



Private Health Insurance Provisions of H.R. 3200

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Summary

This report summarizes key provisions affecting private health insurance in H.R. 3200, America's Affordable Health Choices Act of 2009, as ordered reported by House Committees on Education and Labor and on Ways and Means. Specifically, this report focuses on Division A (or I) of H.R. 3200 from those committees.

Division A of H.R. 3200 focuses on reducing the number of uninsured, restructuring the private health insurance market, setting minimum standards for health benefits, and providing financial assistance to certain individuals and, in some cases, small employers. In general, H.R. 3200 would require individuals to maintain health insurance and employers to either provide insurance or pay into a fund, with penalties/taxes for non-compliance. Several insurance market reforms would be made, such as modified community rating and guaranteed issue and renewal. Both the individual and employer mandates would be linked to acceptable health insurance coverage, which would meet required minimum standards and incorporate the market reforms included in the bill. Acceptable coverage would include (1) coverage under a qualified health benefits plan (QHBP), which could be offered either through the newly created Health Insurance Exchange (the Exchange) or outside the Exchange through new employer plans; (2) grandfathered employment based plans; (3) grandfathered nongroup plans; and (4) other coverage, such as Medicare and Medicaid. The Exchange would offer private plans alongside a public option. Based on income, certain individuals could qualify for subsidies toward their premium costs and cost-sharing (deductibles and copayments); these subsidies would be available only through the Exchange. In the individual market (the nongroup market), a plan could be grandfathered indefinitely, but only if no changes were made to the terms and conditions of that plan, including benefits and cost-sharing, and premiums were only increased as allowed by statute. Most of these provisions would be effective beginning in 2013.

The 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 a public option. Individuals wanting to purchase the public option or a private health insurance *not* through an employer or a grandfathered nongroup plan could *only* obtain such coverage through the Exchange. They would only be eligible to enroll in an Exchange plan if they were not enrolled in other acceptable coverage (e.g., from an employer, Medicare, and generally Medicaid). The public option would be established by the Secretary of Health and Human Services (HHS), would offer three different cost-sharing options, would vary premiums geographically, and would have payments to health care providers set by the Secretary based on Medicare payment rates, with adjustments.

Only within the Exchange, credits would be available to limit the amount of money individuals would pay for premiums. For example, a family of three at 133% of the federal poverty line (\$24,352 in 2009 annual income) would be required to only pay annual premiums of \$365 toward a Basic plan in the Exchange. A family of three at 400% of poverty (\$73,240), where the premium subsidies end, would be required to pay no more than \$8,056 in annual premiums for a Basic Exchange plan. Individuals eligible for premium credits would also be eligible for cost-sharing credits. (Although Medicaid is beyond the scope of this report, H.R. 3200 would extend Medicaid coverage for most individuals under 133 $\frac{1}{3}$ % of poverty; individuals would generally be ineligible for Exchange coverage if they were eligible for Medicaid.)

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Status of House Legislation

H.R. 3200, America's Affordable Health Choices Act of 2009, as introduced on July 14, 2009, was referred to the House Committees on Energy and Commerce, Ways and Means, Education and Labor, Oversight and Government Reform, and the Budget, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned. The Committees on Education and Labor and on Ways and Means each ordered reported, as amended, their versions of H.R. 3200 on July 17, 2009. The Committee on Energy and Commerce has held three days of markup. The Committees on Oversight and Government Reform and the Budget have not taken up the legislation for consideration.

Overview of H.R. 3200

This report summarizes the key provisions affecting private health insurance in America's Affordable Health Choices Act of 2009, found in Division A, as ordered reported by House Committees on Ways and Means and on Education and Labor.¹ Division A of H.R. 3200 focuses on reducing the number of uninsured, restructuring the private health insurance market, setting minimum standards for health benefits, providing financial assistance to certain individuals, and, in some cases, small employers. In general, H.R. 3200 would include the following:

- Individuals would be required to maintain health insurance, and employers would be required to either provide insurance or pay into a fund, with penalties/taxes for noncompliance.
- Several market reforms would be made, such as modified community rating and guaranteed issue and renewal.
- Both the individual and employer mandates would be linked to acceptable health insurance coverage, which would meet required minimum standards and incorporate the market reforms included in the bill. Acceptable coverage would include
 - coverage under a qualified health benefits plan (QHBP), which could be offered either through the newly created Exchange or outside the Exchange through new employer plans;
 - grandfathered employment based plans;
 - grandfathered nongroup plans; and
 - other coverage, such as Medicare and Medicaid.
- The Exchange would be established under a new independent federal agency (the Health Choices Administration), headed by a Commissioner. The Exchange would offer private plans alongside a public option.

