayer and any dependents), adjusted for inflation beginning with taxable years after 2011.

Members of Congress and congressional staff would be required to enroll in a federal health insurance program created under this bill or an amendment made by the bill, or offered through a Gateway.[16]

Some individuals would be provided with subsidies to help pay for their premiums. (A complete description of who is eligible and the amount of subsidies is found in the "Individual Eligibility for Premium Credits" section). Others would be exempt from the individual mandate, including those without coverage for less than 90 days, those who reside in a state that was not a participating or establishing state, Indians (as defined in the Indian Health Care Improvement Act), those for whom affordable health care coverage was not available, or individuals whose adjusted gross income did not exceed 150% of the FPL. The individual mandate requirements

[15] Currently, Medicare is an example of a federal public health insurance program for the aged and disabled. Under Medicare, Congress and the Department of Health and Human Services (HHS) Centers for Medicare and Medicaid Services (CMS) determine many parameters of the program. These include eligibility rules, financing (including determination of payroll taxes, and premiums), required benefits, payments to health care providers, and cost-sharing amounts. However, even within this public plan, CMS subcontracts with private companies to carry out much of the administration of the program.

[16] While the intent of this section may be to require Members of Congress and their staff to enroll in one of the health insurance programs created by this bill, certain questions may be raised regarding application of this section. For example, one may question how to reconcile section 143 (regarding Members of Congress and their staff) with section 131 of the bill (regarding no changes to existing coverage), which provides, among other things, that "[n]othing in this Act (or an amendment made by this Act) shall be construed to require that an individual terminate coverage under a group health plan or health insurance coverage in which such individual was enrolled prior to the date of enactment of this title." Accordingly, it seems unclear whether a Member of Congress or congressional staff who is enrolled in FEHBP (or has other health coverage) prior to the bill's enactment would be allowed to retain that coverage as would be permitted under section 131. In addition, S. 1679 does not allow those who are eligible for certain health insurance coverage, including the Federal Employees Health benefits program, to purchase health insurance through a Gateway. Finally, if Members of Congress and their staff were required to and able to purchase health insurance through a Gateway, it is not clear whether or not they would not receive the 60% contribution toward their premiums that is otherwise only provided employees offered coverage through employer plans.

would be effective beginning in tax years after December 31, 2011. The Secretary would also determine whether coverage was unaffordable (see discussion in "Essential Health Benefits").

Employer Mandate

S. 1679 would require employers either to provide employees with qualifying coverage or to pay a set amount, with some exceptions. One of the requirements for states and residents to receive subsidies through the Gateway would be that states apply the employer mandate and notification requirements to their state and local employees. The employer mandate would become effective beginning in the calendar year in which the state in which the employer is located has a Gateway.

For those employers that chose to offer health insurance, the following rules would apply:

- Employers could offer employment-based coverage, or for certain businesses, they could offer coverage through a Gateway (see section on "Individual and Employer Eligibility for Gateway Plans").
- Current employment-based health plans would be grandfathered as long as no substantial changes were made.
- Employers would have to contribute at least 60% [17] of the premiums of the plan they offered—prorated for part-time employees. Employers would not have to provide coverage for seasonal workers.
- Employers would be required to file a return providing the name of each individual for whom they provide qualifying coverage, the number of months of coverage, and any other information required by the Secretary. They would also be required to provide notice to employees about the existence of the American Health Benefits Gateway, including a description of the services provided by the Gateway.

Employers who did not offer coverage would be required to pay $750 per employee for each full-time employee in excess of 25 employees. Employers would pay $375 for part-time employees. These amounts would be adjusted for inflation after 2013. Employers with 25 or fewer employers who chose not to offer coverage would not be required to pay any fee.

Within 90 days after enactment, the bill would create a temporary reinsurance program, with funding not to exceed $10 billion, to assist employment-based plans (located in states that are not participating or establishing states) with the cost of providing health benefits to eligible retirees who are 55 and older and their dependents. The Secretary would reimburse the plan for 80% of the portion of a claim above $15,000 and below $90,000 (adjusted annually for inflation). Amounts paid to the plan would be used to lower costs directly to participants in the form of premiums, co-payments, and other out-of-pocket costs, but could be not used to reduce the costs of an employer maintaining the plan.

