



# Private Health Insurance Provisions of S. 1796, America's Healthy Future Act of 2009

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November 16, 2009

Congressional Research Service

7-5700

[www.crs.gov](http://www.crs.gov)

R40918

## Summary

This report summarizes key provisions affecting private health insurance in 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 VI of the bill include 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.

In general, the Senate Finance bill would require adult individuals to maintain health insurance, with some exceptions. Employers would not be required to provide health insurance, although certain employers with more than 50 full-time employees who did not provide insurance could be required to pay a tax, under certain circumstances. Several insurance market reforms would be made, such as modified community rating and guaranteed issue and renewal. Both the individual mandates and the employer requirements would be linked to essential health benefits coverage. Essential health benefits coverage would include (1) coverage under a qualified health benefits plan (QHBP); (2) new group or individual coverage that meets or exceeds minimum health benefits; (3) grandfathered employment-based plans; (4) grandfathered nongroup plans; and (5) other coverage, such as Medicare and Medicaid. Individual and small group coverage under qualified health benefits plans would be allowed to be offered through non-profit, member-run health insurance companies. Such non-profit insurers would be eligible for grants and loans distributed through the new Consumer Operated and Oriented Plan (CO-OP) program. QHBP exchanges would offer a choice of private plans for coverage in the individual and small group markets. 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. Existing plans would be grandfathered; however, once the bill is fully implemented, the private market reforms applicable to the small group market would also apply to grandfathered small group plans. New plans would be allowed to be offered in the individual and group markets outside of the Exchange, but only those new plans that meet the minimum requirements specified in the bill would satisfy the requirements on individuals and employers.

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## Status of Legislation

The Senate Finance Committee approved a measure, America's Healthy Future Act of 2009, on October 13, 2009. S. 1796, based on that approved measure, was ordered reported on October 19. Included in the committee report accompanying S. 1796 was preliminary analysis conducted by the Congressional Budget Office (CBO) on October 7 regarding the potential impact of the Chairman's Mark. CBO projected that the Mark legislation would reduce federal deficits by \$81 billion over a 10-year period (2010-2019), and would insure 94% of the non-elderly, legally present U.S. population by 2019.<sup>1</sup>

## Overview of S. 1796

This report summarizes the key provisions affecting private health insurance in Titles I and VI of S. 1796, American's Healthy Future Act of 2009, as ordered reported by the Senate Committee on Finance on October 19, 2009.

Title I of the bill 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 bill includes the following provisions:

- Individuals would be required to maintain health insurance, and certain employers with more than 50 employees 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 insurance renewal.
- Both the individual mandate and any employer requirements would be linked to essential health benefits coverage. Qualifying coverage would include:
  - qualified health benefits plans (QHBP) offered in or out of an exchange;
  - new group or individual coverage that meets or exceeds minimum health benefits;
  - grandfathered employment based plans;
  - grandfathered nongroup plans; and
  - other coverage, such as Medicare and Medicaid.
- 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 nongovernmental entity to establish and operate exchanges in states that did not establish them. Exchanges would not be insurers but provide eligible individuals and small businesses with access to private plans in a comparable way.

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<sup>1</sup> Committee on Finance, "America's Healthy Future Act of 2009," Report to Accompany S. 1796, available at <http://finance.senate.gov/press/Bpress/2009press/prb102109a.pdf>.

- 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. However, existing small group plans would have to meet the applicable private market reforms by July 1, 2013.
- New plans could also be sold in both the individual and group market outside of an exchange, but only those new plans that meet the minimum requirements specified in the bill would satisfy the requirements for individuals and employers.

Title VI 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.

## 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 S. 1796 would reform health insurance. This report summarizes key provisions affecting private health insurance in Titles I<sup>2</sup> and VI of America's Healthy Future Act of 2009, as ordered reported by the Senate Committee on Finance on October 19, 2009. Although most of the provisions would be effective beginning in July 1, 2013, the table in the **Appendix** shows the timeline for implementing provisions effective prior to that date.

Although the description that follows segments the private health insurance provisions into various categories, these provisions are interrelated and interdependent. For example, the bill includes a number of provisions to alter how current private health insurance markets function, primarily for individuals who purchase coverage directly from an insurer or through a small employer. S. 1796 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. 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 pre-existing conditions. If reform eliminates many of the tools insurers use to guard against adverse selection, America's Health Insurance Plans (AHIP),

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<sup>2</sup> This report does not discuss quality, wellness, and other titles of the bill, which are addressed in CRS Report R40831, *Public Health, Workforce, Quality, and Other Provisions in the Affordable Health Choices Act (S. 1679)*, coordinated by Kirsten J. Colello and C. Stephen Redhead.

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.<sup>3</sup>

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:
  - Health Care Cooperatives.  
[Mark Newsom, 7-1686]
  - Premium subsidies.  
[Chris Peterson, 7-4681]
- Title VI: 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.<sup>4</sup>

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<sup>3</sup> 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>.

<sup>4</sup> CRS Report 96-891, *Health Insurance Coverage: Characteristics of the Insured and Uninsured in 2008*, by Chris L. (continued...)

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.<sup>5</sup>

More than 96% of large employers offer coverage.<sup>6</sup> 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 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<sup>7</sup>), other states have learned from these experiences and have fashioned potentially more sustainable models (e.g., Massachusetts’ Connector<sup>8</sup>). 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;<sup>9</sup> 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

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Peterson.

<sup>5</sup> 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.

<sup>6</sup> 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](http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2008/tiaa2.pdf).

<sup>7</sup> 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.