¹ Some of the legislative versions have this as Division I, even though the other two divisions in H.R. 3200 are Division B and Division C.

- Certain individuals with incomes below 400% of the federal poverty level could qualify for subsidies toward their premium costs and cost-sharing; these subsidies would be available only through the Exchange.
- In the individual market (the nongroup market), a plan could be grandfathered indefinitely, but only if no changes were made to the terms and conditions of the plan, including benefits and cost-sharing, and premiums were only increased as allowed by statute.
- This bill would not affect plans covering specific services, such as dental or vision care.
- Most of these provisions would be effective beginning in 2013.

Overview of Report

This report provides a short background describing key aspects of the private insurance market as it exists currently. This information is useful in setting the stage for understanding how and where H.R. 3200 would reform health insurance. Primarily, however, the report summarizes provisions affecting private health insurance in Division A (or Division 1) H.R. 3200,² as ordered reported by the House Committees on Education and Labor and on Ways and Means. Where the House committees' versions of a provision are the same, they are discussed as applying generally under H.R. 3200; where the bills ordered reported differ, the differences are noted.

Although the description that follows segments the private health insurance provisions into various categories, these provisions are interrelated and interdependent. For example, H.R. 3200 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. H.R. 3200 would require that insurers not exclude potential enrollees or charge them premiums based on pre-existing health conditions. In a system where individuals voluntarily choose whether to obtain health insurance, however, individuals may choose to enroll only when they become sick. Enrolling in coverage only after developing a condition could result in coverage that excludes the pre-existing condition, unaffordable premiums, and even greater uninsurance. Thus, America's Health Insurance Plans (AHIP), the association that represents health insurers, has agreed to reform that does away with limitations of pre-existing condition exclusions, but only if individuals are required to purchase coverage, so that not just the sick enroll.³

However, 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

² This report does not address Divisions B or C, which will be addressed in forthcoming reports.

³ 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>.

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 within Division A of H.R. 3200, with the primary CRS contact listed for each:

- Individual and employer mandate: the requirement on individuals to maintain health insurance and on employers to either provide health insurance or pay into the Exchange, with penalties and taxes for noncompliance. [Titles III and IV—Hinda Chaikind, 7-7569]
- Private health insurance market reforms. [Title I—Bernadette Fernandez, 7-0322]
- Health Insurance Exchange [Title II, Subtitle A—Chris Peterson, 7-4681], through which the following two items can only be offered:
 - Public Health Insurance Option. [Title II, Subtitle B—Paulette Morgan, 7-7317]
 - Premium and cost-sharing subsidies. [Title II, Subtitle C—Chris Peterson, 7-4681]

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 2007, approximately 177 million persons had employment-based health insurance, which accounts for nearly 60% of the total population.⁴ 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 Americans were estimated to be uninsured in 2007.

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.⁵

More than 95% of large employers offer coverage. Large employers are generally able to obtain lower premiums for a given health insurance package than small employers and individuals seeking nongroup coverage. This is partly because larger employers enjoy economies of scale and a larger “risk pool” of enrollees that makes the expected costs of care more predictable.

⁴ CRS Report 96-891, *Health Insurance Coverage: Characteristics of the Insured and Uninsured Populations in 2007*, by Chris L. Peterson and April Grady.

⁵ 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.

Employers generally offer large subsidies toward health insurance, thus making it more attractive for both the healthier and the sicker workers to enter the pool. So, not only is the risk pool larger in size, but it is more diverse. States have experimented with ways to create a single site where individuals and small employers could compare different insurance plans, obtain coverage, and sometimes pool risk. Although most of these past experiments failed (e.g., California's PacAdvantage⁶), other states have learned from these experiences and have fashioned potentially more sustainable models (e.g., Massachusetts' Connector⁷). 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, in part because they lack the economies of scale available to larger employers. These pools are generally considered 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 a larger pool. Allowing these firms to purchase insurance through a larger pool, such as an Association or an Exchange, could lower premiums for those with high-cost employees.