[17] In 2008, employers that offered health insurance on average paid 80% of the premium for single coverage and 72% of family coverage. Tables II.C and II.D.3 2008MEPS-IC, http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2008/tiic3.pdf and http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2008/tiid3.pdf.

Small Business Credit

Certain small businesses would be eligible for a credit toward their share of the cost of coverage beginning in calendar year 2010, but only in establishing or participating states. The credit would be available to employers who employed an average of 50 or fewer full-time employees and had an average wage of less than $50,000 for full-time employees. The credit would be limited to three consecutive years. The credit would only be available for months during which the employer provided at least the minimum contribution of 60% toward qualified employee health insurance expenses. This credit would be phased out as the number of employees increased from 10 up to 50 employees, would be greater for firms who contributed more than the required 60% of premiums, and would vary by individual coverage ($1,000), employee +1 coverage ($1,500) and family coverage ($2,000). The credit would also be available to self-employed individuals with net earnings between $5,000 and $50,000, as long as they did not receive premium credits through a Gateway.

Private Health Insurance Market Reforms

S. 1679 would establish new federal health insurance standards applicable to new, generally available health plans specified in the bill. Among the market reforms are provisions that would do the following:

- Prohibit coverage exclusions of preexisting health conditions. (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.)
- Require premiums to be determined using adjusted community rating rules. ("Adjusted, or modified community rating" prohibits issuers from pricing health insurance policies based on health factors, but allows it for other key characteristics such as age or gender.) Under S. 1679, premiums would only be allowed to vary based on age (by no more than a 2:1 ratio across age categories specified by the Commissioner), tobacco use (by no more than 1.5:1 ratio), adherence to or participation in a reasonably designed program of health program and disease prevention, premium rating areas,[18] and family enrollment (for example, for single versus family coverage).
- Require coverage to be offered on both a guaranteed issue and guaranteed renewal basis. ("Guaranteed issue" in health insurance is the requirement that an issuer accept every applicant for health coverage. "Guaranteed renewal" in health insurance is the requirement on an issuer to renew group coverage at the option of the plan sponsor [e.g., employer] or nongroup coverage at the option of the enrollee. Guaranteed issue and renewal alone would not guarantee that the insurance offered was affordable; this would be addressed in the rating rules.)

[18] As an example, some states have enacted rating rules in the individual and small group markets that include geography as a characteristic on which premiums may vary. In these cases, the state has established rating areas. Typically, states use counties or zip codes to define those areas.

- Require public reporting of the percentage of total premium revenue expended on reimbursement for clinical services, quality activities, taxes and fees, and on all other non-claims costs (including an explanation of these costs).
- Impose new nondiscrimination standards building on existing nondiscrimination rules in group coverage and adequacy standards for insurers' networks of providers, such as doctors.

S. 1679 would also require new plans to cover certain broad categories of benefits, prohibit cost-sharing on preventive services, require out-of-pocket limits, prohibit lifetime or annual limits on benefits, continue coverage for dependents until age 26 (but only if the plan chose to cover dependents), and meet the standards for the "essential benefits package," described below.

New individual policies and group policies issued post-enactment could be offered both inside and outside of a Gateway. Existing group plans and nongroup insurance policies would be grandfathered as long as there are no significant changes to benefits and cost-sharing.

Essential Health Benefits

The Secretary would establish "essential health benefits" that would be required of health plans to enroll and receive federal funding for credit-eligible individuals (discussed below in the "Individual Eligibility for Premium Credits" section). Those benefits would include at least the following general categories:

- ambulatory patient services;
- emergency services;
- hospitalization;
- maternity and newborn care;
- mental health and substance abuse services;
- prescription drugs;
- rehabilitative and "habilitative" services and devices (i.e., habilitative services are those that maintain the physical, intellectual, emotional, and social functioning of developmentally delayed individuals);
- laboratory services;
- preventive (certain ones with no cost-sharing permitted), vaccines and wellness services; and
- pediatric services, including oral and vision care.

