Private Health Insurance Provisions in Senate-Passed H.R. 3590, The Patient Protection and Affordable Care Act

Hinda Chaikind
Specialist in Health Care Financing

Bernadette Fernandez
Analyst in Health Care Financing

Chris L. Peterson
Specialist in Health Care Financing

Mark Newsom
Analyst in Health Care Financing

Janemarie Mulvey
Specialist in Aging Policy

January 29, 2010

Congressional Research Service
7-5700
www.crs.gov
R40942

CRS Report for Congress
Prepared for Members and Committees of Congress
c11173008

Summary

This report summarizes key provisions affecting private health insurance in H.R. 3590, the Patient Protection and Affordable Care Act, as amended and passed by the Senate on December 24, 2009 (hereafter referred to simply as H.R. 3590). H.R. 3590 reflects the merged Senate health reform bills, S. 1679, the Affordable Health Choices Act (as ordered reported by the Senate Committee on Health, Education, Labor and Pensions on July 15, 2009), and S. 1796, America's Healthy Future Act of 2009 (as ordered reported by the Senate Committee on Finance on October 19, 2009).

Title I of the bill imposes new requirements on individuals, employers, and health plans; restructures the private health insurance market; sets minimum standards for health benefits; and provides financial assistance to certain individuals and, in some cases, small employers. Title IX of the bill includes a number of new provisions to raise revenues to pay for health care reform. These provisions include excise taxes, annual fees on health insurers, and limits on tax deductions for out-of-pocket health care expenses. Title X contains amendments to many sections of the bill, including Titles I and IX.

In general, the Senate bill would require individuals to maintain health insurance, with some exceptions. Individuals would be required to maintain minimum essential coverage, which includes eligible employer coverage, individual coverage, grandfathered plans, and federal programs such as Medicare and Medicaid, among others. Employers would not be required to provide health insurance, although certain employers with more than 50 full-time employees and smaller firms in the construction industry could be required to pay a penalty if either (1) they did not provide insurance, under certain circumstances, or (2) the insurance they provided did not meet specified requirements. Several insurance market reforms would be made, such as modified community rating and guaranteed issue and renewal.

In addition to establishing new federal private health insurance standards, H.R. 3590 would enable and support states' creation of "American Health Benefit Exchanges." An exchange would not be an insurer; it would provide eligible individuals and small businesses with access to insurers' plans in a comparable way. The exchange would consist of a selection of private plans as well as "multi-state qualified health plans," administered by the Office of Personnel Management. Individuals would only be eligible to enroll in an exchange plan if they were not enrolled in Medicare, Medicaid, or acceptable employer coverage as a full-time employee. Based on income, certain individuals could qualify for a credit toward their premium costs and a subsidy for their cost-sharing; the credits and subsidies would be available only through an exchange. States would have the flexibility to establish basic health plans for low-income individuals not eligible for Medicaid.

Individual and small group coverage under qualified health plans would be allowed to be offered through nonprofit, member-run health insurance companies. Such nonprofit insurers would be eligible for grants and loans distributed through the new Consumer Operated and Oriented Plan (CO-OP) program.

Contents

Figures

Tables

Appendixes

Contacts

Status of Legislation

This report summarizes key provisions affecting private health insurance in H.R. 3590, the Patient Protection and Affordable Care Act, as amended and passed by the Senate on December 24, 2009 (hereafter referred to simply as H.R. 3590). H.R. 3590 reflects the merged Senate health reform bills, S. 1679, the Affordable Health Choices Act (as ordered reported by the Senate Committee on Health, Education, Labor and Pensions on July 15, 2009), and S. 1796, America's Healthy Future Act of 2009 (as ordered reported by the Senate Committee on Finance on October 19, 2009).

Overview of H.R. 3590

This report summarizes the key provisions affecting private health insurance in H.R. 3590, as passed by the Senate.

Title I of the H.R. 3590, as passed by the Senate, focuses on 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. Overall, the Senate bill includes the following provisions:

- Individuals would be required to maintain health insurance, and certain employers with more than 50 employees (or those in the construction industry with at least 5 employees and annual payroll expense exceeding $250,000) would be required to either provide insurance or pay a tax, with some exceptions.
- Several market reforms would be made, such as modified community rating and guaranteed issue and renewal of insurance.
- Either a state would establish separate exchanges to offer individual versus small group coverage, or the Secretary of Health and Human Services (hereafter referred to as the "Secretary" or "HHS Secretary" unless noted otherwise) would contract with a nongovernment entity to establish and operate exchanges in states that did not establish them. Exchanges would not be insurers but would provide eligible individuals and small businesses with access to private plans in a comparable way. The exchange would consist of a selection of private plans as well as a public option, the community health insurance option.
- Certain individuals with incomes below 400% of the federal poverty level could qualify for credits toward their premium costs and subsidies towards their cost-sharing. This financial assistance would be available only through exchanges.
- States would be provided the flexibility to establish basic plans for low-income individuals not eligible for Medicaid.
- Existing plans offered by employers as well as plans offered in the individual market (the nongroup market) would be grandfathered.
- New plans could also be sold in both the individual and group market outside of an exchange.

- Individual and small group coverage under qualified health plans would be allowed to be offered through nonprofit, member-run health insurance companies.

Title IX includes a number of provisions to raise revenues to pay for expanded health insurance coverage. The revenue provisions include excise taxes and annual fees on health insurers, as well as limitations on executive compensation of insurance companies. In addition, a number of revenue provisions limit contributions to tax-advantaged accounts (i.e., flexible spending accounts and health savings accounts) and other itemized deductions used for health care expenses. Title X contains amendments to many sections of the bill, including Titles I and IX.

Congressional Budget Office and Joint Committee on Taxation Analysis

On December 19, 2009, the Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) released its estimate of the direct spending and revenue effects of the Senate Amendment in the nature of a substitute to H.R. 3590, incorporating the effect of the changes proposed in the manager's amendment released on December 19, 2009.[1] CBO projects the Patient Protection and Affordable Car Act incorporating the manager's amendment would reduce federal deficits by $132 billion over the 10-year period of 2010-2019 and, by 2019, would insure 94% of the non-elderly, legally present U.S. population. According to the CBO, the gross 10-year cost of the exchange subsidies ($436 billion), increased federal Medicaid and CHIP expenditures ($395 billion), and tax credits for small employers ($40 billion) would total $871 billion. Taking into account employer and individual tax penalties and other issues pertaining to coverage, the net cost of the coverage provisions, according to the CBO analysis, would be $614 billion over 10 years. "Those costs would be partly offset by receipts or savings, totaling $257 billion over the 10-year budget window, from four sources: net revenues from the excise tax on high-premium insurance plans, totaling $149 billion; penalty payments by uninsured individuals, which would amount to $8 billion; penalty payments by employers whose workers received subsidies via the exchanges, which would total $28 billion; and other budgetary effects, mostly on tax revenues, associated with the expansion of federally subsidized insurance, which would reduce deficits by $65 billion."[2]

Overview of Report

This report begins by providing background information on key aspects of the private health insurance market as it exists currently. This information is useful in setting the stage for understanding how and where H.R. 3590 would reform health insurance. This report summarizes key provisions affecting private health insurance in Titles I[3] and IX of the H.R. 3590, including amendments in Title X. Most of the provisions would be effective beginning in 2014. Some of the

[1] The estimate does not include the effects of other amendments adopted during the Senate's consideration of the Patient Protection and Affordable Care Act, nor does it reflect an incremental effect on the Act from the Department of Defense Appropriation Act. http://cbo.gov/ftpdocs/108xx/doc10868/12-19-Reid_Letter_Managers_Correction_Noted.pdf.

[2] Ibid.

[3] This report does not discuss quality, wellness, administrative simplification and other titles of H.R. 3590, which are addressed in other CRS reports.

provisions would be effective prior to that date, and are listed in the **Appendix** on immediate reforms.

Although the description that follows segments the private health insurance provisions into various categories, these provisions are interrelated and interdependent. For example, the Senate 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. The bill would require that insurers not exclude potential enrollees or charge them premiums based on preexisting health conditions. In a system in which individuals voluntarily choose whether to obtain health insurance, however, individuals may choose to enroll only when they become sick. This can lead to a situation known as "adverse selection," which may result in higher premiums and greater uninsurance. When permitted, insurers often guard against adverse selection by adopting policies such as underwriting health insurance policies based on individual health status and excluding coverage for preexisting conditions. If reform eliminates many of the tools insurers use to guard against adverse selection, America's Health Insurance Plans (AHIP), the association that represents health insurers, has stated that all individuals must be required to have coverage ("individual mandate"), so that not just the sick enroll.[4]

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 without cost-sharing subsidies 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 mandate and employer requirements: the mandate for individuals to maintain health insurance and any requirements for employers.
  [Hinda Chaikind, 7-7569]
- Private health insurance market reforms.
  [Bernadette Fernandez, 7-0322]
- Exchange [Chris Peterson, 7-4681], through which the following two items can only be offered:
  - Multi-state qualified health plans.
    [Hinda Chaikind, 7-7569]
  - Premium subsidies.
    [Chris Peterson, 7-4681]

[4] 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.

- Immediate Individual and Group Market Reforms and Consumer Operated and Oriented Plan—Health Care Cooperatives.
  [Mark Newsom, 7-1686]
- Title IX: Select Revenue Provisions Relating to Private Health Insurance.
  [Janemarie Mulvey, 7-6928]

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.[5]

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.[6]

More than 96% of large employers offer coverage.[7] 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 have a larger "risk pool" of enrollees that 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 large in size, but it is also contains diverse risks. 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[8]), other

[5] CRS Report 96-891, *Health Insurance Coverage: Characteristics of the Insured and Uninsured in 2008*, by Chris L. Peterson.

[6] 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.

[7] 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.

[8] PacAdvantage was created as part of the small business health insurance reforms enacted in California in 1992, as a state-established health insurance purchasing 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.

states have learned from these experiences and have fashioned potentially more sustainable models (e.g., Massachusetts' Connector[9]). 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;[10] 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 impact 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 coverage exclusions for preexisting health conditions. Reforms affecting premium 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).[11] The federal 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 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.

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 related to insurance risk. As of December 2008, only two states (New Jersey and New York) use pure community rating in their nongroup markets, and only New York imposes

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

[10] See footnote 7.

[11] 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.

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).[12]

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.[13] As of January 2009 in the small group market, 21 states had preexisting condition exclusion rules that provided consumer protection above the federal standard.[14] 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.[15] Moreover, while there are a handful of federal benefit mandates for health insurance that apply to group coverage, there are more than 2,000 cumulative benefit mandates imposed by the states.[16]

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 legislation, or in future amendments. Ultimately, opponents are concerned that these advantages might drive private plans from the market.[17]

---

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

[13] Under HIPAA, a plan is allowed to look back only 6 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 6 months prior to your 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).

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

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

[16] 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.

[17] 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.

Private health insurance is generally provided by three basic types of business organizations: for-profit, non-profit, and mutual insurance companies.[18] For-profit health insurers seek a return on the investment of the owner or shareholder through increased profits. Non-profit health insurance companies generally refer to organizations meeting the requirements of section 501(c)(3) of the Internal Revenue Code (IRC), which prohibits any earnings from being paid to a private shareholder or individual.[19] A mutual insurance company is owned by its policyholders and has no stock. According to Atlantic Information Services, in 2008 51% of health plan enrollees were in for-profit plans and 47% were in non-profit plans, while only 2% enrolled in mutual health insurance companies.[20]

In examining the policy options for health reform, some have considered which health insurance models yield the best results, and in doing so have come to different conclusions. Some have argued that the tax status does not matter as much as other structural issues, such as the ability to sell insurance across state lines, or focusing insurance only on catastrophic costs through the use of high deductible plans where the member pays for basic care through a savings account.[21] Others believe that non-profits provide the best care. For example, in reviewing the history of health insurance companies by non-profit and for-profit tax status, Senator Dianne Feinstein concluded that "the medical insurance industry should be nonprofit, not profit-making. There is no way a health reform plan will work when it is implemented by an industry that seeks to return money to shareholders instead of using that money to provide health care."[22] Cooperatives, a subset of non-profit health insurers, have received additional congressional attention.[23] Advocates of health insurance cooperatives argue that these organizations invest their retained earnings[24] in the plan membership via lower premiums, lower cost-sharing, expanded benefits, and innovations such as wellness programs, chronic disease management, and integrated care.[25] While little cost data are available, health insurance cooperatives have performed particularly in recent case studies of Group Health Cooperative of Seattle (GHC-Seattle)[26] and HealthPartners of

[18] For an in-depth review of the health insurance marketplace see CRS Report R40834, *The Market Structure of the Health Insurance Industry*, by D. Andrew Austin and Thomas L. Hungerford.

[19] Per the Internal Revenue Service a section 501(c)(3) organization must not be organized or operated for the benefit of private interests, such as the creator or the creator's family, shareholders of the organization, other designated individuals, or persons controlled directly or indirectly by such private interests. No part of the net earnings of a section 501(c)(3) organization may inure to the benefit of any private shareholder or individual. A private shareholder or individual is a person having a personal and private interest in the activities of the organization. http://www.irs.gov/charities/charitable/article/0,,id=123297,00.html.

[20] Atlantic Information Services, Inc. Directory of Health Plans: 2008.

[21] See Senator Jon Kyl's statement on health reform, Congressional Record, Senate - October 15, 2009, Page: S10444 and Congressman Michael C. Burgess' statement on health care in America, Congressional Record, House of Representatives - April 21, 2009, Page: H4571.

[22] See Senator Dianne Feinstein's statement on the history of the medical insurance industry, Congressional Record, Senate - November 02, 2009, Page: S10976.

[23] Insurance cooperatives can either be collectively owned or governed. The former being a mutual insurance company, and the latter being a non-profit health insurance company with a member controlled board of directors that cooperatively governs the organization, but is not compensated nor holds an equity stake in the firm.