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

States are the primary regulators of the private health insurance market, though some federal regulation applies, mostly affecting employer-sponsored health insurance (ESI).⁸ The Health Insurance Portability and Accountability Act (HIPAA) requires that coverage sold to small groups (2-50 employees) must be sold on a guaranteed issue basis. That is, the issuer must accept every small employer that applies for coverage. All states require issuers to offer policies to firms with 2-50 workers on a guaranteed issue basis, in compliance with HIPAA. As of January 2009 in the small group market, 13 states also require issuers to offer policies on a guaranteed issue basis to the self-employed "groups of one." And as of December 2008 in the individual market, 15 states require issuers to offer some or all of their insurance products on a guaranteed issue basis to non-HIPAA eligible individuals. Most states currently impose 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. Generally, community rating prohibits issuers from pricing health insurance policies based on health factors, but allows it for other factors such as age or gender. All states require

⁶ Pac Advantage was created as part of the small business health insurance reforms enacted in California in 1992, as a state-established health insurance pool to help cover small-business employees in California. PacAdvantage was created to allow small businesses to band together and negotiate lower insurance premiums for their employees, but it did little to make insurance more affordable. Over time, employers whose workers had the lowest health risks exited the pool for plans with cheaper premiums, leaving the program with the highest-risk members and driving up costs.

⁷ See <http://www.mahealthconnector.org>.

⁸ 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.

health issuers to reduce the period of time when coverage for pre-existing health conditions may be excluded. As of January 2009 in the small group market, 21 states had pre-existing condition exclusion rules that provided consumer protection above the federal standard. And as of December 2008 in the individual market, 42 states limit the period of time when coverage for pre-existing health conditions may be excluded for non-HIPAA eligible enrollees in that market. In fact, while there are a handful of federal benefit mandates for health insurance that apply to group coverage, there are more than 2,000 benefit mandates imposed by the states.

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, they fear that these advantages might drive private plans from the market.⁹

Individual and Employer Mandates

Individual Mandate

H.R. 3200 includes an individual mandate to have health insurance, with penalties for noncompliance. Individuals would be required to maintain acceptable coverage, defined as coverage under a qualified health benefits plan (QHBP), an employment-based plan, a grandfathered nongroup plan, Part A of Medicare, Medicaid, military coverage (including Tricare), Veteran's health care program, and coverage as determined by the Secretary in coordination with the Commissioner. Individuals who did not maintain acceptable health insurance coverage for themselves and their children would be required to pay an additional tax, prorated for the time the individual (or family) does not have coverage, equal to the lesser of (1) 2.5 % of the taxpayer's modified adjusted gross income¹⁰ (MAGI) over the amount of income required to file a tax return, or (2) the national average premium for applicable single or family coverage.

Some individuals would be provided with subsidies to help pay for the costs of their premiums and cost-sharing. (A complete description of who is eligible and the amount of subsidies is found in the section on premium and cost-sharing credits). Others would be exempt from the individual mandate, including nonresident aliens, individuals residing outside of the United States,

⁹ 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.

¹⁰ For this purpose, MAGI is defined as adjusted gross income (AGI) without the exclusions for U.S. citizens or residents living abroad, plus tax-exempt interest.

individuals residing in possessions of the United States, those with qualified religious exemptions, those allowed to be a dependent for tax-filing purposes, and others granted an exemption by the Secretary.

Employer Mandate

H.R. 3200 would require employers either to provide full-time employees with a QHBP (or current employment-based plan) or to pay a set amount into the Exchange. Employers would include private sector employers, federal, state, and tribal governmental plans, and church plans. Under the Education and Labor bill, an employer could apply to the Secretary for a waiver from health coverage participation requirements for any two-year period.

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

- Employers could offer employment-based coverage, or they could offer coverage through an Exchange plan (if the employer was eligible to participate in the Exchange—see section on rules for the Exchange).
- Current employment-based health plans would be grandfathered for five years, at which time any plan offered by an employer would have to meet (but could exceed) the requirements of the essential benefits package.
- Employers would have to contribute at least 72.5% of the lowest-cost qualified benefits plan they offered¹¹ (65% for those electing family coverage)—prorated for part-time employees.
- Salary reductions used to offset required employer contributions would not count as amounts paid by the employer.
- Employers would automatically enroll their employees into the plan for individual coverage with the lowest associated employee premium, unless the employee selected a different plan or opted out of employer coverage.