The Secretary would ensure that the scope of essential health benefits is equal (as certified by the Chief Actuary of the Centers for Medicare and Medicaid Services) to the scope of benefits under typical employer-sponsored coverage. In addition, the Secretary would establish criteria for plans meeting "minimum qualifying coverage," which would exclude plans with out-of-pocket maximums above those permitted in Health Savings Account (HSA)-qualified high-deductible

health plans[19] and those that cover only a single disease or condition. The Secretary would also establish the criteria of what coverage is "affordable" to individuals and families at different income levels; the Secretary could consider coverage unaffordable only if the premium paid exceeded 12.5% of an individual's adjusted gross income (AGI).

In addition, no later than one year after the Secretary established criteria for minimum qualifying coverage under the essential benefit package, those plans that failed to provide such coverage would be required to notify prospective and current enrollees. This requirement would seem to also apply to grandfathered plans. However, enrollees in grandfathered plans would still meet the individual mandate, and employers offering grandfathered plans would meet the requirements for the employer mandate, regardless of whether or not the plan meets the criteria for minimum qualifying coverage. For individuals buying new plans in the individual or group market, as well as employers offering new plans, they would only satisfy their respective mandate by enrolling in or offering coverage that meets or exceeds minimum qualifying coverage.

Essential Benefits Commission

A National Independent Commission on Essential Health Care Benefits would be established with a $1.5 million authorization to provide input for the Secretary's initial determination of the essential benefit package and minimum qualifying coverage. In particular, the commission would (1) review typical employer-sponsored insurance and state laws requiring coverage of certain items and services, (2) hold public hearings, and (3) make recommendations to the Secretary regarding specific items and services to be included in the essential benefits package. The commission would have 17 members, appointed by the Secretary within 45 days of enactment. The commission would provide its recommendations and other analyses in a report to Congress and the Secretary within six months of enactment. The commission would terminate within 30 days of the report submission.

American Health Benefit Gateways

Gateway Structure

In addition to establishing new federal private health insurance standards, S. 1679 would enable and support states' creation of "American Health Benefit Gateways," similar in many respects to the Exchange proposed in H.R. 3200 and to existing entities like the Massachusetts Connector and eHealthInsurance. Gateways would not be insurers but would provide eligible individuals and small businesses with access to insurers' plans in a comparable way (in the same way, for example, that Travelocity or Expedia are not airlines but provide access to available flights and fares in a comparable way). Gateways would be government or nonprofit entities that would have additional responsibilities as well, such as certifying plans, establishing risk-adjustment mechanisms to reimburse plans enrolling sicker-than-average populations, and identifying individuals eligible for Medicaid, CHIP, and premium and cost-sharing credits.[20]

[19] In 2009, $5,800 for single coverage and $11,600 for family coverage. For more information on HSAs and HSA-qualified high-deductible health plans, see CRS Report RL33257, *Health Savings Accounts: Overview of Rules for 2009*.

[20] Besides Gateways, S. 1679 would also include entities called Navigators, which would receive grants awards from (continued...)

If states adopt the federal private health insurance provisions described above, and if they agree to make state and local governments subject to the employer mandates, states would have the first opportunity to establish a Gateway—to be an "establishing state"—or to request the Secretary to set up a Gateway—to be a "participating state." If four years after the date of enactment a state is not an establishing state or a participating state, there would be a federal fallback. The Secretary would establish and operate a Gateway in the state, the federal individual- and group-market insurance provisions described above would become effective "notwithstanding any contrary provision of State law,"[21] and the state would be deemed a participating state.

Under S. 1679, within 60 days of enactment (or as soon as possible thereafter), the Secretary would make grant awards to states to create Gateways. The Secretary's formula would consist of two parts: a minimum amount for each state and an additional amount based on population. At least 60% of the total allotted amount would be toward the state-level minimum. S. 1679 sets no limit on the total to be allotted; the bill authorizes whatever sum emerges from the grand total of each state's allotment as calculated by the formula, although the actual appropriation may limit this. A state's allotment could not be renewed after the second year after a Gateway is established in the state. Ongoing operations would be financed by a surcharge on participating plans of up to 4% of premium amounts.

Multiple Gateways could operate in a state, but each would require a geographically distinct area. A Gateway could operate in multiple states.