[24] Retained earnings are the net earnings not paid out as dividends, but retained by the company to be reinvested in its core business or to pay debt.

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

[26] D. McCarthy, K. Mueller, and I. Tillmann, Group Health Cooperative: Reinventing Primary Care by Connecting Patients with a Medical Home, The Commonwealth Fund, July 2009

Minnesota[27] and in data reported by the National Committee for Quality Assurance (NCQA) presented in **Table 1**.[28]

Table 1. NCQA Health Plan Report Cards of Cooperatives

Organization	Accreditation Status	Access and Service	Qualified Providers	Staying Healthy	Getting Better	Living with Illness
GHC-Seattle	Excellent	4 stars	4 stars	4 stars	4 stars	4 stars
Medical Mutual of Ohio	Excellent	4 stars	4 stars	3 stars	3 stars	3 stars
GHC-SCW	Excellent	4 stars	4 stars	4 stars	4 stars	4 stars
HealthPartners	Excellent	4 stars	4 stars	4 stars	4 stars	4 stars

Source: NCQA http://reportcard.ncqa.org/plan/external/plansearch.aspx.

Notes: The report cards are reprinted with permission from NCQA. GHC-SWC stands for Group Health Cooperative of South Central Wisconsin. Each report card presents a summary of a plan's accreditation status and star ratings. The accreditation status refers to the overall score a plan received on their most recent NCQA comprehensive evaluation. This process independently reviews the plan's systems, processes, and quality results on the care and service delivered for diabetes, childhood immunizations, and other critical areas of importance as determined by technical expert panels. Accreditation status is rank ordered (from lowest to highest) as either accredited, commendable, or excellent. The "Access and Service" category refers how well the health plan provides its members with access to needed care and with good customer service. The plans measured may receive up to 4 stars. The "Qualified Providers" category refers to health plan activities that ensure each doctor is licensed and trained to practice medicine and that the health plan's members are happy with their doctors. The plans measured may receive up to 4 stars. The "Staying Healthy" category refers to health plan activities that help people maintain good health and avoid illness. The plans measured may receive up to 4 stars. The "Getting Better" category refers to health plan activities that help people recover from illness. The plans measured may receive up to 4 stars. The "Living with Illness" category refers to health plan activities that help people manage chronic illness. The plans measured may receive up to 4 stars.

Immediate Individual and Group Market Reforms Under Title I

H.R. 3590 would begin implementation of a number of reforms in both the individual and group markets immediately upon enactment. These reforms would include the following (see **Appendix** for additional details):

- no lifetime or annual limits on benefits,
- prohibiting rescissions of health insurance policies,

[27] D. McCarthy, K. Mueller, and I. Tillmann, HealthPartners: Consumer-Focused Mission and Collaborative Approach Support Ambitious Performance Improvement Agenda, The Commonwealth Fund, June 2009

[28] NCQA is a private, 501(c) (3) non-profit organization that develops quality standards and performance measures for a broad range of health care organizations. NCQA began accrediting health insurance plans shortly after its founding in 1990, in response to employer demands for standardized, objective information about performance on the benefits they were providing. Most health insurance organizations participate in NCQA's programs including the publicly available report cards. Among the five major existing cooperatives Medical Mutual of Ohio, Group Health Cooperative-Seattle, Group Health Cooperative-South Central Wisconsin, and HealthPartners of Minnesota participate in the NCQA report card program. Blue Cross Blue Shield of North Dakota does not participate in the NCQA report card.

- requiring coverage of preventive services and immunizations,
- extending dependant coverage up to age 26,
- requiring the Secretary to develop uniform summary of benefits documents so consumers can make easier comparisons when shopping for health insurance,
- prohibiting discrimination based on salary with respect to eligibility for benefits,
- tasking the Secretary with developing requirements for quality of care,
- bringing down costs by capping insurance company non-medical, administrative expenditures,
- ensuring that consumers have access to an effective appeals process,
- providing assistance for those who are uninsured because of a preexisting condition,
- creating a temporary re-insurance program to support coverage for early retirees,
- establishing an internet portal to assist consumers in identifying coverage options,
- facilitating administrative simplification to lower health system costs, and
- patient protections regarding the choice of a primary care provider, and access to emergency services and obstetrical and gynecological care.

Health Insurance Terms Defined Under Title I

The Senate bill would establish new health insurance plans and define existing ones in the private market applicable to Title I. New health plans would include the following:

- A "qualified health plan" (QHP) would be a health plan that has been certified as meeting a specified list of requirements related to marketing, choice of providers, plan networks, and other features, or is recognized by each exchange through which such plan is offered; and provides the essential health benefits package (defined below). A QHP issuer would be licensed and in good standing with each state in which it would offer coverage; would offer at least one QHP each providing silver and gold levels of coverage (levels described below); would charge the same premium for a plan regardless if it was offered in or out of the exchange (including through an insurance agent); and would comply with regulations applicable to exchanges. QHPs include qualified health plans offered through the CO-OP program or the Community Health Insurance Option (both described below).
- A "standard health plan" would be a plan established and maintained by the state under which eligible individuals would be residents of the state who are not eligible to enroll in Medicaid; whose household income exceeds 133% but does not exceed 200% of the poverty line for the size of the family involved; who are not eligible for minimum essential coverage (as defined in section 5000A(f) of 23 the Internal Revenue Code of 1986); or are eligible for an employer-sponsored plan; and have not attained the age of 65 as of the beginning of the plan year.

Such a plan would provide coverage equal to at least the essential health benefits (described below), and have a medical loss ratio[29] of at least 85%.

The bill would define several terms related to health insurance applicable to Title I, including the following:

- "Health plan" refers to health insurance coverage and a group health plan, not including self-insured plans and multiple employer welfare arrangements (MEWAs)[30] not subject to state law.
- "Group health plan" refers to a plan that provides medical care to employees or their dependents, including self-insured plans. MEWAs could be considered group health plans for the purpose of health insurance requirements under Title I.
- "Minimum essential coverage" (i.e., coverage required to fulfill the individual mandate) is defined as coverage under Medicare part A, Medicaid, the Children's Health Insurance Program (CHIP), the TRICARE for Life program, the veteran's health care program, the Peace Corps program, a government plan (local, state, federal) including the Federal Employees Health Benefits Program (FEHBP) and any plan established by an Indian tribal government, any plan offered in the individual, small group or large group market, a grandfathered health plan, and any other health benefits coverage, such as a state health benefits risk pool, as recognized by the HHS Secretary in coordination with the Treasury Secretary.
- "Essential health benefits package" refers to a health plan that would provide coverage for "essential health benefits," would not exceed out-of-pocket and deductible limits specified in the bill, and would not impose a deductible on preventive services.
- "Essential health benefits" refers to categories of benefits specified in the bill which would be provided in an "essential health benefits package."

Individual Mandate and Employer Requirements

Individual Mandate

Beginning in 2014, H.R. 3590 would include a mandate for most individuals to have health insurance, or to pay a penalty for noncompliance.[31] Individuals would be required to maintain

[29] A medical loss ratio refers to the percentage of premiums collected by an insurer that is used to pay medical claims.

[30] The Employee Retirement Income Security Act defines a multiple employer welfare arrangement as an employee welfare benefit plan or other arrangement that is established and maintained to provide specified benefits, including health insurance coverage, to the employees of two or more employers. MEWAs may not include plans covering collective bargaining agreements, rural electric cooperative and rural telephone cooperative associations. Conceptually, MEWAs are designed to give small employers the ability to purchase low cost health coverage on terms similar to those available to large employers. For additional information about MEWAs, see U.S. Department of Labor, Employee Benefits Security Administration, Fact Sheet: MEWA Enforcement, April 2009, available at http://www.dol.gov/ebsa/newsroom/fsMEWAenforcement.html.

[31] Section 1501 includes congressional findings that address the constitutionality of an individual mandate to obtain health insurance. For more information on this issue, see CRS report, CRS Report R40725, *Requiring Individuals to Obtain Health Insurance: A Constitutional Analysis*, by Jennifer Staman and Cynthia Brougher.

minimum essential coverage for themselves and their dependents. Those who did not would be required to pay a penalty, equal to 1/12 of the calendar year "dollar amount" for each month they were in non-compliance, and for themselves and their dependents. The annual dollar amount would be phased-in—$95 in 2014, $495 in 2015, reaching $750 in 2016, reduced by one-half for any dependents under the age of 18. However, the penalty would be limited so that in any given year, the penalty would be the lesser of (1) 300% of the penalty in total for the taxpayer and any dependents, (2) 0.5% of household income for a tax year beginning in 2014, 1.0% for a tax year beginning in 2015, and 2% thereafter; or (3) an amount equal to the national average premium for qualified health plans which have a bronze level of coverage, provide coverage for the applicable family size involved, and are offered through an exchanges for plan years beginning in the calendar year with or within which the taxable year ends. The penalty would be adjusted for inflation, beginning with taxable years after 2016.

Some individuals would be provided with subsidies to help pay for their premiums and cost-sharing. (A complete description of who would be eligible and the amount of subsidies is found in the section on Individual Eligibility for Premium Credits and Cost-sharing Subsidies). Others would be exempt from the individual mandate, including those with qualifying religious exemptions, those in a health care sharing ministry, individuals not lawfully present in the United States, and incarcerated individuals, No penalty would be imposed on those without coverage for less than 90 days (with only one period of 90 days allowed in a year), members of Indian tribes individuals whose household income did not exceed 100% of the federal poverty level (FPL), or any individual who the Secretary of HHS determines to have suffered a hardship with respect to the capability to obtain coverage under a QHP. Additionally, individuals whose required contribution[32] for a calendar year exceeds 8% of household income[33] would be exempt from the penalty. For tax years after 2014, the 8% would be adjusted to reflect the excess rate of premium growth and the rate of income growth for the period. Certain individuals who would otherwise be subject to the mandate, but are residing outside of the United States, as well as bona fide residents of any possession of the United States would be considered to have minimum essential coverage and therefore not subject to the penalty.

Taxpayers who were required to pay a penalty, but failed to do so, would not be subject to any criminal prosecution or penalty for such failure. The Secretary could not file notice of lien or levy on any property, for a taxpayer who does not pay the penalty.

Currently, Members of Congress and their staff are eligible to enroll in the Federal Employees Health Benefits program. Under the Senate bill, Members of Congress and congressional staff could only enroll in health plans created under this Act, or offered through an exchange. Congressional staff would only include all full- and part-time employees employed by the official office of a Member of Congress.[34]

[32] Required contribution is defined as (1) in the case of an individual eligible to purchase minimum essential coverage through an employer (other than through the exchange), the portion of the annual premium that is paid by the individual for self-only coverage, or (2) or for individuals not included above, the annual premium for the lowest cost bronze plan available in the individual market through the exchange in the State in which the individual resides, reduced by the amount of the premium credit for the taxable year.

[33] Household income is defined as the modified gross income of the taxpayer, plus the aggregate modified gross income of all other individuals for whom the taxpayer is allowed a deduction for personal exemptions for the taxable year.

[34] All of the Members of Congress, and most if not all of the staff, would not qualify for premium credits or subsidies through the exchange, and would therefore be responsible for 100% of premiums. Additionally, it appears that this (continued...)

Employer Requirements

H.R. 3590 would not mandate employers to provide employees with coverage, however it would impose certain requirements on employers. All employers with more than 50 full-time employees (defined as employees working on average at least 30 hours per week and excluding seasonal workers) who did not provide coverage could be required to pay a penalty for certain employees, as well as employers who provide access to coverage, but fail to meet certain requirements. The penalties for applicable employers who do provide coverage are similar to, but not exactly the same as, the penalties for applicable employers who do *not* provide coverage.

A special rule would apply to those employers whose substantial annual gross receipts were attributable to the construction industry. For these employers, instead of using the 50 full-time employee count for the employer requirement, employers who employed an average of at least 5 full-time employees on business days during the preceding calendar year and whose annual payroll expenses exceeded $250,000 for such preceding calendar year would be subject to the employer requirements. The same exclusions would apply for the seasonal workers of construction industry employers.

Requirements for Employers Offering Health Insurance

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

- Current employment-based plans would be grandfathered.
- Small employers could offer full-time employees and their dependents coverage in a QHP.
- Large employers could offer full-time employees the opportunity to enroll in a group health plan.
- An employer would not be treated as meeting the employer requirements, if at least one full-time employee is enrolled in a QHP and is eligible for a premium or cost-sharing credit because the employee's required contribution exceeds 9.8% of the employee's household income or if plan offered by the employer pays for less than 60% of covered expenses.
- Employers would be required to file a return providing the name of each individual for whom they provide the opportunity to enroll in minimum essential coverage, the length of any waiting period, the number of months that coverage was available, the monthly premium for the lowest cost option, the employer's share of total allowed cost of benefits, the number for full-time employees, the number of months employees were covered, if any, and any other information required by the Secretary. They would also be required to provide notice to employees about the existence of the exchange, including a description of the services provided by the exchange.

Even if an employer offered coverage to its employees, that coverage may be unaffordable for one or more employees. An employer that offers its employees coverage could be subject to

(...continued)

provision would not allow these individuals to enroll in Medicare, during their service.

penalties, if one or more of its full time employees were enrolled in a QHP for which a premium credit or cost-sharing subsidy is allowed or paid for, for that employee. In 2014, the penalty assessed to the employer for each such employee would be equal to 400% of the "applicable payment amount" (400% of $750 = $3,000 on an annual basis). However, the total penalty for an employer would be limited to the *total* number of the firm's full-time employees times the applicable payment amount, for any applicable month.