In general, employers that elected to provide coverage but failed to meet minimum health coverage participation requirements would be subject to a tax of \$100 per day for each employee to whom the failure applied. This tax would not apply for failures corrected within 30 days, in cases where the employer could not have reasonably been aware of the failure, and other exceptions. The tax would be limited to the lesser of 10% of the employment-based health plan costs for the prior year or \$500,000.

Employers with aggregate wages over \$400,000 that chose not to offer coverage would be required to make contributions equal to 8% of the average wages paid by the employer. Small employers with aggregate wages below \$250,000 would be exempt from requirements. Those with aggregate wages over \$250,000 and below \$300,000 would be required to pay 2% of average wages, those with aggregate wages over \$300,000 and below \$350,000 would be required to pay 4%, and those with aggregate wages above \$350,000 and below \$400,000 would be required to pay 6%.

¹¹ For employers offering coverage through Exchange plans, their minimum contribution would be based on the reference premium amounts (as defined in the Exchange) for the premium rating area in which the individual or family resides.

Even if an employer offered employer sponsored health insurance, employees could decline or disenroll from this insurance and instead enroll in a plan through the Exchange. Beginning in the second year after enactment, employers with aggregate wages above \$400,000 would be required to make contributions equal to 8% of average wages paid by the employer to the Exchange, for those employees, with similar adjustments for small employers as those described above. The employer's contribution for this group of individuals would go into the Exchange but would not apply toward the individual's premium (i.e., absent qualifying for a subsidy, such individual would be responsible for 100% of the premium in the Exchange). This contribution would not be required for an employee who was not the primary insured individual but was covered as a spouse or dependent in an Exchange plan.

Within 90 days after enactment, H.R. 3200 would create a temporary reinsurance program, with funding not to exceed \$10 billion, 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 Secretary would reimburse the plan for 80% of the portion of a claim above \$15,000 and below \$90,000 (adjusted annually for inflation). Amounts paid to the plan would be used to lower costs directly to participants in the form of premiums, co-payments, and other out-of-pocket costs, but could be not used to reduce the costs of an employer maintaining the plan.

The Education and Labor bill adds a provision that would bar group health plans from reducing retiree health benefits for either the retiree or their beneficiaries (as of the date the participant retired) unless such reduction was also made with respect to active participants.

Finally, the Education and Labor bill contains a provision that would allow the Commissioner to enter into arrangements with small employer benefit associations to provide consumer information, outreach, and assistance in the enrollment of small employers and their employees who are members of such an association, under Exchange participating health benefits plans.

Small Business Credit

Certain small businesses would be eligible for a 50% credit toward the cost of coverage. This credit would be phased out as average employee compensation increased from \$20,000 to \$40,000, then as the number of employees increased from 10 to 25. Employees would be counted if they received at least \$5,000 in compensation, but the credit would not apply toward insurance for employees whose compensation exceeded \$80,000. This credit would be treated as part of the general business credit and would not be refundable; it would be available only to a business with a tax liability.

Private Health Insurance Market Reforms

Qualified Health Benefits Plans (QHBP)

H.R. 3200 would establish new federal health insurance standards applicable to new, generally available health plans specified in the bill—"qualified health benefits plans" (QHBP). Among the market reforms applicable to QHBP are provisions that would do the following:

- Prohibit coverage exclusions of pre-existing 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, cares, or treatment was recommended or received before such date.)

- Require premiums to be determined using adjusted community rating rules. (“Adjusted, or modified community rating” prohibits issuers from pricing health insurance policies based on health factors, but allows it for other key characteristics such as age or gender.) Under H.R. 3200, premiums would only be allowed to vary based on age—by no more than a 2:1 ratio within age categories specified by the Commissioner, premium rating areas, and family enrollment—for example, for single versus family coverage.
- Require coverage to be offered on both a guaranteed issue and guaranteed renewal basis. (“Guaranteed issue” in health insurance is the requirement that an issuer accept every applicant for health coverage. “Guaranteed renewal” in health insurance is the requirement on an issuer to renew group coverage at the option of the plan sponsor [e.g., employer] or nongroup coverage at the option of the enrollee. Guaranteed issue and renewal alone would not guarantee that the insurance offered was affordable; this would be addressed in the rating rules.)
- Impose new non-discrimination building on existing non-discrimination rules in group coverage and adequacy standards for insurers’ networks of providers, such as doctors.