Individual and Employer Eligibility for Gateway Plans

Individuals could enroll in a Gateway plan if they are (1) residing in a participating or establishing state; (2) not incarcerated, except individuals in custody pending the disposition of charges; (3) not entitled to Medicare Part A, or enrolled in Medicare Part B; and (4) not eligible for coverage under Medicaid (or a Medicaid waiver), Tricare, the Federal Employees Health Benefits Program, or, in some cases, employer-sponsored insurance.

In an establishing state, the criteria for employers to offer Gateway coverage, including employer size, would be set by the state. In a participating state, criteria for qualified employers would be set by the Secretary. However, in both cases, the cut-off for small business participation in the Gateway could not be lower than 50. If neither the Secretary nor the state establishes criteria on employer size, the maximum employer size would be deemed to be 50.

Benefit Packages in Gateway Plans

Gateway plans would have to meet not only the new federal requirements of all private health insurance plans, but would also have their cost-sharing options somewhat standardized into the three cost-sharing/benefit tiers shown in the table below. Expenditures considered "out of pocket"

(...continued)

the Secretary to conduct public education activities regarding the Gateway, distribute fair and impartial enrollment and premium credit information, facilitate enrollment in a qualified plan, and provide this information in a culturally and linguistically appropriate manner.

[21] The new Sec. 3105(d)(1)(B) of the Public Health Service Act, per Sec. 142(b) of S. 1679.

would be defined as those considered "qualified medical expenses" in the Internal Revenue Code for HSAs.

Cost-sharing tiers	Plan would pay for the following % of total allowed costs	Enrollees' maximum out-of-pocket
Tier A (basic plan)	76%	Same amount set for Health Savings Accounts (HSAs) under current law (in 2009, $5,800 for single coverage and $11,600 for family coverage)
Tier B	Tier A coverage percentage plus 8 percentage points (84%)	50% of the Tier A out-of-pocket maximum
Tier C	Tier A coverage percentage plus 17 percentage points (93%)	20% of the Tier A out-of-pocket maximum

Community Health Insurance Option

Under S. 1679, the Secretary of HHS would establish a community health insurance option through each Gateway. Any individual eligible to purchase insurance through Gateways would be eligible to enroll in the community option and may also be eligible for income-based premium credits.[22] The community option would have to meet the requirements that apply to all plans participating in the Gateway unless otherwise excluded. The requirements would include federal and state laws related to guaranteed renewal, rating, preexisting conditions and nondiscrimination. The community health insurance option would provide coverage only for the essential health benefits, unless it is required by the state to include additional benefits.

The Secretary would be required to establish premiums at a level sufficient to cover expected costs including claims, administration, and a contingency margin. Limited start-up funds would be available but would be repaid within 10 years.

The Secretary would be required to negotiate with medical providers to set payment rates, subject to limits. Specifically, the payment rates in aggregate would not be allowed to be higher than the average rates paid by other qualified health plans offered in Gateways. Subject to the rate negotiations, a State Advisory Council established by each state would be allowed to develop and encourage the use of innovative payment policies to promote quality, efficiency, and savings to the consumer. This proposal does not address provider participation in the community health insurance option.

The Secretary would be required to enter into no-risk contracts for the administration of the community health insurance option, in the same way the Secretary enters into contracts for the administration of the Medicare program. The administrative contractor would have to meet specified criteria, including being a non-profit entity. The fee paid to the contractor could vary based on its performance on specified quality and savings measures. In addition, during the first

[22] The amount of any credit would not be affected by any additional benefits required by the state. A state would be required to make payments to defray the cost of the state-required benefits.

two years and at the Secretary's discretion thereafter, the Secretary would be required to make risk corridor payment adjustments to the administrative contractor based on risk corridor payment adjustments made to Medicare prescription drug plans under Medicare Part D during FY2006 and FY2007. A risk corridor payment adjustment is a method for limiting the losses (or gains) the contractor would experience if their costs (or revenues) fell outside of specified boundaries.

Annually, the Secretary would be required to study the solvency of the community option and submit a report to Congress. If the community option was found to be insolvent, the President would be required to submit proposed legislation to Congress to address the insolvency. Congress would be required to consider the legislation.