For example, consider an employer who did not offer health coverage at any time during the year and had 100 full-time employees of which 30 full-time employees qualified for credits or subsidies through an exchange plan. The penalty amount would be 400% of $750 (since the penalty would apply for the full year) for each of the 30 employees, or $90,000 (4 x $750 x 30). However, the limitation on an employer penalty is equal to the number of full-time employees (100) multiplied by $750, which in this case is $75,000 (100 x $750). Under this example, the employer would pay only $75,000 (the lesser of $75,000 and the $90,000 calculated penalty).[35]

After 2014, the applicable payment amount would be indexed by a premium adjustment percentage for the calendar year.

A fee would also be imposed on employers that required extended waiting periods before employees could enroll in a plan. A fee of $600 (indexed after 2014) per full-time employee would be imposed on applicable large employers that required extended waiting periods (over 60 days) before employees could enroll in a minimum essential coverage under an employer-sponsored plan.

Finally those firms with more than 200 full-time employees that offer coverage would automatically enroll new full-time employees in a plan (and continue enrollment of current employees). Automatic enrollment programs would be required to include adequate notice and the opportunity for an employee to opt out.

Requirements for Employers Not Offering Health Insurance

A firm with more than 50 employees (or applicable construction firm with 5 or more employees) that chose not to offer health insurance could be subject to a penalty if any of its full-time employees were enrolled in a QHP for which a premium credit or cost-sharing subsidy is allowed or paid for, for that employee. In 2014, the penalty assessed to the employer would be equal to the number of full-time employees times 1/12 of $750, for any applicable month. After 2014, the applicable payment amount would be indexed by a premium adjustment percentage for the calendar year.

Employers that did not offer coverage would also be required to file a return stating that they did not offer coverage, the number of full-time employees, and other information required by the Secretary. They would also be required to provide notice to employees about the existence of the exchange, including a description of the services provided by the exchange.

[35] Calculations by CRS.

Free Choice Vouchers

An employer offering minimum essential coverage who pays any portion of the costs of such plan would provide free choice vouchers to each qualified employee. A qualified employee would be one whose required contribution to the employer plan is greater than 8% and less than 9.8% of the employee's household income for the taxable year, whose household income is not greater than 400% of the FPL for the relevant family size, and who does not participate in the plan offered by the employer. Beginning after 2014, the 8% and 9.8% would be indexed by the rate of premium growth.

The amount of a voucher would be equal to the monthly portion of the cost of the employer plan which would have been paid by the employer if the employee were covered under the plan for which the employer pays the largest portion of plan costs, for either self or, if elected by the employee, family coverage.

An exchange would credit the amount of a voucher to the monthly premium of a qualified health plan in which the qualified employee is enrolled, and the employer would pay the exchange the credited amount. If the amount of the voucher exceeded the premium, the excess would be paid to the employee. The voucher would be taken into account in determining the premium credit.

No penalty would be imposed on am employer with respect to any employee who was provided a voucher.

Small Business Tax Credit

Certain small businesses would be eligible for a tax credit[36] toward a share of their cost of health insurance coverage, calculated as the lesser of (1) the employer premium contribution toward QHPs offered by the employer through an exchange, or (2) the contribution the employer would have made if each of those same employees had enrolled in a QHP with a premium equal to the average (determined by the Secretary) for the small group market in the rating area in which the employee enrolls for coverage. Small employers would have to contribute at least 50% of the cost of premiums for QHPs, in order to be eligible for any credits. In each of the four years, 2010 through 2013, the credit could cover up to 35% of a qualified employer's share of health insurance coverage. Beginning in 2014, a qualified small employer purchasing insurance through the exchange could receive a tax credit for two years that covers up to 50% of the employer's contribution.

Small businesses with 10 or fewer full-time employees and with average taxable wages of $25,000 or less could claim the full credit amount. This credit would be phased out as average employee compensation increased from $25,000 to $40,000 and as the number of full-time employees increased from 10 to 25. Full-time employees would be calculated by dividing the total hours worked by all employees during the tax year by 2,080 (with a maximum of 2,080 hours for any one employee). Seasonal workers would be exempt from this calculation.

Nonprofit organizations with 25 or fewer employees would also be eligible to receive tax credits if they meet the same requirements. These organizations would be eligible for the lesser of (1) a

[36] Section 1421.

25% credit for each year from 2010 to 2013 and a 35% credit in 2014 and thereafter, or (2) the amount of employer-paid payroll taxes for the relevant calendar year.

Small Business Cafeteria Plans

The bill would also reduce the administrative costs for small businesses who provided "cafeteria plans" (Section 125 plans). A cafeteria plan is a salary reduction arrangement that allows workers to fund accounts for health care expenses (e.g., copayments, deductibles and non-covered services) on a pre-tax basis. The bill would simplify nondiscrimination testing requirements for cafeteria plans established by small businesses. Nondiscrimination testing measures whether an employer disproportionately favors highly compensated employees within the cafeteria plan. H.R. 3590 would not require nondiscrimination testing by small businesses if they meet certain safe harbor requirements. Under the bill, small employers would have to either provide a uniform percentage of compensation to all employees (not less than 2%) or contribute an amount equal to the greater of: 6% of the employee's compensation for the year or twice the amount of the salary reduction contribution of each employee.

Private Health Insurance Market Reforms

H.R. 3590 would establish new federal standards applicable to private health insurance plans. These standards would affect private health insurance in the individual, small group, and large group markets, depending on the standard in question. These standards would impose new requirements on states related to the allocation of insurance risk, modify the current state-based regulatory system applicable to private plans, and require coverage for specified categories of benefits. Before 2016, states would have the option to define "small employers" either as those with (1) 100 or fewer employees, or (2) 50 or fewer employees. Beginning in 2016, small employers would be defined as those with 100 or fewer employees.[37] A "large employer" would be an employer that had an average of at least 101 employees the preceding calendar year and at least one employee on the first day of the plan year. States would be required to uniformly apply any standard or requirement it adopts under Title I of the bill.

The bill would establish "qualified health plans" (QHPs), a type of new health plan subject to a specified list of requirements related to marketing, choice of providers, plan networks, essential benefits, and other features. A QHP issuer would be licensed and in good standing with each state in which it would offer coverage; would offer at least one QHP each providing silver and gold levels of coverage (described below); would charge the same premium for a plan regardless if it was offered in or out of the exchange (including through an insurance agent); and would comply with regulations applicable to exchanges.

Existing plans could continue to offer coverage as grandfathered plans in the individual and group markets. Enrollment in such plans would be limited to those who were currently enrolled, their families, or for grandfathered employer-sponsored insurance to new employees and their families. Enrollees could continue and renew enrollment in a grandfathered plan indefinitely. Grandfathered plans would still be subject to a couple of market reforms: uniform explanation of

[37] Most of these provisions described in this section are instituted in the legislation by creating a new Title XXII in the Social Security Act. Under the new Sec. 2201(c)(1)(B), self-insured plans and multiple employer welfare arrangements (MEWAs) would largely be exempt from Title XXII, regardless of employer size.

coverage documents and reporting of medical loss ratio and other information. Existing group plans subject to one or more collective bargaining agreements would be grandfathered until the date on which the agreement terminates, at which time the immediate reforms and private market reforms would apply.

Individual and Group Market Reforms

H.R. 3590 would apply new federal health insurance standards to group health plans, and the individual, small group, and large group markets (depending on the standard), effective January 1, 2014. Among the market reforms are provisions that would do the following:

- Prohibit *group health plans* and issuers in the *individual* and *group* markets from excluding coverage for preexisting health conditions. (A "pre-existing 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.)
- Prohibit *group health plans* and issuers in the *individual* and *group* markets from basing eligibility for coverage on health status-related factors. (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). It would allow for the offering of premium discounts or rewards based on enrollee participation in wellness programs (described in "Other Provisions" section).
- Prohibit *group health plans* and issuers in the *individual* and *group* markets from imposing a waiting period greater than 90 days. (A "waiting period" refers to the time period that must pass before an individual is eligible to use health benefits.)
- Impose non-discrimination requirements on *group health plans* and issuers in the *individual* and *group* markets with respect to participating health care providers and individuals enrolled in such coverage.
- Require *individual* and *group* health insurance issuers to offer coverage on 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 individual coverage at the option of the enrollee. Guaranteed issue and renewal alone would not guarantee that the insurance offered was affordable.)
- Require issuers in the *individual* and *small group* markets to determine premiums for such coverage 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 the bill, premiums would vary based only on the following risk factors: self-only or family enrollment; rating area,[38] as specified by the

[38] As an example, some states have enacted rating rules in the individual and small group markets that include (continued...)

state; age (by no more than a 3:1 ratio across age rating bands established by the Secretary, in consultation with the National Association of Insurance Commissioners (NAIC)), and tobacco use (by no more than 1.5:1 ratio).

- Require *QHPs* and issuers in the *individual* and *small group* markets to offer coverage that includes the "essential health benefits package."
- Prohibit *health plans* that provide the essential health benefits package from imposing annual cost-sharing requirements that exceed the out-of-pocket limits applicable to high deductible health plans (HDHPs) as defined under the health savings account (HSA) section of the IRC[39] beginning in 2014; limits would be annually adjusted thereafter by rate of growth in health care premiums.

Reforms Related to Allocation of Insurance Risk

H.R. 3590 would include provisions which take into account the variation of insurance risk among plan enrollees and across health plans. Such provisions would:

- Require any issuer in the *individual* or *small group* market to consider all enrollees in all plans offered by the issuer in the applicable market as members of a single risk pool, including enrollees not enrolled in such plans offered through the exchange. ("Pooling" refers to the insurance industry practice of pooling the insurance risk of individuals or groups in order to determine premiums.) It would give states the option to merge the individual and small group markets.
- Require each state to establish a reinsurance program for the *individual* market by no later than January 1, 2014. ("Reinsurance" typically is thought of as insurance for insurers. When issuing policies, an insurer faces the risk that the premiums it collects will not be sufficient to cover its expenses and generate profit. For a health insurer, an unusually high health care claims could lead to significant financial loss. Reinsurance shifts the risk of covering such high expenses from the primary insurer to a reinsurer.) It would require all health insurance issuers and third-party administrators (TPAs) of group health plans to contribute to a temporary reinsurance program for individual policies that is administered by a nonprofit reinsurance entity. The aggregate contribution amounts for all states would be equal to $10 billion in plan year 2014, $6 billion in 2015, and $4 billion in 2016. States would modify or terminate any existing high-risk pools to the extent that such pools would be consistent with the reinsurance provisions.
- Require the Secretary to establish and administer temporary risk corridors, under which payments to QHPs in the *individual* and *small group* markets would be made according to applicable risk corridor rules, based on the program for regional participating provider organizations under Part D of the Medicare program. ("Risk corridors" refer to a mechanism which adjusts payments to plans

(...continued)

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.

[39] For 2010, the out-of-pocket maximum for HSA-qualified HDHPs is $5,950 for single coverage and $11,900 for family coverage.

according to a formula based on each plan's actual, allowed expenses in relation to a target amount. If a plan's expenses exceed a certain percentage above the target, the plan's payment is increased. Likewise, if a plan's expenses exceed a certain percentage below the target, the plan's payment is decreased.)

- Require each state to adopt a risk-adjustment model, established by the Secretary, to apply risk adjustment to *health plans* and issuers in the *individual* and *small group* markets. ("Risk adjustment" refers to a mechanism that adjusts payments to health plans to take into account the risk that each plan is bearing based on its enrollee population.) Plans with enrollment of less than average risk would pay an assessment to the state. States would provide payments to plans with higher than average risk.

Essential Health Benefits Package

The Secretary would specify the "essential health benefits" included in the "essential health benefits package" that QHPs would be required to cover. Essential health benefits would include at least the following general categories:

- 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 and chronic disease management; and
- pediatric services, including oral and vision care.

Coverage provided for the essential health benefits package would provide bronze, silver, gold, or platinum level of coverage (described below). A health plan providing the essential health benefits package would be prohibited from imposing an annual cost-sharing limit that exceeds the thresholds applicable to HDHPs. Small group health plans providing the essential health benefits package would be prohibited from imposing a deductible greater than $2,000 for self-only coverage, or $4,000 for any other coverage in 2014; deductible limits would be annually adjusted thereafter. Such limits would be applied in a manner that would not affect the actuarial value of any health plan,[40] including a bronze level plan (described below). Plans providing the essential

[40] "Actuarial value" is a summary measure of a health plan's benefit generosity. It is expressed as the percentage of medical expenses estimated to be paid by the insurer for a standard population and set of allowed charges. For a background discussion about actuarial value, see CRS Report R40491, *Setting and Valuing Health Insurance Benefits*, by Chris L. Peterson.

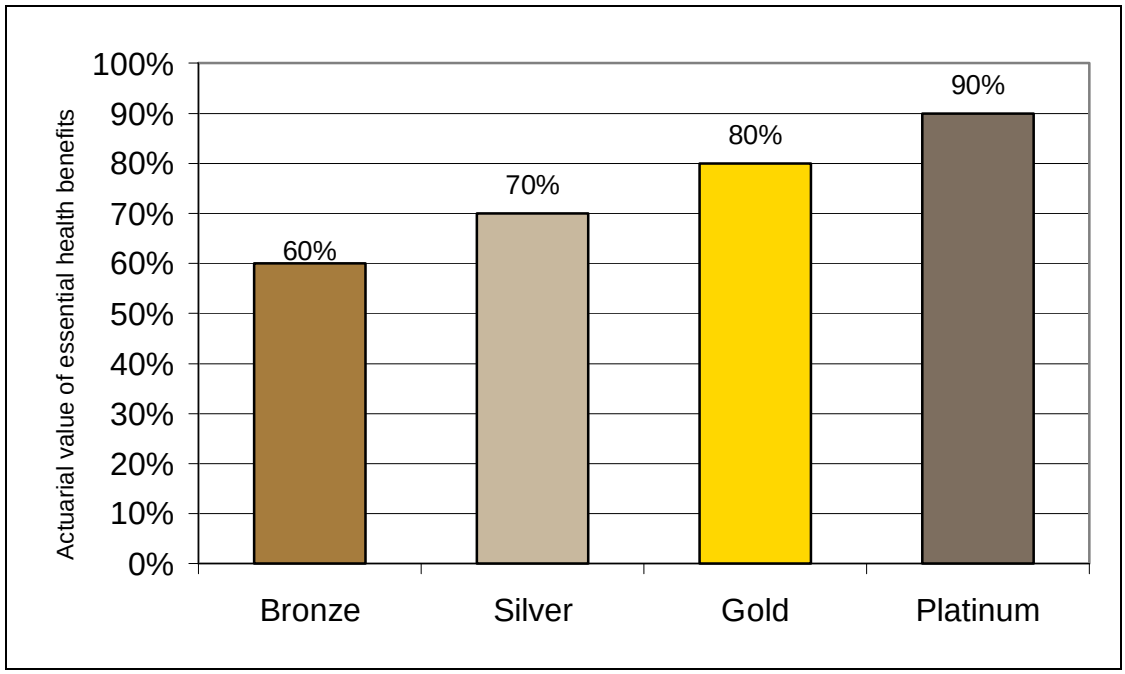
health benefits package would be prohibited from applying a deductible to preventive health services.