H.R. 3200 would also require QHBPs to cover certain broad categories of benefits, prohibit cost-sharing on preventive services, limit annual out-of-pocket spending, and meet the standards for the “essential benefits package,” described below. In addition, under the Ways and Means version, QHBPs would comply with a medical loss ratio¹² standard to be determined by the Commissioner. Under the Education and Labor version, QHBPs would be required to meet a medical loss ratio of 85%.

New individual policies issued post enactment could be offered only as an Exchange plan. Existing group plans would have to transition to QHBP standards by 2018. Existing nongroup insurance policies would be grandfathered as long as there are no changes to the terms or conditions of the coverage (except as required by law), including benefits and cost-sharing. Such policies would be required to meet other conditions, including increasing premiums only according to statute.

In addition, the Education and Labor version would shorten the current federal allowance for pre-existing health conditions exclusions (from 12 months to 3 months for most individuals) effective 6 months after enactment of the bill, and applicable until such time that federal standards eliminate exclusions for pre-existing health conditions. Special rules would apply to health plans subject to collective bargaining agreements.

¹² Medical loss ratio is the share (expressed as a percentage) of total premium revenue spent on medical claims, as opposed to administration or profit.

Essential Benefits Package

QHBP would be required to cover at least an “essential benefit package” but could offer additional benefits. The essential benefits package would cover specified items and services, limit cost-sharing, prohibit annual and lifetime limits on covered services, ensure the adequacy of provider networks, and are equivalent (as certified by the Office of the Actuary of the Centers for Medicare and Medicaid Services) to the average prevailing employer-sponsored coverage.

The essential benefits package would be required to cover the following items and services:

- hospitalization;
- outpatient hospital and clinic services, including emergency department services;
- services of physicians and other health professionals;
- services, equipment, and supplies incident to the services of a physician or health professional in appropriate settings;
- prescription drugs;
- rehabilitative and “habilitative” services (i.e., services to maintain the physical, intellectual, emotional, and social functioning of developmentally delayed individuals);
- mental health and substance use disorder services;
- certain preventive services (with no cost-sharing permitted) and vaccines;
- maternity care;
- under the Ways and Means version, well baby and well child care *and* oral health, vision, and hearing services, equipment, and supplies for those under age 21;
- under the Education and Labor version, well baby and well child care *and* early and period screening, diagnostic and treatment services (EPSDT, as available under Medicaid) for those under age 21; and
- under the Education and Labor version, durable medical equipment, prosthetics, orthotics, and related supplies.

The annual out-of-pocket limit in 2013 would be \$5,000 for an individual and \$10,000 for a family, adjusted annually for inflation. To the extent possible, the Commissioner would establish cost-sharing levels using copayments (a flat dollar fee) and not coinsurance (a percentage fee). Cost-sharing under the essential benefits package would be designed so that the plan covers approximately 70% of the full value of benefits in the essential benefits package; QHBPs could cover a higher percentage.

Health Benefits Advisory Committee

A Health Benefits Advisory Committee (HBAC) would be established to make recommendations to the Secretary regarding coverage offered through the Health Insurance Exchange, including covered benefits, cost-sharing, and updates to the essential benefits package. The Committee

would develop cost-sharing structures to be consistent with actuarial values specified for different plan tiers (i.e., Basic, Enhanced, and Premium plans) offered in the Exchange. In developing its recommendations, the Committee would incorporate innovation in health care, consider how the benefits package would reduce health disparities, and allow for public input as part of developing its recommendations.

Health Insurance Exchange

Exchange Structure

In addition to federalizing private health insurance standards, H.R. 3200 would also create a “Health Insurance Exchange,” similar in many respects to existing entities like the Massachusetts Connector and eHealthInsurance, to facilitate the purchase of QHBPs by certain individuals and small businesses. The Exchange would not be an insurer; it would provide eligible individuals and small businesses with access to insurers’ plans in a comparable way (in the same way, for example, that Travelocity or Expedia are not airlines but provide access to available flights and fares in a comparable way). The Exchange would have additional responsibilities as well, such as negotiating with plans, overseeing and enforcing requirements on plans (in coordination with state insurance regulators), and determining eligibility for and administering premium and cost-sharing credits.