Individual Eligibility for Premium Credits

The Secretary would pay an annual premium credit to each Gateway for qualified, enrolled individuals. The Gateway would remit the credit to the qualified health plan an individual is enrolled in.

The amount of the annual premium credit would be determined by the Secretary so that an eligible individual whose AGI is 400% of the federal poverty level (FPL) would not have to pay more than 12.5% of income in premiums. (Individuals above 400% FPL would not be eligible for credits.) Eligible individuals with an income of 150% FPL or lower would pay no more than 1% of income in premiums. Between 150% FPL and 400% FPL, the percentage of income one would have to pay toward premiums would rise in a straight line from 1% of income to 12.5% of income, as illustrated in the solid line of **Figure 1** and the table below. For a family of three in the 48 contiguous states in 2009, 150% FPL is $27,465, and 400% FPL is $73,240.[23]

The premium credit amount would also be based on the "reference premium" for the area. For an individual whose family income is at or below 200% of poverty, the reference premium would be the weighted average annual premium of the three lowest-cost plans in Tier C offered in the individual's community rating area. For an individual whose family income is above 200% of poverty but is not above 300% of poverty, the reference premium would be the weighted average annual premium of the three lowest-cost plans in Tier B offered in the individual's area. For an individual whose family income is above 300% of poverty but is not above 400% of poverty, the reference premium would be the weighted average annual premium of the three lowest-cost plans in Tier A (basic plan) offered in the individual's area. (The community health insurance option could not be considered in determining the three lowest-cost plans.) Regardless of their credit amount, individuals could enroll in any qualified health plan, but would have to pay the difference between the premium and the credit, if any.

S. 1679 offers more generous plans with lower cost sharing to lower-income individuals in lieu of a separate cost-sharing credit (as included in H.R. 3200).

[23] CRS computation based on "Annual Update of the HHS Poverty Guidelines," 74 *Federal Register* 4200, January 23, 2009, http://aspe.hhs.gov/poverty/09fedreg.pdf. For other FPL amounts, see Table 1 in CRS Report R40734, *Health Insurance Premium Credits Under H.R. 3200*.

Table 1. Maximum Out-of-Pocket Premium Payments Under S. 1679, If Implemented in 2009

For the 48 contiguous states and the District of Columbia

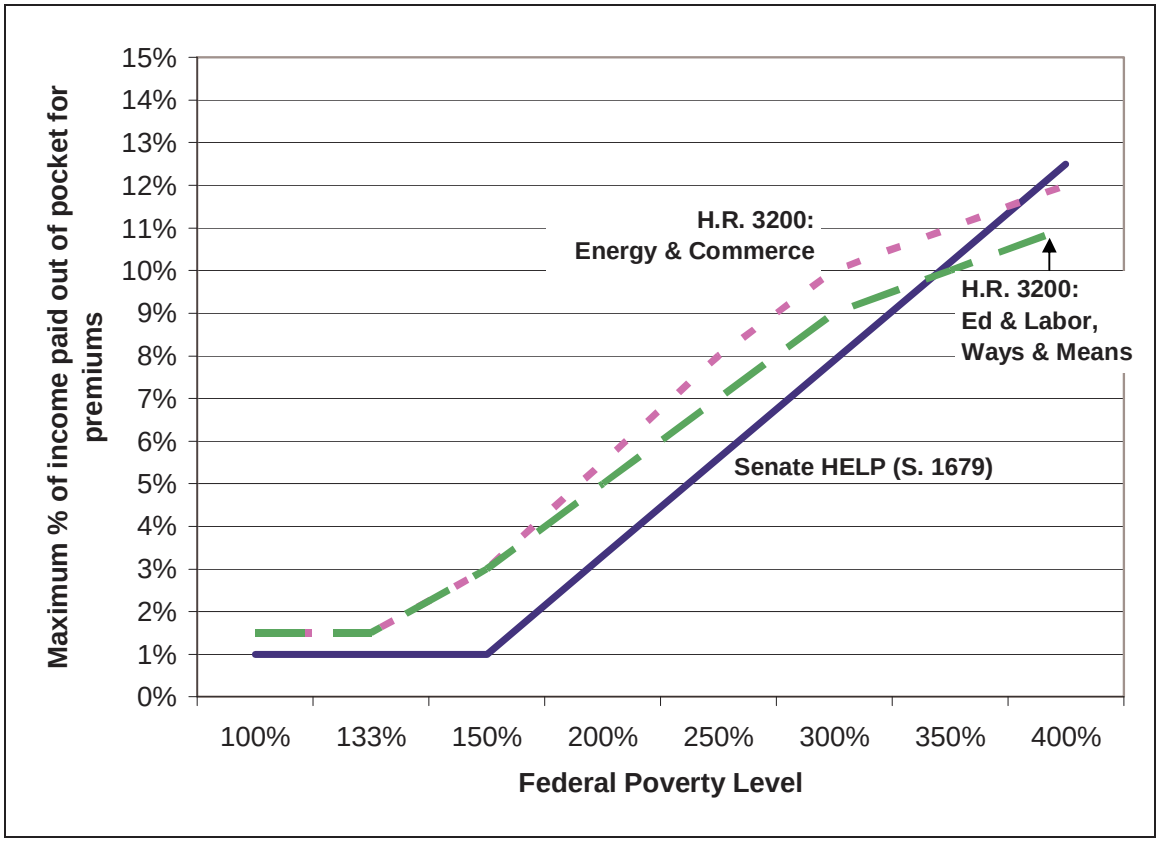
Federal Poverty Line (FPL)	Maximum Premium as a % of Income	Maximum Annual Premium, by Family Size			
		1	2	3	4
100%	1.0%	$108	$146	$183	$221
133%	1.0%	$144	$194	$244	$293
150%	1.0%	$162	$219	$275	$331
200%	3.3%	$715	$962	$1,208	$1,455
250%	5.6%	$1,516	$2,040	$2,563	$3,087
300%	7.9%	$2,567	$3,453	$4,339	$5,226
350%	10.2%	$3,866	$5,201	$6,537	$7,872
400%	12.5%	$5,415	$7,285	$9,155	$11,025