The Senate bill would require the Secretary to define and periodically update coverage that provides essential health benefits. The Secretary would ensure that the scope of essential health benefits is equal to the scope of benefits under a typical employer-provided health plan (as certified by the Chief Actuary of the Centers for Medicare and Medicaid Services). A health plan would be allowed to provide benefits in excess of the essential health benefits defined by the Secretary.

Levels of Coverage

H.R. 3590 would require QHPs that include the essential health benefits to provide coverage at one of the following levels: bronze, silver, gold, or platinum. This requirement would apply regardless of whether or not the plan is offered through an exchange. Each coverage level would be based on a specified share of the full actuarial value of the essential health benefits (see **Figure 1**). A health insurance issuer that offers coverage in any of these four levels would be required to offer the same level of coverage in a plan specifically designed for individuals under age 21.

Figure 1. Actuarial Values for Levels of Coverage



Source: CRS analysis of the Nature of a Substitute to H.R. 3590, Patient Protection and Affordable Care Act.

A health plan that did not provide coverage that meets the levels described above would be allowed to offer a catastrophic plan. A catastrophic plan would provide coverage for essential health benefits and have deductibles equal to the amounts specified as out-of-pocket limits for qualified HDHPs. Such deductibles would not apply to at least three primary care visits. A catastrophic plan would be permitted only for young adults (those under age 30 before the plan year begins) and those persons exempt from the individual mandate because no affordable coverage is available or they have a hardship exemption.

State Flexibility in Operation and Enforcement of Exchanges

The Senate bill would require the Secretary, in consultation with the National Association of Insurance Commissioners (NAIC), to set standards for exchanges, QHPs, reinsurance, and risk adjustment as soon as possible after enactment. It would further require states to implement these standards by 2014. If the Secretary determines before 2013 that a state will not have an exchange operational by 2014, or will not be able to implement the standards, the Secretary would be required to establish and operate an exchange in the state and to implement the standards. The Senate bill would presume that a state operating an exchange before 2010 meets the standards, but would require the Secretary to establish a process to assist a state in coming into compliance with the standards, should the Secretary find that a state is not in compliance.

Consumer Operated and Oriented Plan (CO-OP)

Under H.R. 3590, as passed by the Senate, the creation of new health insurance cooperatives would be encouraged primarily through the distribution of $6 billion in funding under the Consumer Operated and Oriented Plan (CO-OP) program. The Secretary would use the authorized funds to foster the creation of new nonprofit member-run health insurance issuers that offer QHPs in the individual and small group markets.[41] Federal funds would be distributed as loans for start-up costs and grants for meeting solvency requirements.

Under H.R. 3590, as passed by the Senate, the Secretary would make grant and loan awards, no later than July 1, 2013, after taking into account the recommendations of the advisory board.[42] The Secretary would make grant and loan awards giving priority to applicants that offer QHPs on a statewide basis, that use an integrated care model, and have significant private support.[43] The Secretary would ensure that there is sufficient funding to establish at least one qualified nonprofit health insurance issuer in each state and the District of Columbia. If no health insurance issuer applies within a state, the Secretary would use funds for the program to award grants to encourage the establishment of qualified issuers within the state or the expansion of an issuer from another state to the state with no applicants. Grantees would enter into an agreement with the Secretary to follow the provisions of the bill, and any regulations promulgated by the Secretary. The agreement would include prohibitions for the use of loan or grant funds for carrying on propaganda, attempting to influence legislation, or marketing.

The Senate bill would define a qualified nonprofit health insurance issuer as an organization meeting the following requirements:

- It must be organized as a nonprofit, member corporation under state law.

[41] The definition at section 1301 of QHPs requires that a health insurance issuer offer at least one QHP at the silver and gold levels in an exchange, but not all its offering would be required to participate in the exchange.

[42] The advisory board would consist of 15 members appointed by the Comptroller General and would be subject to ethics and conflict of interest standards protecting against insurance industry involvement and interference. Board members would receive no compensation, but would be reimbursed for their travel expenses.

[43] Not later than July 1, 2013, and prior to awarding loans and grants under the CO-OP program, the Secretary would promulgate regulations with respect to the repayment of loans and grants in a manner that is consistent with state solvency regulations and other similar state laws that may apply. In promulgating such regulations, the Secretary would provide that such loans would be repaid within 5 years and such grants would be repaid within 15 years, taking into consideration any appropriate state reserve requirements, solvency regulations, and requisite surplus note arrangements that must be constructed in a state to provide for such repayment prior to awarding such loans and grants.

- It must not be an existing organization that provides insurance as of July 16, 2009, and must not be an affiliate or successor of any such organization.
- Substantially all of its activities must consist of the issuance of QHPs in the individual and small group markets in each state in which it is licensed to issue such plans.
- It must not be sponsored by a state, county, or local government, or any government instrumentality.
- Its governing documents incorporate ethics and conflict of interest standards protecting against insurance industry involvement and interference.
- Governance of the organization must be subject to a majority vote of its members.
- It must operate with a strong consumer focus, including timeliness, responsiveness, and accountability to members in accordance with regulations to be promulgated by the Secretary of HHS.
- Any profits made would be required to be used to lower premiums, improve benefits, or other programs intended to improve the quality of health care delivered to members.
- It must meet all the requirements that other issuers of QHPs in any state where the issuer offers a QHPs, including solvency and licensure requirements, rules on payment to providers, network adequacy standards, rate and form filing rules, applicable state premium assessments, and any other applicable state law.
- It must coordinate with state insurance reforms by not offering a health plan in the state until that state has in effect the market reforms required by the H.R. 3590.

The Senate bill would permit qualified nonprofit health insurance issuers participating in the CO–OP program to enter into collective purchasing arrangements for services and items that increase administrative and other cost efficiencies, especially to facilitate start-up of the entities, including claims administration, general administrative services, health information technology, and actuarial services. The Senate bill would also permit establishment of a purchasing council to execute these collective purchasing agreements. The council would be explicitly prohibited from setting payment rates for health care facilities and providers. There would not be any representatives of federal, state, or local government or any employee or affiliate of an existing private insurer on the council. The Secretary of HHS would be prohibited from participation in any negotiations between qualified health insurance issuers or a private purchasing council and any health care facilities, providers or drug manufacturer. The Secretary would also be prohibited from establishing or maintaining a price structure or interfering in any way with the competitive nature of providing health benefits through the program.

Under the Senate bill, a CO–OP program grantee qualifies for exemption from federal income tax only with respect to periods for which the organization is in compliance with the requirements of the CO–OP program and with the terms of any CO–OP grant or loan agreement to which such organization is a party. CO–OP organizations would also be subject to organizational and operational requirements applicable to certain nonprofits under tax law, including the prohibitions on net earnings benefiting any private shareholder or individual, on substantial involvement in political activities, and on lobbying activities. CO–OP grantees would be required to file an

application for exempt status with the Internal Revenue Service and would be subject to annual information reporting requirements. In addition, CO–OP grantees would be required to disclose on their annual information return the amount of reserves required by each state in which it operates ("solvency requirement") and the amount of reserves on hand.

Level Playing Field

The Senate bill would require that QHPs in the CO-OP program, under the Community Health Insurance Option discussed below, or as a nationwide plan, to be subject to all federal and state laws applicable to private health insurers.

State Flexibility to Establish a Basic Health Program

There is no existing federal law providing direct ongoing program financing to the states for health insurance coverage of low-income individuals not eligible for Medicaid either under standard criteria or via waivers. However, the Senate bill would establish a program to support this population modeled after the Washington State Basic Health (BH) Plan program administered and financed by the Washington State Health Care Authority (HCA). BH started as a pilot program established by the Washington State "Health Care Access Act of 1987."[44] The Senate bill would create a state option for individuals who are not eligible for Medicaid, have not reached the age of 65, and whose household income exceeds 133%, but does not exceed 200% of the poverty line for the size of the family involved.

The Senate bill would require the Secretary to establish a program where a state or a regional compact of states would establish one or more standard health plans. The Secretary would transfer to the state for each fiscal year for which one or more standard health plans are operating within the state the amount equal to 95% of the premium tax credits under section 36B of the IRC of 1986, and the cost-sharing reductions under section 1402, that would have been provided for the fiscal year to eligible individuals enrolled in standard health plans if such eligible individuals were allowed to enroll in QHPs through an exchange. A standard heath plan would be defined as a health benefits plan that the state contracts with that

- would not be open for enrollment to a broad group of individuals, but only to individuals eligible for the program;[45]
- provides at least the essential health benefits defined by the bill; and
- in the case of a plan that provides health insurance coverage offered by a health insurance issuer, has a medical loss ratio of at least 85%.

The Senate bill would provide that a state basic health program establish a competitive process for entering into contracts with standard health plans including negotiation of premiums and cost-

[44] "Basic Health Plan 2008 Annual Report" http://www.basichealth.hca.wa.gov/documents/2008AnnualReport.pdf.

[45] In other words, the plan would be program specific and not open to the broader market. Eligibility requirements include being a resident of the State that is not eligible to enroll in Medicaid; whose household income exceeds 133%, but does not exceed 200% of the poverty line for the size of the family involved; who is not eligible for minimum essential coverage (as defined in section 5000A(f) of 23 the Internal Revenue Code of 1986); or is eligible for an employer-sponsored plan; and has not attained the age of 65 as of the beginning of the plan year.

sharing and negotiation of benefits in addition to the essential health benefits. The competitive process would consider the following:

- innovative features including, but not limited to care coordination and care management (emphasizing chronic conditions);
- incentives for use of preventive services, and establishment of patient/doctor relationships that maximize patient involvement in health care decision-making;
- contracting with managed care systems or with systems that offer as many of the attributes of managed care as feasible in the local health care market; and
- specific performance measures and standards for coverage of providers that focus on quality of care and improved outcomes, in addition to requiring providers to report measures and standards.

Under the Senate bill, states would be instructed to seek participation by multiple health plans to allow enrollees a choice between two or more plans, whenever possible. States would also be allowed to enter into health care choice compacts to form multi-state risk pools for the purposes of negotiating with health care systems. State administrators would be encouraged to find ways to integrate their negotiations with any Medicaid or other state administered health care programs to maximize efficiency and improve the continuity of care between all state administered health programs.

Waiver for State Innovation

Beginning in 2017, the Senate bill would permit states to apply for a waiver for up to five years of requirements relating to QHPs, exchanges, cost-sharing reductions, tax credits, the individual responsibility requirement, and shared responsibility for employers. The state applying for the waiver would be required to enact a law, provide a 10-year budget plan ensuring budget neutrality for the federal government, and to comply with regulations that ensure transparency. The Secretary would be required to provide to a state the aggregate amount of tax credits and cost-sharing reductions that would have been paid to residents of the state in the absence of a waiver. The Secretary would only be permitted to grant a request for a waiver if the Secretary determined that the state plan would

- provide coverage that is at least as comprehensive as the coverage offered through exchanges as certified by Office of the Actuary of the Centers for Medicare & Medicaid Services based on sufficient data from the state and from comparable states about their experience with programs created by H.R. 3590;
- provide coverage and cost sharing protections against excessive out-of-pocket spending;
- provide coverage to at least a comparable number of its residents as would be provided without the waiver; and
- not increase the federal deficit.

Offering Plans in More Than One State

Under the Senate bill, not later than July 1, 2013, the Secretary, in consultation with NAIC, would promulgate regulations for interstate health care choice compacts, which could be entered into beginning in 2016. Under such compacts, QHPs would be offered in all participating states, but insurers would still be subject to the consumer protection laws of the purchaser's state. Insurers would be required to be licensed in all participating states and to clearly notify consumers that a policy may not be subject to all the laws and regulations of the purchaser's state. The bill would also require that states enact a law to enter into compacts and to obtain approval of the Secretary, but only if the Secretary determines that the compact will provide coverage that is at least as comprehensive and affordable, to at least a comparable number of residents, as would otherwise be provided. Moreover, the bill would require that the compact would not increase the federal deficit or weaken enforcement of state consumer protection laws.

This provision would also allow insurers in the individual and small group markets to offer a QHP nationwide, which would be subject not only to the state benefit mandate laws of the state in which the plans are issued, but would require such plans to provide the essential benefits package. States would be permitted to enact a law to opt out of allowing the offering of nationwide plans. Insurers would be required to file plan forms for review with each state.

American Health Benefit Exchanges

Exchange Structure

In addition to establishing new federal private health insurance standards, the bill would enable and support states' creation of "American Health Benefit Exchanges," similar in many respects to existing entities like the Massachusetts Connector and eHealthInsurance. Exchanges would not be insurers, but would provide qualified individuals and small businesses with access to insurers' QHPs[46] in a comparable way (in a similar way, for example, that Travelocity or Expedia are not airlines but provide access to available flights and fares in a comparable way). Exchanges would be state-established government or nonprofit entities that would have additional responsibilities as well, such as certifying plans and identifying individuals eligible for Medicaid, CHIP, and premium and cost-sharing credits.