Under H.R. 3200, the Exchange would be established under a new independent federal agency (the Health Choices Administration), headed by a Commissioner. The federal Exchange’s startup and operating costs, along with payments for premium and cost-sharing credits discussed below, would be paid for out of a new Health Insurance Exchange Trust Fund, funded by (1) taxes on certain individuals who did not obtain acceptable coverage, (2) penalties for employers whose coverage failed to meet the requirements for coverage, (3) payments by employers who opted not to provide insurance coverage, (4) payments by employers whose employees opt for Exchange coverage instead of employment-based coverage, and (5) such additional sums as necessary to be appropriated for the Exchange.

Only one Exchange could operate in a state. The Commissioner would be required to approve a state-based Exchange that met specified criteria. (A group of states could also operate an Exchange.) A state-based Exchange would be funded through a federal matching grant to states. Under the Education and Labor version, a state may operate a “single payer system,” in which the state could require and set employer contributions and use a single state agency to finance and administer all health care benefits for its residents.

Individuals could obtain coverage outside the Exchange, and insurers could offer plans outside the Exchange (through employer and grandfathered plans). However, the Public Health Insurance Option and the income-based premium and cost-sharing credits would be available only through the Exchange.

Individual and Employer Eligibility for Exchange Plans

Under H.R. 3200, beginning in 2013, individuals would be eligible for Exchange coverage unless they were enrolled in the following:

- a group plan through a full-time employee (including a self-employed person with at least one employee) for which the employer makes an adequate contribution (described in the section on employer mandates),
- Medicare,
- Medicaid (except in certain cases),¹³ or
- Military and VA coverage.

With some exceptions, individuals would lose eligibility for Exchange coverage once they become *eligible* for Medicare Part A, Medicaid, and other circumstances as the Commissioner provides. Besides those cases, once individuals enroll in an Exchange plan, they would continue to be eligible until they are no longer enrolled.

An open-enrollment period would be offered annually, sometime during September to November, lasting at least 30 days. There would also be special enrollment periods for certain circumstances (e.g., loss of acceptable coverage, change in marital or dependent status).

Exchange-eligible employers could meet the requirements of the employer mandate by offering and contributing adequately toward employees' enrollment through the Exchange. Those employees would be able to choose any of the available Exchange plans. Once employers are Exchange eligible and enroll their employees through the Exchange, they would continue to be Exchange eligible, unless they decided to then offer their own QHBPs.

In the Ways and Means version of H.R. 3200, in 2013, employers with 10 or fewer employees would be Exchange-eligible. In 2014, employers with 20 or fewer employees would be Exchange-eligible. Beginning in 2015, the Commissioner could permit larger employers to participate in the Exchange; these additional employers could be phased in or made eligible based on the number of full-time employees or other considerations the Commissioner deems appropriate.

In the Education and Labor version of H.R. 3200, in 2013, employers with 15 or fewer employees would be Exchange-eligible. In 2014, employers with 25 or fewer employees would be Exchange-eligible. In 2015, employers with 50 or fewer employees would be Exchange-eligible. Beginning in 2015, the Commissioner could permit larger employers to participate in the Exchange; these additional employers could be phased in or made eligible based on the number of full-time employees or other considerations the Commissioner deems appropriate.

¹³ Regarding Medicaid, individuals could still participate in the Exchange if their Medicaid eligibility was related to COBRA continuation coverage, tuberculosis, or breast or cervical cancer. Section 1701 of H.R. 3200, which is beyond the scope of this report, requires states with Medicaid programs to expand coverage to individuals up to 133⅓% of the federal poverty level who are not eligible under current state Medicaid programs. These newly eligible individuals are called "non-traditional Medicaid eligible individuals" in H.R. 3200. A non-traditional Medicaid eligible individual could be Exchange-eligible if the individual was enrolled in a qualified health benefits plan, grandfathered health insurance coverage, or current group health plan during the six months before the individual became a non-traditional Medicaid eligible individual. During the period in which such an individual had chosen to enroll in an Exchange plan, the individual would be ineligible for regular Medicaid.

Benefit Packages in the Exchange

Exchange plans would have to meet not only the new federal requirements of all private health insurance plans (i.e., be QHBPs), but would also have their cost-sharing options somewhat standardized into the following four cost-sharing/benefit tiers:

- An Exchange-participating “entity” (insurer) must offer only one Basic plan in the service area. The Basic plan would be equivalent to the minimum requirements of the essential benefits package (e.g., actuarial value of approximately 70%).
- If the entity offers a Basic plan in a service area, it may offer one Enhanced plan in the service area, which would have a lower level of cost-sharing for benefits in the essential benefits package (i.e., actuarial value of approximately 85%).
- If the entity offers an Enhanced plan in a service area, it may offer one Premium plan in the service area, which would have a lower level of cost-sharing for benefits in the essential benefits package (i.e., actuarial value of approximately 95%).
- If the entity offers a Premium plan in a service area, it may offer one or more Premium-Plus plans in the service area. A Premium-Plus plan is a Premium plan that also provides additional benefits, such as adult oral health and vision care.