<sup>8</sup> See <http://www.mahealthconnector.org>.

<sup>9</sup> See footnote 5.

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 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).<sup>10</sup> 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 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).<sup>11</sup>

Federal law requires that group health plans and health insurance issuers offering group health coverage must limit the period of time when coverage for pre-existing health conditions may be excluded.<sup>12</sup> As of January 2009 in the small group market, 21 states had pre-existing condition

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<sup>10</sup> 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.

<sup>11</sup> If a state establishes a rate band of +/- 25 percent, then insurance carriers can vary premiums, based on health factors, up to 25 percent above and 25 percent below the index rate.

<sup>12</sup> 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 (continued...)”

exclusion rules that provided consumer protection above the federal standard.<sup>13</sup> 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 certain enrollees in that market.<sup>14</sup> 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.<sup>15</sup>

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.<sup>16</sup>

Health insurance is provided by organizations that are either for-profit or non-profit in terms of their tax status. Some studies have suggested that non-profits perform better in key areas such as quality. For example, a study published in the *Journal of the American Medical Association (JAMA)* in 1999 found that non-profit health maintenance organizations (HMOs) scored higher on all 14 Healthplan Employer Data and Information Set (HEDIS®)<sup>17</sup> quality measures studied.<sup>18</sup> These results were generally replicated in a study published in 2006 of 272 health plans conducted by researchers at the University of California at Berkeley and the National Committee for Quality Assurance (NCQA).<sup>19</sup> Health insurance co-operatives, a subset of non-profit plans,

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(...continued)

coverage” (prior group coverage that meets the statutory requirements).

<sup>13</sup> See “Small Group Health Insurance Market Pre-Existing Condition Exclusion Rules, 2009,” at <http://www.statehealthfacts.org/comparetable.jsp?ind=352&cat=7>.

<sup>14</sup> See “Individual Market Portability Rules, 2008,” at <http://www.statehealthfacts.org/comparetable.jsp?ind=355&cat=7>.

<sup>15</sup> 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](http://www.cahi.org/cahi_contents/resources/pdf/HealthInsuranceMandates2009.pdf).

<sup>16</sup> 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.

<sup>17</sup> HEDIS is a registered trademark of the National Committee for Quality Assurance and is a tool used by more than 90% of health plans to measure performance. In total, HEDIS consists of 71 measures across 8 domains of care.

<sup>18</sup> Himmelstein, Wollhandler, Hellander & Wolf (1999). Quality of care in investor-owned vs. not-for-profit HMOs. *JAMA*, 281(2), 159-163.

<sup>19</sup> Gillies et al (2006). The Impact of Health Plan Delivery System Organization on Clinical Quality and Patient Satisfaction. *Health Services Research*, 14(4), 1181-1199.

have performed particularly well as detailed in recent case studies of Group Health Cooperative of Seattle (GHC)<sup>20</sup> and HealthPartners of Minnesota.<sup>21</sup>

As of 2008, 47% of the enrollment in private health plans was in non-profit health insurance organizations.<sup>22</sup> However, there are relatively few health insurance co-operative organizations in the United States. Some Congressional attention has been focused on options to incentivize the creation of new health insurance co-operatives. Advocates of this position argue that co-operatives invest retained earnings back into the plan or return the dollar to the membership, thus resulting in lower premiums, lower cost-sharing, expanded benefits, and innovations such as wellness programs, chronic disease management, and integrated care. Opponents of the proposal assert that co-operatives have not been successful in most of the country and that evidence is lacking that co-operatives would make health insurance more affordable.

## **Health Plans Defined Under Title I**

S. 1796 would establish new health insurance plans and define existing ones in the private market applicable to Title I. New health plans include the following:

- In the individual and small group markets, any new health plan must meet the specified requirements to be a “qualified health benefits plan” (QHBP). QHBPs must comply with new federal standards related to market reforms (e.g., guaranteed issue) and essential benefit requirements, and state rules including licensure requirements. Any plan offered through the Exchange (described below) must be a QHBP.
- A “qualified basic health plan” would be a plan established and maintained by the state under which only eligible individuals may enroll. Such a plan would provide coverage equal to at least the essential benefits package (described below), and have a medical loss ratio<sup>23</sup> of at least 85%.

The Senate Finance bill defines several terms related to health insurance applicable to Title I, including:

- “Health benefits plan” refers to health insurance coverage and a group health plan, not including self-insured plans and multiple employer welfare arrangements (MEWAs).
- “Offeror” refers to the plan sponsor in the case of a group health plan and health insurance coverage, or the employer in the case of a plan jointly offered by one or more employers and one or more employee organizations in which the employer is the primary financing source.

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<sup>20</sup> 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

<sup>21</sup> D. McCarthy, K. Mueller, and I. Tillmann, *HealthPartners: Consumer-Focused Mission and Collaborative Approach Support Ambitious Performance Improvement Agenda*, The Commonwealth Fund, June 2009

<sup>22</sup> Atlantic Information Services (AIS) *Health Plans facts, trends and data: 2008-2009* 13<sup>th</sup> edition.

<sup>23</sup> A medical loss ratio refers to the percentage of premiums collected by an insurer that is used to pay medical claims.

- Essential health benefits coverage (i.e. coverage required to fulfill the individual mandate) is defined as coverage under a QHBP, a grandfathered health benefits plan, eligible employer-sponsored plans,<sup>24</sup> Medicare part A, Medicaid, coverage for members of the Armed Forces and their dependents (including Tricare), certain veteran's health care program coverage, Federal Employees Health Benefits Program (FEHBP), and as determined by the HHS Secretary and Secretary of Labor, any other health benefits coverage such as a State health benefits risk pool or coverage while incarcerated.