Within one year of enactment, the Secretary would determine and make grant awards to states to create exchanges, with such sums appropriated as necessary. The grants could be renewed to states making progress in establishing an exchange, implementing the private health insurance market reforms, and meeting other benchmarks established by the Secretary. However, no grant could be awarded after January 1, 2015. Exchanges would have to be self-sustaining by then, using assessments on insurers or some other way to generate funds to support their operations.

States would be required to have implemented the market reforms and to have established an exchange by January 1, 2014. If states have not elected to do so, or if the Secretary determines by January 1, 2013, that a state will not have an exchange operational in time or will not have taken

[46] QHPs are described in an earlier section. An exchange could only make available (1) QHPs, and (2) standalone dental plans meeting certain requirements regarding pediatric dental benefits.

necessary actions to implement the private market reforms, then the Secretary would implement and enforce those requirements, and would establish and operate an exchange—either directly or through an agreement with a nonprofit entity. [47]

The bill permits the creation of separate exchanges in each state for individuals versus small employers ("a Small Business Health Options Program … [or] SHOP exchange'"),[48] for which the Secretary would provide technical assistance to states. A state would be permitted to merge them into a single exchange, "but only if the exchange has separate resources to assist individuals and employers."[49]

An exchange could be permitted to operate in multiple states, if each state agrees to the operation of the exchange and if the Secretary approves. A state could have more than one exchange ("subsidiary exchanges") if each served a geographically distinct area and the area served was adequately large.

New individual and small-group QHPs could be offered inside and outside of an exchange, but the premiums would have to be the same.[50] However, premium credits, cost-sharing subsidies and, where available, the community health insurance or CO-OP options, would only be available through an exchange.

The bill specifies several minimum requirements of an exchange:

- implement procedures to certify, recertify and decertify QHPs;
- provide for the operation of a toll-free hotline;
- maintain a website through which individuals can view standardized comparative information on plans;
- assign a rating to each exchange plan based on criteria developed by the Secretary;
- use a standardized format for presenting exchange plan options;
- inform individuals of eligibility requirements for Medicaid, CHIP or any other state or local program and, if through the screening process the exchange determines they are eligible for one of those programs, enroll them;
- provide for a calculator to determine the actual cost of coverage to individuals after taking into account any premium credits and cost-sharing subsidies;
- certify whether individuals are exempt from the individual mandate excise tax and transfer the list of such individuals to the Treasury Secretary;
- provide to employers the name of the employees who dropped the employer's coverage and received premium tax credits because the employer's plan was unaffordable or did not provide the required minimum actuarial value; and

[47] Sec. 1321(c).

[48] Sec. 1311(b)(1)(B).

[49] Sec. 1311(b)(2).

[50] Sec. 1301(a)(1)(C)(iii). See also 1312(d)(1), (2), and (3)(B).

- establish the Navigator program.[51]

The Secretary would also establish procedures under which a state could permit insurance agents or brokers to enroll individuals in an exchange plan and to assist them in applying for premium credits and cost-sharing subsidies.

The Secretary, in coordination with the HHS Inspector General, would have authority to investigate exchanges. Exchanges would be subject to annual HHS audits. If the Secretary found serious misconduct, payment otherwise due to the exchange could be rescinded, up to 1% of such payments, until corrective actions are taken that are deemed adequate by the Secretary. By January 1, 2019, GAO would conduct an ongoing study on exchange activities and the enrollees in exchange plans, reviewing the operation and administration of exchanges, any significant observations regarding the use and adoption of exchanges, recommendations for their improvement, and how many physicians are not accepting new patients enrolled in federal government health care programs and whether those programs' available provider networks are adequate.

Individual and Employer Eligibility for Exchange Plans

Individuals could enroll in a plan through their state's exchange if they are (1) residing in a state that established an exchange, (2) not incarcerated, except individuals in custody pending the disposition of charges, and (3) lawful residents. Only lawful residents could obtain exchange coverage; undocumented aliens would be prohibited from obtaining coverage through an exchange, even if they could pay the entire premium without any subsidy.[52]

Initially, only small employers could opt to offer coverage to their workers through an exchange. (They would have to make all of their full-time employees exchange eligible.) Before 2016, states would have the option to define "small employers" either as those with (1) 100 or fewer employees, or (2) 50 or fewer employees. Beginning in 2016, small employers would be defined as those with 100 or fewer employees. Beginning in 2017, states could allow large employers to obtain coverage through an exchange (but could not be required to do so). Participating employers could limit their workers' choice of exchange plans to a particular benefit level (tier); workers could then choose any available exchange plan at that level (e.g., silver).

Premium Credits and Cost-Sharing Subsidies

Some individuals would be eligible for premium credits (i.e., subsidies) toward their required purchase of health insurance, based on income. However, even when individuals have health insurance, they may be unable to afford the cost-sharing (deductible and copayments) required to obtain health care. Thus subsidies may also be necessary to lower the cost-sharing. Under the bill, those eligible for premium credits would also be eligible for cost-sharing subsidies. Cost-sharing

[51] H.R. 3590 would require exchanges to establish a grant program for Navigators, which would receive funding from exchanges (not the federal government) to conduct public education activities regarding the availability of QHPs, distribute fair and impartial information on enrollment in plans and subsidies, facilitate enrollment in a qualified plan, provide referrals to individuals with grievances or questions, and provide information in a culturally and linguistically appropriate manner.

[52] Sec. 1312(f)(3). For more information about the treatment of noncitizens under the legislation, see CRS Report R40889, *Noncitizen Eligibility and Verification Issues in the Health Care Reform Legislation*, by Ruth Ellen Wasem.

subsidies would only be available for silver plans sold through an exchange, including private plans and, where available, the public option and cooperatives.

Premium Credits

Beginning January 1, 2014, qualifying individuals could receive advanceable, refundable tax credits toward the purchase of an exchange plan. Individuals above 400% of the federal poverty level (FPL) would not be eligible for credits. Based on the premium of the second lowest cost silver plan available to the individual in an exchange, qualifying individuals between 300% and 400% FPL would have to pay no more than 9.8% of their incomes in premiums. For qualifying individuals with income above 133% to 300% FPL, the percent of income they would have to pay toward premiums would rise in a straight line from 4% of income to 9.8% of income, as illustrated in the solid line of **Figure 2** and in **Table 2** below.[53] Qualifying individuals at or below 133% FPL would pay no more than 2% of income toward premiums. Currently, for a family of three in the 48 contiguous states, 133% FPL is $24,352, and 400% FPL is $73,240.[54] The current dollar amount of income those maximum out-of-pocket premium payments represent are also shown in **Table 2**. The premium credits are described in greater detail CRS Report R40935, *Health Insurance Premium Credits in Senate-Passed H.R. 3590*.

As mentioned above, the premium credit amount would be based on the second lowest cost silver plan available to the individual in an exchange. Individuals who enrolled in more expensive plans would have to pay any additional amount. However, the cost-sharing subsidies would only be available to credit-eligible individuals enrolled in a silver plan.

Table 2. Maximum Out-of-Pocket Premium Payments Under Senate-Passed H.R. 3590, If Currently Implemented

for the 48 contiguous states and the District of Columbia

Federal Poverty Line (FPL)	Maximum Premium as a % of Income	Maximum Annual Premium (current), by Family Size			
		1	2	3	4
100%	2.0%	$217	$291	$366	$441
133.00%	2.0%	$288	$388	$487	$587
133.01%	4.0%	$570	$766	$963	$1,160
150%	4.6%	$739	$994	$1,250	$1,505
200%	6.3%	$1,365	$1,836	$2,307	$2,778
250%	8.1%	$2,180	$2,932	$3,685	$4,438
300%	9.8%	$3,184	$4,284	$5,383	$6,483
350%	9.8%	$3,715	$4,998	$6,280	$7,563
400%	9.8%	$4,245	$5,711	$7,178	$8,644

[53] In years after 2014, the percentages would be adjusted to reflect any percentage by which premium growth exceeded income growth.

[54] 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. Per P.L. 111-118, the 2009 FPLs will be in effect until at least March 1, 2010.

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 Senate-passed H.R. 3590—for the second least expensive Silver plan available to eligible individuals. Per P.L. 111-118, the 2009 FPLs will be in effect until at least March 1, 2010. If individuals choose more expensive plans, they would be responsible for additional premiums.

Although the Medicaid provisions of the bill are generally beyond the scope of this report, eligibility for Medicaid as expanded under the bill interacts with the provisions regarding premium credits and cost-sharing subsidies available for exchange coverage. From 2011 to 2013, states would have the *option* to expand Medicaid to all non-elderly, non-pregnant individuals (i.e., childless adults and certain parents, except for those ineligible based on certain noncitizenship status) who are otherwise ineligible for Medicaid up to 133% FPL. Beginning in 2014, states would be *required* to extend Medicaid to these individuals. Thus, in 2014, all non-elderly *citizens* and certain legal aliens up to 133% FPL would be eligible for Medicaid. (If a person who applied for exchange coverage was determined to be eligible for Medicaid, the exchange would have them enrolled in Medicaid.[55]) The bill would not change noncitizens' eligibility for Medicaid. [56] Thus, for example, certain legal permanent residents (LPRs) who are below 133% FPL would be ineligible for Medicaid. However, when the credits become available in 2014, lawfully present taxpayers below 133% FPL who are not eligible for Medicaid could be eligible for premium credits.[57]

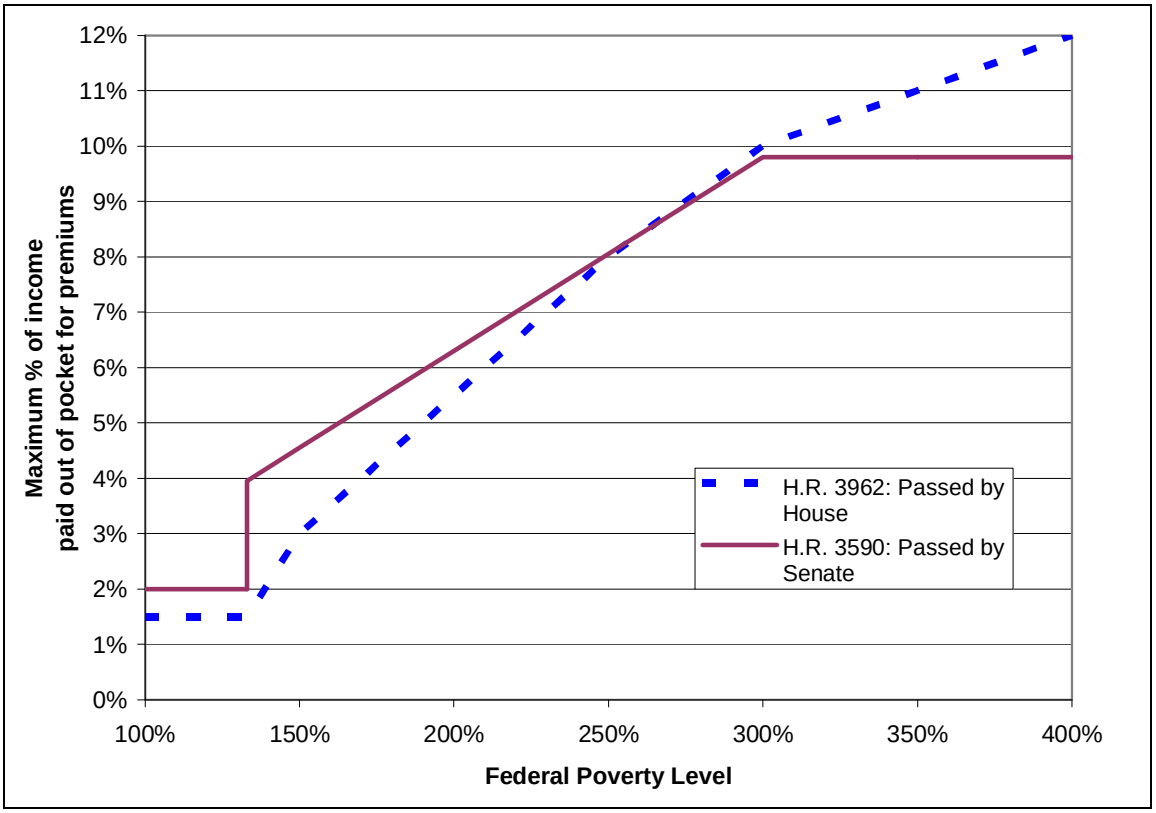
Besides the previously mentioned eligibility criteria, individuals would also generally be ineligible for credits if they were *eligible* for Medicare, Medicaid, CHIP, coverage related to military service, an employer-sponsored plan, a grandfathered plan, and other coverage recognized by the Secretary. An individual eligible for, but not enrolled in, an employer-sponsored plan could still be eligible for subsidies if the employee's contribution to premiums exceeded 9.8% of household income or if the plan's payments cover less than 60% of total allowed costs, as long as the individual qualified for the credit on the basis of their income.

[55] Sec. 1311(d)(4) and Sec. 1413(a).

[56] As under current law, certain legal aliens would be eligible for full Medicaid benefits (e.g., refugees and some legal permanent residents (LPRs) who have been here at least five years) while others would not (e.g., certain LPRs who have been here less than five years).

[57] For more information about the treatment of noncitizens and the verification of individuals' eligibility for premium credits under the various bills, see CRS Report R40889, *Noncitizen Eligibility and Verification Issues in the Health Care Reform Legislation*, by Ruth Ellen Wasem.

Figure 2. Maximum Out-of-Pocket Premiums for Eligible Individuals, by Federal Poverty Level (FPL)



Source: CRS analysis.