Plans would use the cost-sharing levels specified by the HBAC for each benefit category in the essential benefits package, for each cost-sharing tier (Basic, Enhanced and Premium)—although plans would be permitted to vary the cost-sharing from HBAC’s specified levels by up to 10%. If a state requires health insurers to offer benefits beyond the essential benefits package, such requirements would continue to apply to Exchange plans, but only if the state has entered into an arrangement satisfactory to the Commissioner to reimburse the Commissioner for the amount of any resulting net increase in premium credits.

Public Health Insurance Option

Under H.R. 3200, the Secretary of Health and Human Services (HHS) would establish a public health insurance option through the Exchange. Any individual eligible to purchase insurance through the Exchange would be eligible to enroll in the public option, and may also be eligible for income-based premium and cost-sharing credits. The public option would have to meet the requirements that apply to all Exchange-participating plans, including those related to benefits, provider networks, consumer protections, and cost-sharing. The public option would be required to offer Basic, Enhanced, and Premium plans, and could offer Premium-Plus plans.

The Secretary would be required to establish geographically adjusted premiums that comply with the premium rules established by the Commissioner and at a level sufficient to cover expected costs (including both claims and administration). Limited start-up funding would be available, but would be repaid within 10 years.

The Secretary would be required to establish payment rates for services and health care providers, and would have the authority to change payment rates in accordance with reforms. In general,

during the first three years of the public option, the Secretary would be required to base payment rates on the rates for similar services and providers under Medicare, with adjustments.¹⁴

Physicians would be able to participate in the public option as preferred or non-preferred providers; preferred physicians would be prohibited from balance-billing, that is billing amounts above the established rates, while non-preferred physicians could balance-bill up to 115% of the established payment rate. Non-physician providers would be prohibited from balance-billing. Payments for outpatient prescription drugs would be based on negotiated rates.

Medicare-participating providers would also be providers for the public option, unless they chose to opt out. For the first three years of the public option, physicians and other health care practitioners who participate in both Medicare and the public option, and certain other providers, would receive a 5% payment increase above the adjusted Medicare rate. Beginning in the fourth year, the Secretary would use an administrative process to establish rates to promote payment accuracy, to ensure adequate beneficiary access to providers, or to promote affordability and the efficient delivery of health care. The Secretary could not set rates at levels expected to increase overall medical costs beyond what would have been expected if payments were set at the adjusted Medicare level plus 5%. The Secretary would also have the authority to use innovative payment mechanisms and policies to determine payments for items and services under the public option.

The Secretary would be allowed to enter into no-risk contracts for the administration of the public option, in the same way the Secretary enters into contracts for the administration of the Medicare program. The administrative functions would include, subject to restrictions, determination of payment amounts, making payments, beneficiary education and assistance, provider consultative services, communication with providers, and provider education and technical assistance.

Premium and Cost-Sharing Credits

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 H.R. 3200, those eligible for premium credits would also be eligible for cost-sharing credits (i.e., subsidies).

In 2103 and 2014, these subsidies would only be available for Basic plans sold through the Exchange, including both the private plans and public option. Beginning in 2015, individuals eligible for credits could obtain an Enhanced or Premium plan, but would be responsible for any additional premiums. Individuals who were eligible for credits and offered employment-based health insurance outside of the Exchange would have to decline or disenroll from that coverage, in order to access the subsidies by enrolling in plans through the Exchange. Beginning in 2014, employers would be required to pay an amount to the Exchange for any employee choosing coverage in the Exchange, regardless of whether the employee had access to the subsidies;

¹⁴ The payments for physicians' services otherwise established under Medicare would be applied to the public option without regard to the sustainable growth rate—one component of the formula used to update Medicare payments to physicians. The yearly update for payments for physicians' services under the public option would not be less than 1%. Also, the Secretary would have authority to determine which adjustments to base payment rates under Medicare would apply to rates under the public option.

however, in this case, the employer's contribution would not be applied toward the individual's premium.