## **Individual Mandate and Employer Requirements**

### **Individual Mandate**

S. 1796 would include a mandate for most individuals age 18 and over<sup>25</sup> to have health insurance beginning July 1, 2013, or to pay a penalty for noncompliance. Individuals would be required to maintain essential health benefits coverage for themselves and their dependents. Most individuals who do not maintain essential health benefits coverage for themselves and their dependents would be required to pay a penalty. The penalty would be phased-in—\$200 in 2014, \$400 in 2015, \$600 in 2016, reaching \$750 in 2017. In any given year, there would be a limit of no more than two times the penalty amount in total for the taxpayer and any dependents. The penalty amount would be adjusted for inflation, beginning with taxable years after 2017.

Members of Congress and congressional staff would be qualified to enroll in a QHBP in the individual market offered through an exchange in the state in which they reside. Any employer contribution made on their behalf could only be paid to the offeror of the QHBP in the which they were enrolled in the exchange. Employer contributions for Members of Congress and congressional staff could not be made to a plan offered through the Federal Employees Health benefit program (FEHBP).

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 without coverage for less than 90 days, Indians (as defined in the Indian Health Care Improvement Act), those with qualifying religious exemptions, those in a health care sharing ministry, undocumented aliens, individuals whose adjusted gross income did not exceed 100% of the federal poverty level (FPL), or any individual who the Secretary of Labor determines to have suffered a hardship with respect to the capability to obtain coverage under a QHBP. Additionally, individuals whose required

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<sup>24</sup> An "eligible employer-sponsored plan" is a health benefits plan (other than a grandfathered plan) that, in the case of a small employer is a QHBP and in the case of a large employer, is a plan that meets requirements relating to annual and lifetime limits, annual limits on cost-sharing, and provides preventive items and services with cost-sharing only as allowed.

<sup>25</sup> Certain individuals over 18 could still be covered under a family policy. The mandate for either having health insurance or paying a penalty would apply to applicable individuals 18 and over, who were not eligible to file taxes as a dependent of another taxpayer. For those who file a joint return, both individuals would be jointly liable for any penalty.

contribution<sup>26</sup> for a calendar year exceeds 8% of household income<sup>27</sup> would be exempt from the mandate. For tax years after 2013, the 8% would be adjusted by the Secretary to reflect the excess rate of premium growth and the rate of income growth for the period.

## **Employer Requirements**

S. 1796 would not mandate employers to provide employees with coverage, however employers with more than 50 full-time employees (defined as working on average at least 30 hours per week) who did not provide coverage could be required to pay a penalty for certain employees.

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 QHBP.
- Large employers could offer full-time employees the opportunity to enroll in a group health plan, as long as the plan met requirements relating to annual and lifetime limits, annual limits on cost-sharing, and provided preventive items and services with cost-sharing only as allowed.
- An employer would not be treated as meeting the employer requirements for an employee, if (1) the employee is eligible for a premium credit because the employee's required contribution exceeds 10% of the employee's household income or (2) the plan's share of the total allowed costs of benefits provided under the plan is less than 65% of the costs (this requirement would not apply to QHBPs). Employers would not have to provide coverage for seasonal workers.
- Employers would be required to file a return providing the name of each individual for whom they provide essential health benefits coverage, the number of months of coverage, and any other information required by the Secretary. They would also be required to provide notice to employees about the existence of the exchange, including a description of the services provided by the exchange.

A firm with more than 50 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 QHBP for which a premium credit or cost-sharing subsidy is allowed or paid for, for that employee. The penalty assessed to the employer for each such employee would be equal to the sum of the average annual credit and the average annual cost-sharing subsidy.<sup>28</sup> However, the

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<sup>26</sup> Required contribution is defined as (1) in the case of an individual eligible to purchase health insurance coverage through an employer (other than through the exchange), the portion of the annual premium for the lowest cost coverage offered that is paid by the individual 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.

<sup>27</sup> 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. Household income for the purpose of determining affordability would be based on the second taxable year preceding the taxable year for which a penalty might be imposed. For example, an individual's required contribution for his or her share of health insurance premiums in 2010, would be based on the household income in 2008.

<sup>28</sup> For 2013, the average annual credit and subsidy would be based on the aggregate amount of credit and subsidy for which applicants were determined eligible during the initial open enrollment period in an exchange.

total penalty for an employer would be limited to \$400 times the average number of the firm's employees. For example, consider an employer who did not offer health coverage and had 100 employees of which 30 full-time employees qualified for credits or subsidies through an exchange plan. If the penalty amount set by the Secretary of HHS for that year is \$3,000 per employee, the total penalty for the firm would be \$90,000 (30 x \$3,000). Since the maximum amount an employer must pay per year is limited to the number of employees multiplied by \$400, which in this case is \$40,000 (100 x \$400), the employer must pay only \$40,000 (the lesser of \$40,000 and the \$90,000 calculated tax). After 2013, the \$400 amount would be indexed by a premium adjustment percentage for the calendar year.

### **Small Business Tax Credit**

Certain small businesses would be eligible for a tax credit toward their share of the cost of health insurance coverage. In 2011 and 2012, the credit could cover up to 35% of a qualified employer's share of health insurance coverage. Beginning in 2013, 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 \$20,000 or less could claim the full credit amount. This credit would be phased out as average employee compensation increased from \$20,000 to \$40,000 and as the number of full-time 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 (highly compensated employees). Adjustments would be made for inflation after 2010.<sup>29</sup> 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. Non-profit 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 a 25 percent credit from 2011–2013 and a 35 percent credit in 2013 and thereafter. The credit would not be available to self-employed individuals.