Cost-Sharing Subsidies

Those who qualify for premium credits and are enrolled in an exchange plan at the silver tier would also be eligible for assistance in paying any required cost-sharing for their health services. As previously mentioned, exchange plans would be required to limit out-of-pocket costs based on high deductible health plans (HDHPs) that qualify individuals for health savings accounts (HSAs). For 2010, the out-of-pocket maximum for HSA-qualified HDHPs is $5,950 for single coverage and $11,900 for family coverage.[58] As shown in **Table 3**, the cost-sharing subsidies would further reduce those out-of-pocket maximums by two-thirds for qualifying individuals between 100% and 200% FPL, by one-half for qualifying individuals between 201% and 300% FPL, and by one-third for qualifying individuals between 301% and 400% FPL. Additional cost-sharing subsidies (i.e., reductions in copayments, deductibles, etc.), if necessary, would be provided to ensure that the plan cost-sharing was equivalent to the platinum tier for qualifying individuals between 100% and 150% FPL, was equivalent to the gold tier for qualifying individuals between 151% and 200% FPL, but was not more than the silver tier for qualifying individuals between 201% and 400% FPL.

[58] Internal Revenue Service (IRS) Rev. Proc. 2009-29, Section 2, available at http://www.irs.gov/pub/irs-drop/rp-09-29.pdf.

The Secretary would make periodic payments to insurers (potentially using capitated, risk-adjusted payments) for the cost-sharing subsidies of their qualified enrollees. However, subsidy amounts could also be reduced to ensure H.R. 3590 does not increase the federal deficit.

Table 3. Cost-Sharing Subsidies in H.R. 3590: Average Percentage of Covered Benefits Paid by Plan, and Out-of-Pocket Maximum, by Income Tier

Federal poverty level (FPL)	Out-of-pocket limit relative to maximum permissible for HSA-qualified high deductible health plans	Benefit tier equivalent from additional cost-sharing subsidies
Up to 150%	Reduced two-thirds	Equal to platinum
151% - 200%	Reduced by two-thirds	Equal to gold
201% - 300%	Reduced by one-half	Not more than silver
301% - 400%	Reduced by one-third	Not more than silver

Source: CRS analysis of Senate-passed H.R. 3590.

Multi-State Qualified Health Plans

Under the Senate bill, the Director of the Office of Personnel Management (OPM) would enter into contracts with health insurance issuers to offer at least two multi-state qualified health plans (MSQHPs) through each exchange in each state, providing individual, or in the case of small employers, group coverage. Any individual eligible to purchase insurance through the exchange could enroll in a MSQHP. Enrollment would be voluntary and individuals could be eligible for premium credits and cost-sharing assistance.

A health insurance issuer offering a MSQHP would have to meet the requirements in each exchange in each state; be licensed in each state and subject to all requirements of state law not inconsistent with this section (including the standards and requirements that a state imposes that do not prevent the application of a requirement of relating to health insurance coverage in the Public Health Service Act or a requirement of this title); comply with the minimum standards prescribed for carriers offering health benefits plans under the Federal Employees Health Benefits Program (FEHBP); and met other requirements as determined appropriate by the Director, in consultation with the Secretary.

Additionally an MSQHP would be required to offer a uniform benefits package in each state consisting of the essential benefits; meet all requirements of a qualified health plan, including requirements relating to the offering of the bronze, silver, and gold levels of coverage and catastrophic coverage in each state exchange; meet the rating requirements of this Act (except for certain state rating requirements); and offer the plan in all geographic regions, and in all states that adopted adjusted community rating before the date of enactment of this Act.

Each contract for an MSQHP would be for at least one year, and could be automatically renewed if neither party provided notice to terminate. At least one contract would be with a non-profit entity. The Director would enter into a contract with a health insurance issuer if the issuer offered the plan in at least 60% of states in the first year, at least 70% in the second year, at least 85% in the third year, and in all states thereafter.

The Director would implement this section of the bill similar to the way the Director implements the contracting provisions with respect to carriers under FEHBP—through negotiating with each MSQHP on (1) medical loss ratio, (2) profit margin, (3) premiums to be charged, and (4) such other terms and conditions of coverage as are in the interests of enrollees in such plans. The Director could prohibit the offering of any MSQHP that did not meet these terms and conditions.

States could require additional benefits, but there would be no additional premium tax credit provided for the state-only mandated benefits. The states would make payments to an individual enrolled in a multi-state plan or on behalf of such an individual to defray the cost of additional benefits.

The requirements of the FEHBP program would only apply to MSQHPs to the extent that they were not in conflict with the requirements of this Act. The Director could not reduce financial or personnel resources to the functions of OPM related to the administration of FEHBP. The Director could (1) establish separate units or offices within OPM, to ensure that the administration of MSQHPs did not interfere with the administration of FEHBP, and (2) appoint additional personal to carry out activities under this section. The program under this section would be separate from FEHBP, with a separate risk pool and FEHBP plans would not be required to offer a MSQHP.

Selected Revenue Provisions Relating to Private Health Insurance

H.R. 3590 includes a number of provisions in Title IX that would raise revenues in order to pay for expanded health insurance coverage. The revenue provisions would include excise taxes and limitations on employer deductions that would impact health insurers, health plan sponsors and administrators. In addition, there are a number of revenue provisions that would affect workers through modifications to current tax-advantaged accounts and deductions used for health care spending and coverage. **Table 4** shows those revenue provisions directly related to private health insurance, their effective dates and estimates by the Joint Committee on Taxation (JCT) of the revenues each provision will raise over a 10-year period. According to the JCT, these provisions are expected to raise $249.3 billion in revenues over a 10-year period.[59]

[59]The Senate bill would also impose an additional Medicare tax of 0.9% on high-income workers with wages over $200,000 for single filers and $250,000 for joint filers effective for taxable years after December 31, 2012.

Table 4. Selected Revenue Provisions in Title IX of H.R. 3590

	Effective Date	Increase in Revenues (FY2010-FY2019)
Excise Taxes and Limitations On Employer Deductions		
40% Excise Tax on High-Cost Plans	January 1, 2013	$148.9 billion
Impose Annual Fee On Health Insurance Providers	January 1, 2011	$59.6 billion
Eliminate Deductions for Expenses Allocable to Medicare Part D subsidy	January 1, 2011	$5.4 billion
Limit deduction for compensation to $500,000 for executives of health insurance companies	December 31, 2012[a]	$0.6 billion
Modifications to Tax-Advantaged Accounts and Itemized Deductions Used for Health Care		
Limit Health Flexible Spending Accounts (FSAs) to $2,500	January 1, 2011	$13.3 billion
Raise penalty for non-qualified HSA withdrawals from 10% to 20%	January 1, 2011	$1.3 billion
Change the definition of medical expenses for FSAs and Health Savings Accounts (HSAs)	January 1, 2011	$5.0 billion
Raise 7.5% floor for itemized medical expenses to 10% for those under age 65.	January 1, 2013	$15.2 billion
Total Revenues Relating To Private Health Insurance	—	$249.3 billion

Source: Joint Committee on Taxation, December 19, 2009, JCX-61-09

Notes: This table does not include those revenue provisions not directly related to health insurance coverage or the addition of SIMPLE Cafeteria plans for small businesses which are discussed in the Small Business section.

a. Effective for remuneration paid in taxable years beginning after 2012 with respect to services performed after 2009.

Excise Taxes and Limitations on Employer Deductions

The Senate bill would impose excise taxes on health insurers and health plan administrators.[60] Specifically, two provisions would impose the following taxes directly on health insurers and plan administrators:

- an excise tax on high-cost employer-sponsored health insurance, and
- an annual fee on health insurance providers.

In addition, the bill would limit the deductibility of compensation for health insurance executives. The bill would also limit the ability of employers to deduct from their taxable income federal subsides for retiree prescription drug coverage. The following discusses these provisions in greater detail.

[60] There is also an excise tax on health care manufacturers (e.g., medical devices and branded prescription drugs). See CRS Report RL32826, *The Medical Device Approval Process and Related Legislative Issues*, by Erin D. Williams, for a discussion of proposed excise taxes on health care device manufacturers.

Excise Tax on High-Cost Employer-Sponsored Health Insurance Coverage

H.R. 3590 would impose an excise tax of 40% on health insurers and health plan administrators for coverage that exceeds certain thresholds in 2013. The thresholds are $8,500 for single coverage and $23,000 for family coverage, and would be indexed by growth in the Consumer Price Index (CPI) plus 1% in subsequent years. Taxpayers who are retired and ages 55 to 64, and workers engaged in high risk professions would be subject to higher thresholds ($9,850 for single coverage and $26,000 for family coverage in 2013). In addition, for individuals residing in high-cost states the thresholds would be phased in between 2013 and 2016.[61] Specifically, they would be 20% above the proposed levels in 2013, 10% above in 2014, and 5% above in 2015.

Health insurance coverage subject to the excise tax is broadly defined to include not only the employer and employee premium payments for health insurance (including self-insured plans), but also premiums paid by the employee and the employer for dental and vision. In addition, tax-advantaged accounts such as flexible spending accounts (FSAs), health savings accounts (HSAs) and health reimbursement accounts (HRAs) are also specified as health insurance coverage and subject to the excise tax. For these tax-advantaged accounts, the plan administrator (which is often the employer) would be subject to the excise tax. The excise tax would be levied on each of these components (i.e., health insurance, dental and vision, FSAs, etc.) based on their share of the total for health insurance coverage. This share would then be applied to the amount of the total contribution that exceeds the applicable threshold to determine the excise tax imposed on each component.

The Senate bill would impose additional reporting requirement on employers providing health insurance coverage. Specifically, employers would be responsible for

- determining the aggregate amount of health insurance coverage subject to the excise tax,
- estimating the share of the tax allocated to the insurer and the plan administrator,
- reporting these amounts to the insurer, plan administrator and the Internal Revenue Service, and
- reporting the total value of health insurance coverage subject to the excise tax on the worker's W2 form.

Employers who under-report the amount of the excise tax to be paid by insurers and plan administrators would be subject to a penalty. The amount of the excise tax would not be deductible from federal income taxes.

The Joint Committee on Taxation (JCT) has estimated that the excise tax would raise about $149 billion in revenues from 2010 to 2019.[62]

[61] The Secretary of HHS will determine the 17 highest costs states (in terms of health insurance premiums) based on the most recent available data as of August 31, 2012.

[62] Joint Committee on Taxation, December 19, 2009, JCX-61-09.

Annual Fee on Health Insurance Plans

In addition to an excise tax on high-cost plans, the bill would also impose a fee on all health insurers based on their market share. The fee would be applied to net premiums written and would be imposed beginning in 2010.[63] The fee would not apply to self-insured plans or federal, state or government entities. Certain non-profit insurers who have medical loss ratios within specific limits would also be excluded. However, the annual fee would apply to companies or organizations that underwrite these government-funded insurance (i.e., Medicaid managed care plans, Federal Employees Health Benefits Program [FEHBP]). According to the JCT, this fee is expected to raise about $60 billion over a 10-year period (see **Table 4**).

Limitation on Deduction for Executive Compensation of Health Insurers

H.R. 3590 would limit the amount of executive compensation that is deductible by health insurers. Specifically, health insurance providers where at least 25% of their gross premium income is derived from health insurance plans that meet the minimum creditable coverage requirements (i.e., covered health insurance provider) would not be able to deduct compensation above $500,000 per year. This income threshold would include deferred compensation. This provision would be effective for compensation paid in taxable years beginning after 2012 with respect to services performed after 2009. According to the JCT, this limitation on executive compensation would raise $600 million over a 10-year period (see **Table 4**).

Eliminate Employer Deduction for Retiree Prescription Drug Plans Eligible for Federal Subsidy

Under current law, employers who provide their retirees with prescription drug coverage that meets or exceeds federal standards are eligible for subsidy payments from the federal government. These qualified retiree prescription drug plan subsidies are excludible from the employer's gross income for the purposes of regular income tax and alternative minimum tax calculations. The employer is also allowed to claim a business deduction for retiree prescription drug expenses even though they also receive the federal subsidy to cover a portion of those expenses. The bill would require employers to coordinate the subsidy and the deduction for retiree prescription drug coverage. The amount allowable as a deduction for retiree prescription drug coverage would be reduced by the amount of the federal subsidy received. According to the JCT, this provision would raise $5.4 billion over a 10-year period (see **Table 4**).

Tax-Advantaged Accounts and Itemized Deductions Used to Pay for Health Care Expenses

There are a number of tax-advantaged accounts and tax deductions for health care spending and coverage that would be affected by the revenue provisions in Title IX of the Senate bill.

[63] See CRS Report R40834, *The Market Structure of the Health Insurance Industry*, by D. Andrew Austin and Thomas L. Hungerford, for information on market share of individual health insurance companies.

Modifications to Tax-Advantaged Accounts

H.R. 3590 includes a number of provisions that directly and indirectly would affect tax-advantaged accounts to help workers pay for their health care expenses. Under current law FSAs, HSAs, HRAs and Medical Saving Accounts (MSAs) all allow workers under varying circumstances to exclude a certain portion of qualified medical expenses from income taxes.[64]

Under current law, health FSAs are employer-established benefit plans that reimburse employees for specified health care expenses (e.g., deductibles, co-payments, and non-covered expenses) as they are incurred on a pre-tax basis.[65] About one-third of workers in 2007 have access to an FSA.[66] Each employer may set their limits on FSA contributions. In 2008, the average FSA contribution was $1,350.[67] The bill would limit the amount of annual FSA contributions to $2,500 per FSA beginning in 2011. According to the JCT, this provision would raise $14.6 billion over 10 years (see **Table 4**).