Individual Eligibility for Premium Credits and Cost-Sharing Credits

Under H.R. 3200, Exchange-eligible individuals could receive a credit in the Exchange if they

- are lawfully present in a state in the United States, with some exclusions;¹⁵
- are not enrolled under an Exchange plan as an employee or their dependent (through an employer who purchases coverage for its employees through the Exchange and satisfies the minimum employer premium contribution amounts);¹⁶
- have modified adjusted gross income¹⁷ (MAGI) of less than 400% of the federal poverty level (FPL);¹⁸ and
- are ineligible for Medicaid, except for the few previously mentioned exceptions.¹⁹

If individuals apply for a premium credit, the Exchange would first determine whether they are eligible for Medicaid and, if so, would facilitate their enrollment into Medicaid (“screen and enroll”).

Calculation of Premium Credit

The premium credit is based on what is considered an “affordable premium amount” for individuals to pay. The affordable premium amount is a percentage of individuals' income (MAGI) relative to the poverty level, as specified in the table below.

¹⁵ Nonimmigrants are those who are in the United States for a specified period of time and a specific purpose. The exceptions include aliens with nonimmigrant status because they are trafficking victims, crime victims, fiancées of U.S. citizens, or have had applications for legal permanent residence (LPR) status pending for three years. It is expected that almost all aliens in these nonimmigrant categories will become LPRs (i.e., immigrants) and remain in the United States permanently.

¹⁶ The Commissioner would make exceptions to this rule for divorced or separated individuals, or dependents of employees who would otherwise be eligible for credits. Exceptions would also be made, beginning in 2014, for full-time employees whose premium costs under a group health plan exceed 11% of family income.

¹⁷ For this purpose, MAGI is defined as adjusted gross income (AGI) without the exclusions for U.S. citizens or residents living abroad, plus tax-exempt interest.

¹⁸ The federal poverty level used for public program eligibility varies by family size and by whether the individual resides in the 48 contiguous states and the District of Columbia versus Alaska and Hawaii. For a two-person family in the 48 contiguous states and the District of Columbia, the federal poverty level (i.e., 100% of poverty) was \$14,570. See 74 *Federal Register* 4200, January 23, 2009, <http://aspe.hhs.gov/poverty/09fedreg.pdf>.

¹⁹ Exceptions to the Medicaid prohibition are described in an earlier footnote. H.R. 3200 includes extending Medicaid eligibility extended to most individuals with income of 133⅓% FPL or less, although income is counted differently for Medicaid than for MAGI.

Federal poverty level (FPL)	Premium payment limit (as a percent of income)
133% or less	1.5%
150%	3.0%
200%	5.0%
250%	7.0%
300%	9.0%
350%	10.0%
400%	11.0%

For example, a family of three at 133% of the federal poverty line (\$24,352 in 2009 annual income) would be required to only pay annual premiums of \$365 toward a Basic plan in the Exchange. A family of three at 400% of poverty (\$73,240), where the premium subsidies end, would be required to pay no more than \$8,056 in annual premiums for a Basic Exchange plan.

More specifically, the premium against which credits would be calculated—the “reference premium”—would be the three Basic plans with the lowest premiums in the area (although the Commissioner could exclude plans with extremely limited enrollment). The “affordability premium credit” would be the lesser of (1) how much the enrollee’s premium exceeds the affordable premium amount, or (2) how much the reference premium exceeds the affordable premium amount.

The Commissioner would establish premium percentage limits so that for individuals whose family income is between the income tiers specified in the table above, the percentage limits would increase on a linear sliding scale. The affordable premium credit amount would be calculated on a monthly basis.

Calculation of Cost-Sharing Credit

In addition, those who qualified for premium credits would also be eligible for assistance in paying any required cost-sharing for their health services. The Commissioner would specify reductions in cost-sharing amounts and the annual limitation (out-of-pocket maximum) on cost-sharing under a Basic plan so that the average percentage of covered benefits paid by the plan (as estimated by the Commissioner) is equal to the percentages (actuarial values) in the table for each income tier.

Federal poverty level (FPL)	Actuarial value (percentage)
150% or less	97%
200%	93%
250%	85%
300%	78%
350%	72%
400%	70%

The Commissioner would pay insurers additional amounts to cover the reduced cost-sharing provided to credit-eligible individuals.

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