### **Small Business Cafeteria Plans**

The Senate Finance 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. S. 1796 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. The bill 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.

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<sup>29</sup> The first \$20,000 of the credit would not be adjusted for inflation. The second \$20,000 would be adjusted each year.

## **Private Health Insurance Market Reforms**

S. 1796 would establish new federal standards applicable to private health insurance plans. These standards would primarily affect private health insurance in the individual market and the small group (small employer) market. 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 2015, 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 2015, small employers would be defined as those with 100 or fewer employees.<sup>30</sup>

Large employers would be affected by some provisions. After 2009, health insurance offered in the large and small group markets (excluding grandfathered plans and qualified health benefits plans) would be prohibited from imposing “unreasonable annual or lifetime limits” on plan enrollees. After June 30, 2013, health plans offered in the large group market could not charge cost-sharing for preventive services and would be required to adhere to the annual out-of-pocket limits applicable to high deductible health plans (HDHPs) as defined under the health savings account (HSA) section of the Internal Revenue Code (IRC).<sup>31</sup> Employers with more than 200 employees that offer coverage would be required to automatically enroll new employees in a plan unless the employee opted out.

### **Qualified Health Benefits Plan (QHBP)**

S. 1796 would require that all new health benefits plans offered in the individual and small group market be qualified health benefit plans (QHBP) that meet the insurance rating reforms and essential benefits package requirements specified in the bill (described below). A QHBP would be issued certification or recognized by the state that it meets the requirements relating to market reforms and health insurance affordability. Additionally, the offeror of the plan would be licensed by the state and comply with other requirements established by the Secretary or the state. QHBPs would be required to provide coverage for essential benefits and to charge the same premium regardless of whether the plan is purchased through an exchange (described below), the offeror, or an insurance agent. QHBPs also would be prohibited from excluding coverage for pre-existing conditions and would be required to offer coverage in the individual and small group markets on a guaranteed issue and guaranteed renewal basis.

### **Individual and Small Group Market Reforms**

S. 1796 would apply new federal health insurance standards to new, generally available health plans in the individual and small group markets. Among the market reforms are provisions that would do the following:

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<sup>30</sup> 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.

<sup>31</sup> For 2009, the out-of-pocket maximum for HSA-qualified HDHPs is \$5,800 for single coverage and \$11,600 for family coverage. See CRS Report RL33257, *Health Savings Accounts: Overview of Rules for 2009*, by Janemarie Mulvey.

- Prohibit qualified health benefits plans (QHBP) from excluding coverage for pre-existing health conditions, or imposing limits on coverage based on health status-related factors. (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.)
- Require QHBPs 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 nongroup coverage at the option of the enrollee. Guaranteed issue and renewal alone would not guarantee that the insurance offered was affordable.)
- Require health benefits plans, offered in a rating area<sup>32</sup> established by states, to determine premiums using adjusted community rating rules. (“Adjusted, or modified, community rating” prohibits issuers from pricing health insurance policies based on health factors, but allows it for other key characteristics such as age or gender.) Under S. 1796, premiums would only be allowed to vary according to specified ratios for the following risk factors: family enrollment (Individual, 1:1; Adult with child, 1.8:1, Two adults, 2:1, and Family, 3:1); age (by no more than a 4:1 ratio across age rating bands established by the Secretary), and tobacco use (by no more than 1.5:1 ratio).
- Require health benefits plans to provide an outline of the plan’s coverage that meets uniformity standards adopted by the Secretary. Such standards would ensure that the outline both accurately describes the coverage offered by the plan, and is presented in a uniform format.

## **Reforms Related to Allocation of Insurance Risk**

S. 1796 would include provisions which take into account the variation of insurance risk among plan enrollees and across health plans. Such provisions would:

- Require individual and small group issuers that offer a QHBP through an exchange (described below) to consider all enrollees of that plan as members of a single risk pool. (“Pooling” refers to the insurance industry practice of pooling the insurance risk of individuals or groups in order to determine premiums.) Give states the option to merge the individual and small group markets for the purposes of applying the pooling requirements.
- Require each state to adopt a risk-adjustment model, established by the Secretary, to apply risk adjustment to QHBPs and grandfathered plans 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.)

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<sup>32</sup> As an example, some states have enacted rating rules in the individual and small group markets that include geography as a characteristic on which premiums may vary. In these cases, the state has established rating areas. Typically, states use counties or zip codes to define those areas.

- Require each state to establish a reinsurance program no later than July 1, 2013. (“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.) Require all plan offerors to contribute to a temporary reinsurance program for individual policies that is administered by a non-profit reinsurance entity.
- Require the Secretary to establish and administer temporary risk corridors, under which payments to QHBPs in the individual and small group markets would be made according to applicable risk corridor rules. (“Risk corridors” refer to a mechanism which adjusts payments to plans 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 the Secretary to establish one or more temporary high risk pools that offer coverage with no coverage exclusions for pre-existing health conditions. High risk pools would provide coverage for the essential benefits package (described below), and provide the bronze level of coverage (described under the Exchange section).
- Require the Secretary 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. Funding would not exceed \$5 billion. 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 Senate Finance bill would also require states to (1) implement regulations or standards that effectuate the reforms applicable to the private individual and small group markets; (2) establish one or more exchanges including a small business exchange; (3) require QHBPs to provide an internal claims appeal process; and (4) establish an external review process. In addition, S. 1796 would allow states to (1) establish programs to allow for the automatic enrollment of individual and employees in QHBPs; (2) establish or continue any health insurance requirements that offer greater protections to consumers than the new federal standards specified in this bill; and (3) apply for a waiver of any and all private market requirements and the individual mandate. The Senate Finance bill also would allow QHBPs to be subject to the health insurance laws and regulations of one state while operating in multiple states.