HSAs are also tax-advantaged accounts that allow individuals to fund unreimbursed medical expenses (deductibles, copayments, and services not covered by insurance) on a pre-tax basis.[68] Eligible individuals can establish and fund accounts when they have a qualifying high deductible health plan and no other health plan (with some exceptions). Unlike FSAs, HSAs may be rolled over and the funds accumulated over time. Distributions from an HSA that are used for qualified medical expenses are not included in taxable income. Distributions from an HSA that are not used for qualified medical expenses are taxable as ordinary income and, under current law, an additional 10% penalty tax for those under age 65. The Senate bill would raise this penalty on non-qualified distributions to 20% of the disbursed amount. According to the JCT, this provision would raise $1.3 billion over 10 years (see **Table 4**).

H.R. 3590 would also modify the definition of qualified medical expenses. Under current law qualified medical expenses for FSAs, HSAs, and HRAs can include over-the-counter medications. The bill would restrict this practice and exclude over-the counter medications (except those prescribed by a physician) as a qualified medical expense. According to the JCT, this provision would increase revenues by $5 billion over 10 years (see **Table 4**).

Modify Itemized Deduction for Medical Expenses

Currently, taxpayers who itemize their deductions may deduct unreimbursed medical expenses that exceed 7.5% of adjusted gross income (AGI). Medical expenses include health insurance premiums paid by the taxpayer, but also can include certain transportation and lodging expenses related to medical care as well as qualified long-term care costs, and long-term care premiums that do not exceed a certain amount. About 7% of tax returns for tax year 2007 reported a deduction for medical expenses.[69] Taxpayers with adjusted gross income below $50,000

[64] See CRS Report RL33505, *Tax Benefits for Health Insurance and Expenses: Overview of Current Law and Legislation*, by Janemarie Mulvey.

[65] See CRS Report RL32656, *Health Care Flexible Spending Accounts*, by Janemarie Mulvey.

[66] Bureau of Labor Statistics, *Table 24. Pretax benefits: Access, private industry workers*, National Compensation Survey, March 2007.

[67] Mercer Human Resources Consulting, *National Survey of Employer-Sponsored Health Plans 2008.*

[68] See CRS Report RL33257, *Health Savings Accounts: Overview of Rules for 2009*, by Janemarie Mulvey.

[69] Internal Revenue Service, Statistics of Income, *Table 1.3: All Returns: Source of Income, Adjustments, Deductions,* (continued...)

accounted for 52% of those taking this itemized deduction for medical expenses.[70] The bill would increase the threshold to 10% of AGI for taxpayers who are under age 65 which would limit the amount of medical expenses that can be deducted. Taxpayers over age 65 would be temporarily excluded from this provision and still be subject to the 7.5% limit for the time period 2013 and 2016. According to the JCT, this provision would raise revenues by $15.2 billion over 10 years (see **Table 4**).

Other Provisions

Abortion

In addressing the coverage of abortion services by qualified health plans offered through an exchange, H.R. 3590 refers to the so-called "Hyde Amendment" to distinguish between two types of abortions: abortions for which federal funds appropriated for HHS may be used, and abortions for which such funds may not be used. Under the Hyde Amendment, funds appropriated for HHS may be used to pay for an abortion if a pregnancy is the result of an act of rape or incest, or if a woman's life would be endangered if an abortion were not performed. Such funds may not be used, however, for elective abortions. Under H.R. 3590, individuals who receive a premium assistance credit or cost-sharing reduction would be permitted to purchase an exchange plan that includes coverage for elective abortions. However, to ensure that funds attributable to a premium subsidy are not used to pay for elective abortion services, H.R. 3590 prescribes payment and accounting requirements for plan enrollees and issuers.

Under H.R. 3590, the issuer of a qualified health plan would determine whether to provide coverage for either elective abortions or abortions for which federal funds appropriated for HHS are permitted. A plan issuer would also appear able to not cover either type of abortion. In addition, H.R. 3590 would permit a state to prohibit abortion coverage in exchange plans by enacting a law to with such a prohibition.

The issuer of a qualified health plan that provides coverage for elective abortions would be required to collect two separate payments from each enrollee in the plan: one payment that reflects an amount equal to the portion of the premium for coverage of health services other than elective abortions; and another payment that reflects an amount equal to the actuarial value of the coverage for elective abortions. The plan issuer would be required to deposit the separate payments into separate allocation accounts that consist solely of each type of payment and that are used exclusively to pay for the specified services. State health insurance commissioners would ensure compliance with the segregation requirements in accordance with applicable provisions of generally accepted accounting requirements, Office of Management and Budget circulars on funds management, and Government Accountability Office guidance on accounting.

To determine the actuarial value of the coverage for elective abortions, the plan issuer would estimate the basic per enrollee, per month cost, determined on an average actuarial basis, for

(...continued)

Credits and Tax Items, by Marital Status, Tax Year 2007.

[70] Joint Committee on Taxation, *Tax Expenditures: Compendium of Background Material on Individual Provisions*, December 2008.

including such coverage. The estimate could take into account the impact on overall costs of including coverage for elective abortions, but could not take into account any cost reduction estimated to result from such services, such as prenatal care, delivery, or postnatal care. The per month cost would have to be estimated as if coverage were included for the entire population covered, but could not be less than $1 per enrollee, per month.

Under H.R. 3590, a qualified health plan that provides coverage for elective abortions would also be required to provide notice of such coverage to enrollees as part of a summary of benefits and coverage explanation at the time of enrollment. The notice, any plan advertising used by the issuer, any information provided by the exchange, and any other information specified by the Secretary would provide information only with respect to the total amount of the combined payments for elective abortion services and other services covered by the plan.

H.R. 3590 also provides for conscience protection and the preservation of certain state and federal abortion-related laws. The measure would prohibit exchange plans from discriminating against any individual health care provider or health care facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortions. State laws concerning the prohibition or requirement of coverage or funding for abortions, and state laws involving abortion-related procedural requirements would not be preempted. Federal conscience protection and abortion-related antidiscrimination laws, as well as Title VII of the Civil Rights Act of 1964, would not be affected by the bill.

Prohibition Against Discrimination on Assisted Suicide

H.R. 3590 would prohibit the federal government, and any state or local government or health care provider that receives federal financial assistance under this proposed law (or under an amendment made by this proposed law) or any health plan created under this proposed law (or under an amendment made by this proposed law), from subjecting an individual or institutional health care entity to discrimination on the basis that the entity does not provide any health care item or service furnished for the purpose of causing, or assisting in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing. Nothing in the above would be construed to apply or to affect any limitation relating to (1) the withholding or withdrawing of medical treatment or medical care; (2) the withholding or withdrawing of nutrition or hydration; (3) abortion; or (4) the use of an item, good, benefit, or service furnished for the purpose of alleviating pain or discomfort, even if such use may increase the risk of death, so long as it is not also furnished for the purpose of causing, or assisting in causing, death. The HHS Office for Civil Rights would be designated to receive complaints of discrimination based on this section.

Medical Malpractice

H.R. 3590 (Section 6801) expresses the Sense of the Senate that (1) health care reform presents an opportunity to address issues related to medical malpractice and medical liability insurance; (2) states should be encouraged to develop and test litigation alternatives while preserving an individual's right to seek redress in court; and (3) Congress should consider establishing a state demonstration program to evaluate alternatives to the existing civil litigation system with respect to medical malpractice claims.

H.R. 3590 (Section 10607) would authorize the Secretary of Health and Human Services (Secretary) to award demonstration grants to states for the development, implementation, and

evaluation of alternatives to current tort litigation. These grants would exist for no more than five years. Under the provision, a state desiring a grant would be required to develop an alternative that (1) allows for the resolution of disputes caused by health care providers or organizations, and (2) promotes a reduction of health care errors by encouraging the collection and analysis of patient safety data. Each state would have to identify the sources from and methods by which compensation would be paid, and demonstrate that its proposed alternative to tort litigation meets certain goals and criteria. The Secretary is to provide to the states that are applying for the grants technical assistance, including guidance on common definitions, non-economic damages, avoidable injuries, and disclosure to patients of health care errors and adverse events.

The Secretary would consult with a review panel composed of relevant experts appointed by the Comptroller General when reviewing states' applications. Furthermore, each state receiving a grant would be required to submit a report to the Secretary covering the impact of the activities funded on patient safety and on the availability and price of medical liability insurance. Similarly, the Secretary would submit a report to Congress that examines any differences that may result in the area of quality of care, number and nature of medical errors, medical resources used, length of time for dispute resolution, and the availability and price of liability insurance. Additionally, the Secretary, in consultation with the review panel, would conduct an overall evaluation of the effectiveness of grants awarded and to submit the findings of such evaluation to Congress. The Medicare Payment Advisory Commission would also be required to conduct an independent review on the impact of state alternatives implemented on the Medicaid and CHIP programs and its beneficiaries.

The provision would not limit any prior, current, or future efforts of any state to establish any alternative to tort litigation. It would appropriate $50,000,000 for five years beginning FY2011 to carry out this section.

Multiple Employer Welfare Arrangements

H.R. 3590 contains certain provisions intended to combat fraud and abuse relating to multiple employer welfare arrangements (MEWAs). For example, the bill would prohibit persons (in connection with MEWAs) from knowingly making false statements or representations in connection with the marketing or sale of the plan that concerns, among other things, the financial solvency and the benefits provided by the MEWA. Pursuant to regulations promulgated by the Secretary of Labor, MEWAs would be required to register with the Secretary before operating in a state. In addition, the Secretary would have the authority to adopt regulatory standards or issue orders that a person engaged in the business of providing insurance through a MEWA is subject to the laws of the state in which such person operates. The bill would also allow the Secretary to issue cease and desist orders against certain MEWAs if it appears to the Secretary that the alleged conduct of the MEWA is fraudulent, creates an immediate danger to the public safety or welfare, or is causing or can be reasonably expected to cause significant, imminent, and irreparable public injury.

Wellness Programs Offered by Employers/Private Insurers

While the Health Insurance Portability and Accountability Act of 1996 (HIPAA) currently prohibits group health plans and group health insurance issuers from imposing higher premiums or contributions among "similarly situated" participants based on certain health-related factors, it does allow the provision of premium discounts, rebates, or reduced cost-sharing for enrollee

participation in wellness programs. Among other provisions related to wellness programs, the Senate-passed H.R. 3590 would codify an amended version of the HIPAA wellness program regulations.[71] Consistent with current regulation, the bill indicates that wellness programs that do not require an individual to satisfy a standard related to a health factor as a condition for obtaining a reward (or do not offer a reward) would not violate HIPAA, so long as participation in the programs is made available to all similarly situated individuals. However, if any of the conditions for obtaining a reward under a wellness program are based on an individual meeting a certain standard relating to a health factor, the program must meet additional requirements. Among these requirements, the reward must be capped at 30% of the cost of the employee-only coverage under the plan, but the Secretaries of Health and Human Services, 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. Further, this type of wellness program must be reasonably designed to promote health or prevent disease. A program complies with this requirement if it has a reasonable chance of improving the health of, or preventing disease in, participating individuals and it is not overly burdensome; is not a subterfuge for discriminating based on a health status factor; and is not highly suspect in the method chosen to promote health or prevent disease. The bill would also require the Secretary of Health and Human Services, in consultation with the Secretaries of the Treasury and Labor, to establish a 10-state pilot program no later than July 1, 2014, in which participating states would be required to apply the wellness program provisions to health insurers in the individual market.

Tax Treatment of Indian Tribe Health Benefits

H.R. 3590 would exclude the value of specified Indian tribe health benefits from gross income. The exclusion would apply to: (1) health services or benefits provided or purchased by the Indian Health Service (IHS), an Indian tribe or tribal organization or through programs of third parties funded by the IHS; (2) medical care services including those provided, purchased or reimbursed by an Indian tribe or tribal organization or to a member of an Indian tribe and the member's spouse or dependents; (3) accident or health plan coverage (or an arrangement having the same effect) provided by an Indian tribe or tribal organization for medical care to a member of an Indian tribe and the member's spouse or dependents; and (4) any other medical care provided by an Indian tribe that supplements, replaces, or substitutes for the programs and services provided by the federal government to Indian tribes or tribal members. This section would not apply to other benefits provided by Indian tribes, to benefits provided prior to enactment, to qualified health care benefits that are not included in the gross income of the beneficiary or to amounts that beneficiaries are already permitted to deduct. This provision would be effective at enactment.

[71] Sec. 1201, which creates section 2705 of the PHSA.

Appendix. Immediate Individual and Group Market Reforms Under Title I

High-Risk Pools for Individuals with a Preexisting Condition

Not later than 90 days after enactment, the Secretary would establish a temporary high-risk pool program to provide health insurance coverage for eligible individuals during the period beginning on the date the program is established and ending on January 1, 2014. The high-risk pool would be required to not impose any preexisting condition exclusions, and the out-of-pocket limit would not be greater than the amount for health savings accounts under the IRC, except that the Secretary would be permitted to modify the limit if necessary to ensure the pool meets the actuarial limit for the program. The premium rate charged for the high-risk pool coverage would vary on the basis of age by a factor of not greater than 4 to 1 and be established at a standard rate for a standard population. The Secretary would be granted the authority to issue additional requirements determined to be appropriate for the calculation of premium rates. An individual would be eligible if he/she:

- is a citizen or national of the United States or is lawfully present in the United States;
- has not been covered under creditable coverage, in effect on the date of enactment of this Act, during the six-month period prior to the date on which such individual is applying for coverage through the high-risk pool; and
- has a pre-existing condition, as determined in a manner consistent with guidance issued by the Secretary.

Reducing Health Insurance Premiums and Increasing Value

Issuers in the group and individual markets (including grandfathered health plans) would be required to submit to the Secretary a report concerning the ratio of incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums.[72] The report would also include the percentage of total premium revenue, after accounting for risk adjustment, risk corridors, and payments for reinsurance, that the coverage expends on

- reimbursement for clinical services;
- for activities that improve health care quality; and
- on all other non-claims costs including an explanation of the nature of such costs and excluding federal and state taxes, licensing, or regulatory fees.