Source: CRS computation based on "Annual Update of the HHS Poverty Guidelines," 74 *Federal Register* 4200, January 23, 2009, http://aspe.hhs.gov/poverty/09fedreg.pdf, and S. 1679—for the least expensive plan available to eligible individuals. If individuals choose more expensive plans, they may be responsible for additional premiums.

Eligibility would be calculated based on (1) an applicant's AGI from two years prior or (2) in the case of an individual seeking a credit based on claiming a significant decrease in AGI, the applicant's reported or estimated AGI for a most recent period. For individuals who would receive a premium credit payment on their behalf for a year and who claim a significant decrease in AGI in that year, the individual would file an income reconciliation statement. Based on the income reconciliation statement, the Secretary would determine the size of overpayments or underpayments. Individuals would be liable to the Secretary for overpayment amounts. If such a person had a verified AGI of no more than 400% of poverty, the amount of repayment could not exceed $250 for an individual tax filer or $400 for a joint filer. The Secretary would pay to the individual any deficit associated with underpayments.

The Secretary would verify, through the Internal Revenue Service (IRS), the income data received from individuals submitting applications for credits. To be eligible to receive a credit, an individual would have to authorize the disclosure of tax return information. The Secretary would delegate to a Gateway or state the authority to carry out these eligibility-determination activities. The Gateway could consult with the IRS to verify income data received from individuals submitting applications for credits.

Figure 1. Maximum Out-of-Pocket Premiums for Eligible Individuals, S. 1679 and H.R. 3200, by Federal Poverty Level (FPL)



Source: CRS analysis.

An individual who has been determined to be eligible for subsidies would be responsible to notify a Gateway of any changes that might affect his or her eligibility status. Upon an individual's notice, the Gateway would promptly re-determine the individual's eligibility. The Gateway would terminate payments on behalf of the individual, if the individual fails to provide the status change information in a timely basis or the Gateway determines the individual is no longer eligible for the premium credits.

Applications for this process could be done in person, by mail, telephone, and the Internet. The Secretary would determine the form of the application and the manner of submission, and the application could require documentation. An application could be submitted to the Gateway or a state agency for determination.

No payments could be made for individuals who are not lawfully present in the United States.

Necessary amounts to finance these credits would automatically be paid out of the U.S. Treasury.

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