Plans could continue to offer coverage in a grandfathered plan in both the individual and group market. Enrollment would be limited to those who were currently enrolled, their dependents, or for grandfathered employer-sponsored insurance to new employees and their dependents. Beginning July 1, 2013, the insurance reform requirements of this bill (relating to the requirements in the small group market, such as a prohibition of pre-existing condition exclusions) would apply to grandfathered plans in the small group market. If a state is phasing in

those requirements for QHBPs, the phase-in would apply in the same manner to grandfathered plans. Additionally, health insurance coverage in the individual market (in effect before enactment) that is actuarially equivalent to a catastrophic plan for young individuals would be treated as a grandfathered plan.

### **Essential Benefits Package**

The Secretary would specify the benefits included in the “essential benefits package” that qualified health benefits plans would be required to cover. Those benefits would include at least the following general categories:

- hospitalization;
- outpatient hospital and clinic services, including emergency department services;
- professional services of physicians and other health professionals;
- medical and surgical care;
- such services, equipment, and supplies incident to the services of a physician’s or a health professional’s delivery of care in institutional settings, physician offices, patients’ homes or place of residence, or other settings as appropriate;
- prescription drugs;
- rehabilitative and habilitative services;
- mental health and substance use disorder services, including behavioral health treatment;
- preventive services, including those services recommended with a grade of A or B by the U.S. Preventive Services Task Force and those vaccines recommended for use by the Advisory Committee on Immunization Practices;
- maternity benefits; and
- well baby and well child care and oral health, vision, hearing services, equipment, and supplies for children under 21 years of age.

Essential benefits package coverage would be prohibited from imposing any annual or lifetime limits. No cost-sharing would be allowed for preventive services. For all other services included in the essential benefits package, cost-sharing could not exceed the minimum deductible and would have to meet the out-of-pocket limits applicable to high deductible health plans (HDHPs) as defined under the health savings account (HSA) section of the IRC.<sup>33</sup>

By July 1, 2012, the Senate Finance bill would require the Secretary to specify the covered treatments, items, and services within each of the categories listed above, and update such benefits annually thereafter. The Secretary would ensure that the scope of the essential benefits package is not more extensive (as certified by the Chief Actuary of the Centers for Medicare and

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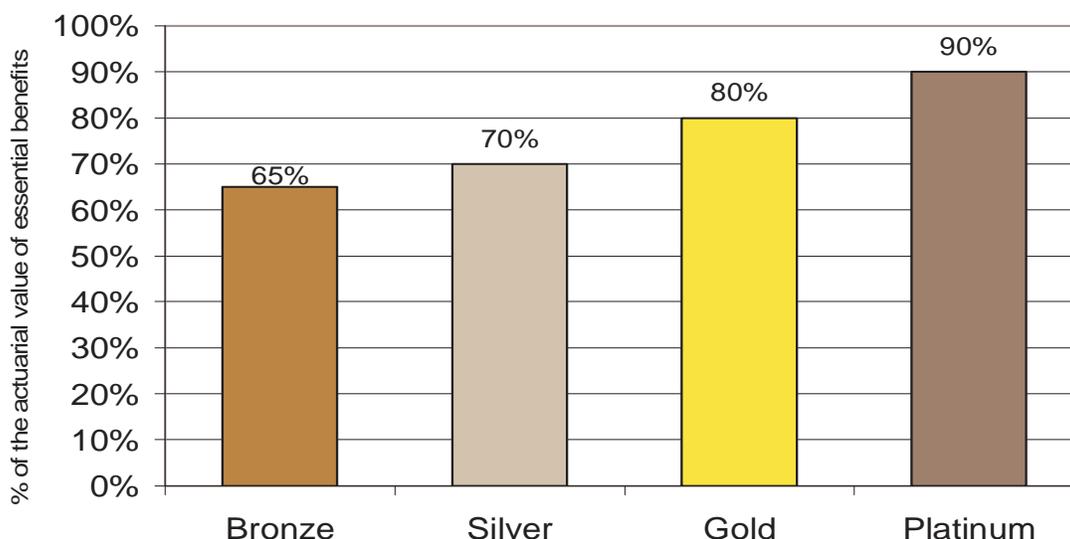
<sup>33</sup> For 2009, the minimum deductible for HSA-qualified HDHPs is \$1,150 for single coverage and \$2,300 for family coverage. For 2009, the out-of-pocket maximum for HSA-qualified HDHPs is \$5,800 for single coverage and \$11,600 for family coverage. For additional information, see CRS Report RL33257, *Health Savings Accounts: Overview of Rules for 2009*.

Medicaid Services) than the scope of benefits under a typical employer-provided health plan. Each state would be required to ensure that at least one plan offered in the exchange is actuarially equivalent to the standard Blue Cross Blue Shield plan offered to Federal employees.