Beginning not later than January 1, 2011, a health insurance issuer offering group or individual health insurance coverage (including grandfathered health plans) would provide an annual rebate to each enrollee on a pro rata basis if the ratio of the amount of premium revenue expended by the

[72] Beginning on January 1, 2014 , this calculation would be based on the averages of the premiums expended on the costs for each of the previous three years for the plan. The Secretary would make these reports available to the public on the Internet site of the Department of Health and Human Services.

issuer on clinical claims and health quality costs, after accounting for taxes, regulatory fees, risk adjustment, risk corridors, and reinsurance, is less than 85% in the large group market and 80% for the small group and individual markets. States would be permitted to increase the percentages, but the Secretary may adjust the state percentage for the individual market if it is determined that the application of 80% would destabilize the market. The rebate amount would be equal to the product of the amount by which the percentage exceeds the ratio (both described above) and the total amount of premium revenue (excluding federal and state taxes and licensing or regulatory fees) and after accounting for risk adjustment, risk corridors and reinsurance.

No Lifetime or Annual Limits

Under the bill, for plan years prior to January 1, 2014, group health plans and a health insurance issuers offering group or individual plans would be prohibited from establishing lifetime limits on the dollar value of benefits for any participant or beneficiary, or annual limits except with respect to the scope of benefits that are essential health benefits under the bill as determined by the Secretary. The Secretary would ensure that there is access to needed services available with minimal impact on premiums. Group health plans and health insurance issuers would be permitted to place annual or lifetime limits on specific covered benefits that are not essential health benefits, to the extent that such limits are otherwise permitted by federal and state law.

Prohibition on Rescissions

Rescission refers to the practice of canceling medical coverage after policyholders have become sick or injured. The Senate bill would generally prohibit rescissions for a group health plan and a health insurance issuer offering group or individual health insurance coverage. Rescissions would 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 or coverage. A cancellation of coverage in this case would require prior notice to the enrollee.

Sunshine on Health Insurance Premium Rates

The Secretary would, in conjunction with the states, establish a process for the annual review of unreasonable increases in premiums for health insurance coverage beginning in the 2010 plan year. Health insurance issuers would be required to submit to the Secretary, and the relevant state, a justification for an unreasonable premium increase prior to implementation of the premium.

The Secretary would carry out a program of grants to states during the five-year period beginning with FY2010 for carrying out the premium review. There would be appropriated to the Secretary $250 million available for these grants. As a condition of these grants, states would be required to provide the Secretary with information about trends in premium increases and make recommendations about if a particular issuer should be excluded from participation in the exchange due to a pattern or practice of excessive or unjustified premium increases.

Coverage of Preventive Health Services

Under the Senate bill, group health plans and health insurance issuers in the group and individual markets would be required to provide coverage for preventive health services. These preventive services would include the following:

- evidence-based items or services that have in effect a rating of "A" or "B" from the United States Preventive Services Task Force (USPSTF);[73]
- immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC);[74]
- with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA);[75] and
- with respect to women, such additional preventive care and screenings not described by the USPSTF as provided in comprehensive guidelines supported by HRSA.

A plan or issuer would be permitted to cover or deny additional services not recommended by the USPSTF. For the purposes of this section the current recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention would be considered the most current other than those issued in or around November 2009.

The Senate bill would also permit the Secretary to develop guidelines permitting group health plans and health insurance issuers in the group and individual markets to utilize value-based insurance designs. Value-based insurance designs, as defined in prior testimony before the Senate Committee on Budget, refers to coverage that encourages the use of services that have clinical benefits exceeding the costs, while discouraging the use of services when the expected clinical benefits do not justify the costs.[76]

Extension of Dependent Coverage

A group health plan and a health insurance issuer offering coverage in the group or individual markets that provided dependent coverage would extend that coverage to unmarried adult

[73] 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. A rating of "A" means the service is recommended and there is high certainty that the net benefit is substantial. A rating of "B" means the service is recommended, and there is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial. See "U.S. Preventive Services Task Force Grade Definitions" available online at http://www.ahrq.gov/CLINIC/uspstf/gradespost.htm#brec.

[74] The ACIP consists of 15 experts in fields associated with immunization who have been selected by the Secretary of Health and Human Services 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. http://www.cdc.gov/vaccines/recs/acip/.

[75] 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. HRSA provides leadership and financial support to health care providers in every state and U.S. territory. HRSA grantees provide health care to uninsured people, people living with HIV/AIDS, and pregnant women, mothers and children. For more background see http://www.hrsa.gov/about/default.htm.

[76] Statement of Peter R. Orszag "Health Care and the Budget: Issues and Challenges for Reform" before the Committee on the Budget, United States Senate, June 21, 2007.

children until the individual is 26 years of age.[77] This would not apply to a child of the child receiving dependent coverage.

Development and Utilization of Uniform Explanation of Coverage Documents

No later than 12 months after enactment, the Secretary would develop standards for group health plans and health insurance offers in the group and individual markets with respect to providing their enrollees with a summary of benefits (SB) and coverage. The Secretary would periodically review and update the standards developed. The Secretary would consult with the National Association of Insurance Commissioners (NAIC), and representatives of health-insurance related consumer advocacy organizations, health insurance issuers, health care professionals, patient advocates including those representing individuals with limited English proficiency, and other qualified individuals as deemed appropriate. These standards would preempt any standards developed under state law. The standards for the SB are summarized in the table below.

Not later than 24 months after the date of enactment, each plan would provide a SB to an applicant at the time of application, to an enrollee prior to the time of enrollment or re-enrollment, and to a policyholder or certificate holder at the time of issuance of the policy or delivery of the certificate. The SB can be in paper or electronic form. Enrollees would have to be given notice of any materials 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 would be subject to a fine of not more than $1,000 for each such failure, as defined to be each enrollee that did not receive the required information.

Table A-1. Summary of Benefits and Coverage Document Requirements

Issue area	Requirements
Prohibitions	• Cannot exceed 4 pages in length. • Cannot use smaller than 12-point font.
Required description	• 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.

[77] The Federal Employees Health Benefits Program (FEHBP) has a provision in current law for extending depended coverage. It is defined as for unmarried dependent child under 22 years of age at chapter 89 of title 5, United States Code. The Senate bill does not amend this law. Some stakeholders have sought clarification on the applicability of this provision to the FEHBP. For example, see http://www.nteu.org/Documents/FEHBPLetter1-12-10.pdf.

Issue area	Requirements
Other requirements	• 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: CRS analysis of H.R. 3590 as passed by the Senate.

Prohibition of Discrimination Based on Salary

Under the Senate bill, the sponsor of a group health plan (other than a self-insured plan) would be prohibited from establishing rules relating to health insurance eligibility of any full-time employee that are based on the total hourly or annual salary of the employee. In no way would eligibility rules be permitted to discriminate in favor of higher wage employees.

Ensuring the Quality of Care

Beginning upon enactment and concluding not later that two years after enactment, the Secretary would develop reporting requirements for use by a group health plan or health insurance issuers in the group and individual markets including regulations governing acceptable provider reimbursement structures.[78] The Secretary would develop these requirements in consultation with experts in health care quality and stakeholders. Once implemented, plans and health insurance issuers would annually submit to the Secretary and to enrollees a report on the use of the following reimbursement structures and quality programs that

- improve health outcomes through use of quality reporting, case management, care coordination and chronic disease management;
- implement activities to prevent hospitalization readmissions;
- implement activities to improve patient safety and reduce medical errors through the use of best clinical practices, evidence based medicine, and health information technology; and
- implementation of wellness and health promotion activities.[79]

This section also contains provisions relating to gun rights. A wellness or promotion activity could not require disclosure or collection of any information relating to (1) the presence or storage of a lawfully possessed firearm or ammunition in the residence or on

[78] No later than 180 days after promulgation of these regulations the Government Accountability Office (GAO) would also be required to conduct a study regarding the impact of these activities and report their findings to the Senate Committee on Health, Education, Labor, and Pensions, and the House Committee on Energy and Commerce.

[79] Wellness and prevention would be permitted to include health risk assessments and ongoing face-to-face, telephonic, or web-based interventions including smoking cessation, weight management, stress management, physical fitness, nutrition, heart disease prevention, healthy lifestyle support, and diabetes prevention. For more background on wellness issues see CRS Report R40661, *Wellness Programs: Selected Legal Issues*, coordinated by Nancy Lee Jones.

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 bill would be 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.

Appeals Process

The bill would require that a group health plan and a health insurance issuer in the group or individual markets would implement an effective appeals process for coverage determinations and claims. The process would at a minimum

- have in effect 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, group plans would be expected to initially incorporate the claims and appeals procedures set forth at 29 CFR § 2560.530-1 and would update their processes in accordance with any standards established by the Secretary of Labor.[80] To comply with the requirements, issuers offering individual health coverage would provide internal claims and appeals procedures set forth under applicable law and updated by the Secretary of HHS.

A group health plan and health insurance issuer offering group or individual coverage would comply with the applicable state external review process that at a minimum includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the NAIC. The plan or issuer would be required to implement an effective external review process that meets the minimum standards established by the Secretary if the applicable state has not established standards that meet the NAIC model requirements, or if the plan is self-insured and therefore is not subject to state insurance regulation.

Health Insurance Consumer Information

The Secretary would award grants to states to enable them, or the exchanges operating in the states, to establish, expand, or provide support for an Office of Health Insurance Consumer Assistance or Health Insurance Ombudsman. There would be $30 million appropriated for the first fiscal year of the program and an authorization for appropriations, in such sums as necessary, in subsequent fiscal years. To be eligible to receive a grant, a state would designate an independent Office of Health Insurance Consumer Assistance or Health Insurance Ombudsman, that would directly or in coordination with state health insurance regulators and consumer

[80] 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.

assistance organizations, receive, and respond to inquires and complaints concern health insurance coverage. The Secretary would establish criteria for the grant, and the Office of Health Insurance Consumer Assistance or Health Insurance Ombudsman would

- assist with the filing of complaints and appeals;
- collect, track, and quantify problems and inquires;
- assist consumers with enrollment in a group health plan or health insurance coverage; and
- resolve problems with obtaining premium tax credits.

Reinsurance For Early Retirees

The Secretary would be required to create, within 90 days after enactment, a temporary reinsurance program to assist participating employment-based plans with the cost of providing health benefits to eligible retirees who are 55 and older and their dependents. The bill would define eligible employment-based plans as those plans provided to retirees and maintained by one or more employers (including any state or political subdivision), former employers or employee organizations or associations, or a voluntary employees' beneficiary association or a multiemployer plan. Health benefits would be defined as medical, surgical, hospital, prescription drug, and other benefits as determined by the Secretary. A retiree would be defined as an individual who is 55 years of age or older and is not eligible for Medicare and is not an active employee.

Participating plans would submit claims for reimbursement to the Secretary which would contain documentation of the actual costs of the items and services. In determining the amount of the claim the plan would take into account any negotiated price concessions obtained by the plan and any costs paid by the retiree or beneficiary in deductibles, copayments, and coinsurance would be included along with the amounts paid by the plan. The Secretary would determine if a claim is valid and in such cases would pay 80% of the portion of costs that exceeds $15,000, but is less than $90,000. These amounts would be adjusted annually by the medical care component of the Consumer Price Index (CPI) for all urban consumers rounded to the nearest multiple of $1,000. Amounts paid to plans would be required to be used to reduce premium costs, deductibles, copayments, coinsurance, or other out-of-pocket costs for plan participants and beneficiaries.

Immediate Information to Identify Affordable Coverage

The Senate bill would require the Secretary in consultation with the states to establish, not later than July 1, 2010, an Internet portal for beneficiaries to easily access affordable and comprehensive coverage options. The bill would also require that, not later than 60 days after enactment, the Secretary would develop a standardized format to be used for the presentation of information used on the Internet portal. The information on the portal would include eligibility, availability, premium rates, cost sharing, and the percentage of total premium revenues spent on health care compared to administrative costs.

Standards for electronic billing and other administrative transactions

The bill would seek to create uniformity in the use of HIPAA electronic transactions standards. It would establish a timeline, extending through mid-2014, for the adoption of a single set of

operating rules for each HIPAA transaction for which there is an existing standard. It also would mandate the adoption of an electronic funds transfer (EFT) standard for the payment of health claims. By December 31, 2015, health plans would have to certify that their health information technology systems comply with the most current standards and operating rules. Health plans that failed to meet the certification requirements would be fined.

Patient Protections

Under the bill, if a group health plan or health insurance issuer in the group or individual markets requires or provides for designation by a participant, beneficiary or enrollee of a participating primary care provider, then the plan or issuer would be required to permit the designation of any participating primary care provider who is available to accept the individual. This same provision would apply for pediatric care for any child who is a participant, beneficiary, or enrollee of a group health plan or health insurance issuer in the group or individual markets.

If the group health plan or health insurance issuer in the group or individual markets covers services in an emergency department of a hospital they would be 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 would be the same as the cost-sharing for an in-network provider. Patients would also have protected access to obstetrical and gynecological care.

Author Contact Information

Hinda Chaikind
Specialist in Health Care Financing
hchaikind@crs.loc.gov, 7-7569

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

Chris L. Peterson
Specialist in Health Care Financing
cpeterson@crs.loc.gov, 7-4681

Mark Newsom
Analyst in Health Care Financing
mnewsom@crs.loc.gov, 7-1686

Janemarie Mulvey
Specialist in Aging Policy
jmulvey@crs.loc.gov, 7-6928

Acknowledgments

Jon O. Shimabukuro (7-7990) contributed the section on abortion. Kirsten Colello (7-7839) contributed the section on assisted suicide. Vivian Chu (7-4576) contributed the section on medical malpractice. Jennifer Staman (7-2610) contributed the sections on MEWAs and wellness programs. Elayne Heisler (7-4453) contributed the section on tax treatment of Indian Tribe benefits. In addition, Ruth Ellen Wasem (7-7342) made contributions to this report in reference to undocumented aliens.