### Tiers of Coverage in Individual and Small Group Markets

S. 1796 would require insurers in the individual or small group market to offer QHBPs that include the essential benefits package and that provide coverage at one of the following tiers of coverage: bronze, silver, gold, or platinum. This requirement on insurers in the individual and small group market would apply regardless of whether or not the plan is offered through an exchange. For each coverage tier, the Senate Finance bill specifies an actuarial value (i.e., the average percentage of total covered costs in the essential benefits package paid for by the plan for a given population), as shown in **Figure 1**. An insurer that offers coverage in any of these tiers would be permitted to offer a separate plan in that tier that covers only those (1) who are under age 21, or (2) who are 21 or older but are the dependent of another person.

**Figure 1. Actuarial Values for Tiers of Coverage**



**Source:** CRS analysis of S. 1796 as ordered reported by Senate Finance Committee.

Besides these four tiers, S. 1796 also would permit some additional plan options. A catastrophic plan would be permitted for young adults (those under age 26 before the plan year begins) and for those exempt from the individual mandate because no affordable coverage is available. The catastrophic plan could have no cost-sharing for preventive services, but for all other expenses would have a deductible in 2013 equal to the largest annual out-of-pocket maximum permitted for QHBPs, which is based on the limitations for HSA-qualified HDHPs.<sup>34</sup>

<sup>34</sup> For 2009, the out-of-pocket maximum for HSA-qualified HDHPs is \$5,800 for single coverage and \$11,600 for family coverage. For additional information, see CRS Report RL33257, *Health Savings Accounts: Overview of Rules for 2009*.

## **State Flexibility to Establish Basic Health Plans for Low-Income Individuals Not Eligible for Medicaid**

There is no existing Federal law providing direct on-going 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, S. 1796 would establish a program that is modeled after the 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."<sup>35</sup> The Washington State HCA contracts with private health plans to implement the BH program. In turn, the private plans contract with health care providers for services under the BH benefits plan. Currently the following five private insurers participate: Columbia United Providers, Community Health Plan of Washington, Group Health Cooperative, Kaiser Permanente, and Molina.<sup>36</sup> Choice of plans is made at the county level. Not every participating plan is available in every county.

S. 1796 would require the Secretary to establish a program where a state or a regional compact of states would establish one or more qualified basic health plans ("basic plan")<sup>37</sup> to provide at least an essential benefits package to eligible individuals rather than offering coverage to them through an exchange.<sup>38</sup> The Secretary would be required to certify that the state's basic plan has premiums and cost-sharing that does not exceed the costs under QHBPs within the state, and that the benefits provided under the qualified basic health plan covers the items and services required under an essential benefits package.

The Senate Finance bill would also require states to establish a competitive process to enter into contracts with coverage providers under the plan. Contract negotiations would include payment rates, premiums, cost-sharing, and extra benefits.<sup>39</sup> The competitive process would also require consideration of 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. The bill would also mandate consideration in the competitive process of establishment of specific performance measures that focus on quality of care and improved outcomes, in addition to requiring providers to report measures and standards. These data would have to be made available to enrollees.

Under the bill, if the Secretary determines that a state meets the requirements of the program, then the Secretary would provide funds to participating states in order to provide affordable health care coverage through private health care systems under contract. A state's Basic Health Plan funding level would be based on the Secretary's estimates of 85 percent of the value of individual tax

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<sup>35</sup> "Basic Health Plan 2008 Annual Report" <http://www.basicealth.hca.wa.gov/documents/2008AnnualReport.pdf>

<sup>36</sup> <http://www.basicealth.hca.wa.gov/plans>

<sup>37</sup> A basic plan would be a plan established by the state under which only individuals eligible for this program could enroll. The plan would be required to have at least an essential benefits package and a medical loss ratio of 85%.

<sup>38</sup> Eligible individual is defined by the following (1) must be a resident of the State who is not eligible to enroll in the State's Medicaid program for benefits that, at a minimum, are consistent with the essential benefits package in section 2242; (2) must have a household income between 133 percent and 200 percent of the Federal Poverty Level (FPL) for the size of the family involved; (3) is not eligible for an employer-sponsored plan that is not affordable coverage; and (4) has not attained the age of 65 as of the beginning of the plan year.

<sup>39</sup> States would be instructed to allow enrollees a choice between two or more plans, and would be allowed 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.

credits and cost sharing subsidies that otherwise would have been made for enrollment in QHBPs offered through an exchange. This amount would be calculated on a per enrollee basis. Funds distributed to the states would be provided to independent trusts and would be used by the states only to reduce the premiums and cost sharing for eligible enrolled individuals.

## QHBP Exchanges

### Exchange Structure

If states do not implement the reforms to the individual and small group markets described above by July 1, 2013, then the Secretary would implement and enforce those requirements. States that implemented the reforms would also be required to establish an exchange by July 1, 2013, through which individuals and small employers could obtain QHBPs—otherwise, the Secretary would enter into a contract with a “nongovernmental entity to establish and operate the exchanges within the state.”<sup>40</sup> (S. 1796 also would permit the creation of “interim exchanges” prior to July 1, 2013, discussed in the **Appendix**.)

Exchanges would be similar in many respects to existing entities like the Massachusetts Connector and eHealthInsurance. Exchanges would not be insurers but would provide eligible individuals and small businesses with access to insurers’ plans in a comparable way (in the same way, for example, that Travelocity or Expedia are not airlines but provide access to available flights and fares in a comparable way).

The Senate Finance bill calls for the creation of separate exchanges in each state for individuals versus small employers (“a Small Business Health Options Program ... [or] SHOP exchange”).<sup>41</sup> 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.”<sup>42</sup> 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.

All plans offered by insurers in the individual and small groups markets would have to be offered through an exchange, but could also be offered outside an exchange. Insurers would have to offer plans in the silver and gold tiers, but could also offer plans in the bronze and platinum tiers. Insurers could also offer through an exchange the catastrophic and child-only plans described in the Tiers section above. The exchange could also include dental-only plans.

The Secretary would enter into an agreement with each state to specify which of the following functions would be done by the Secretary, the state, or the exchange:

- provide for the state to establish procedures to certify, recertify and decertify QHBPs;
- establish an outreach plan, call centers, internet portals, and a system to rate exchange plans;

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<sup>40</sup> Sec. 2225(b)(1)(B) of S. 1796.

<sup>41</sup> Sec. 2235(a) of S. 1796.

<sup>42</sup> Sec. 2235(b)(1) of S. 1796.

- determine whether applying individuals and employers are eligible to participate in the exchange;
- establish and carry out a process which provides for enrollment in person, by mail, by telephone (call center), or electronically (internet portal)—including through local hospitals and schools, state motor vehicle offices, local Social Security offices, locations operated by Indian tribes and tribal organizations, and other locations specified by the exchange;
- provide open enrollment periods from March 1 through May 31 (with some exceptions), beginning in 2013;
- establish uniform enrollment forms, standardized marketing requirements, and a standardized format for presenting options among exchange plans;
- provide for a calculator to determine the actual cost of coverage to individuals after taking into account any premium credits and cost-sharing subsidies; and
- certify whether individuals are exempt from the individual mandate excise tax because there is no affordable QHBP through the exchange or the through individual's employer, and transfer the list of such individuals to the Treasury Secretary.

The HHS and Treasury Secretaries would have responsibility for advance determination of premium credits and cost-sharing subsidies. The HHS Secretary would designate an office to provide technical assistance to states for SHOP exchanges. The Secretary would pay states “the amount the Secretary reasonably estimates to be the unreimbursed start-up costs for any exchange.”<sup>43</sup> The Secretary could not make payment for exchanges’ ongoing operations; that funding would be from assessments on QHBPs set by exchanges.

The Secretary would also establish procedures under which a state would be required to allow insurance agents or brokers to enroll individuals in an exchange plan and to assist them in applying for premium credits and cost-sharing subsidies. Each state would establish rate schedules for broker commissions paid by exchange plans.

## **Individual and Employer Eligibility for Exchange Plans**

Individuals could enroll in a plan through their state’s exchange if they are (a) residing in a state that established an exchange, (b) not incarcerated, except individuals in custody pending the disposition of charges, and (c) are lawful residents. Undocumented aliens would be prohibited from obtaining coverage through an exchange.<sup>44</sup>

Only small employers may opt to offer coverage to their workers through an exchange. Before 2015, 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 2015, 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).

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<sup>43</sup> Sec. 2237(c)(1) of S. 1796.

<sup>44</sup> 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.

Participating employers could limit the choice of exchange plans available to their employees; plan choice could be limited to a particular benefit level (tier) or even to a single plan.

As previously mentioned, Members of Congress and congressional staff would be eligible to obtain coverage through an exchange. Indeed, the only way they could obtain their employer's contribution toward premiums would be to enroll in an exchange plan. Otherwise, they would be responsible for 100% of the premium (unless their income was low enough to qualify for premium credits).

## **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 S. 1796, those eligible for premium credits would also be eligible for cost-sharing subsidies. Both premium credits and cost-sharing subsidies would only be available for silver plans sold through an exchange, including both the private plans and public option.

### **Premium Credits**

Beginning January 1, 2013, 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. Qualifying individuals between 300% and 400% FPL would have to pay no more than 12% of their incomes in premiums. For qualifying individuals with income between 133% (100% after 2013) and 300% FPL, the percent of income they would have to pay toward premiums would rise in a straight line from 2% of income to 12% of income, as illustrated in the solid line of **Figure 2** and **Table 1** below.<sup>45</sup> For a family of three in the 48 contiguous states in 2009, 100% FPL is \$18,310, and 400% FPL is \$73,240.<sup>46</sup>

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.

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<sup>45</sup> In years after 2013, the percentages would be adjusted to reflect any percentage by which premium growth exceeded income growth. However, credit amounts could also be reduced to ensure S. 1796 does not increase the federal deficit.

<sup>46</sup> 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>.

**Table I. Maximum Out-of-Pocket Premium Payments Under S. 1796, If Implemented in 2009**

For the 48 contiguous states and the District of Columbia

Federal Poverty Line (FPL)	Maximum Premium as a % of Income	Maximum Annual Premium (2009), by Family Size			
		1	2	3	4
100%	2.0%	\$217	\$291	\$366	\$441
133%	3.7%	\$526	\$707	\$889	\$1,070
150%	4.5%	\$731	\$983	\$1,236	\$1,488
200%	7.0%	\$1,516	\$2,040	\$2,563	\$3,087
250%	9.5%	\$2,572	\$3,460	\$4,349	\$5,237
300%	12.0%	\$3,899	\$5,245	\$6,592	\$7,938
350%	12.0%	\$4,549	\$6,119	\$7,690	\$9,261
400%	12.0%	\$5,198	\$6,994	\$8,789	\$10,584

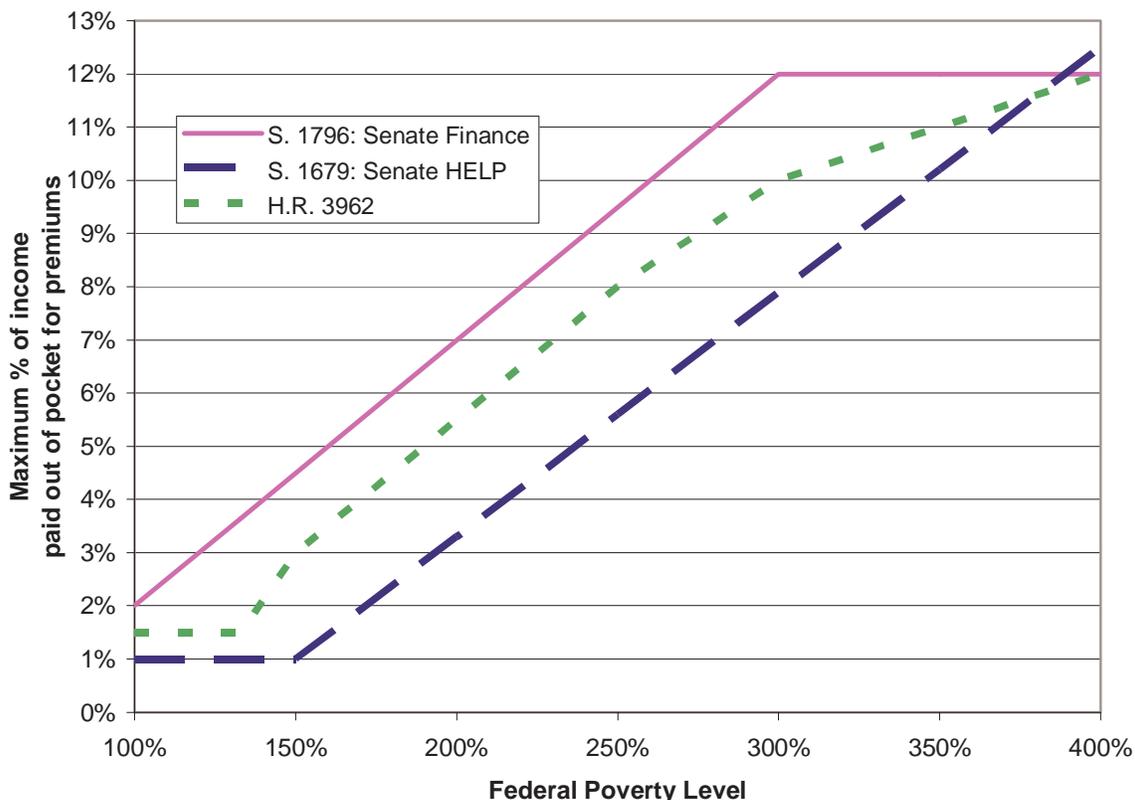
**Source:** CRS computation based on “Annual Update of the HHS Poverty Guidelines,” 74 *Federal Register* 4200, January 23, 2009, <http://aspe.hhs.gov/poverty/09fedreg.pdf>, and S. 1796—for the least expensive plan available to eligible individuals. If individuals choose more expensive plans, they may be responsible for additional premiums.

Although the Medicaid provisions of S. 1796 are generally beyond the scope of this report, eligibility for Medicaid as expanded under S. 1796 interacts with the bill’s provisions regarding premium credits and cost-sharing subsidies. From 2011 to 2013, states could 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, all non-elderly citizens up to 133% FPL would be eligible for Medicaid. S. 1796 would not change noncitizens’ eligibility for Medicaid. Thus, for example, in 2013, legal permanent residents (LPRs) who are below 100% FPL could be ineligible for Medicaid and would also be ineligible for premium credits. However, beginning in 2014, lawfully present taxpayers below 100% FPL who are not eligible for Medicaid would be eligible for premium credits.<sup>47</sup>

Besides the previously mentioned eligibility criteria, individuals would also generally be ineligible for credits if they were *eligible* for an employer-sponsored plan, Medicare, Medicaid, coverage related to military service, FEHBP, 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 10% of household income or if the plan covered less than 65% of total allowed costs.

<sup>47</sup> For more information about the treatment of noncitizens and the verification of individuals’ eligibility for premium credits under S. 1796, 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, S. 1796, S. 1679 and H.R. 3962, by Federal Poverty Level (FPL)**



Source: CRS analysis.

### Cost-Sharing Subsidies

Those who qualified for premium credits and were 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 2009, the out-of-pocket maximum for HSA-qualified HDHPs is \$5,800 for single coverage and \$11,600 for family coverage. As shown in **Table 2**, 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 gold tier for qualifying individuals between 201% and 400% FPL.

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 S. 1796 does not increase the federal deficit.

**Table 2. Cost-Sharing Subsidies: 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
100% (133% in 2013) - 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 gold
301% - 400%	Reduced by one-third	Not more than gold

Source: CRS analysis.

## Consumer Operated and Oriented Plan (CO-OP)

S. 1796 would provide incentives for the creation of health insurance co-operatives. The bill provides these incentives 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 non-profit member-run health insurance companies that offer qualified health benefits that serve eligible individuals in one or more states. CO-OP grantees would compete in the reformed individual and small group insurance markets on a level regulatory playing field. Federal funds would be distributed as loans for start-up costs and grants for meeting solvency requirements.

S. 1796 would direct the Secretary to make grant and loan awards after taking into account the recommendations of an advisory board. The Secretary would make grant and loan awards giving priority to applicants that offer qualified health benefits on a statewide basis, use an integrated care model, and have significant private support. The Secretary would ensure that there is sufficient funding to establish at least one qualified non-profit 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 S. 1796 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.

S. 1796 would define a qualified nonprofit health insurance issuer as an organization meeting the following requirements:

- It must be organized as a non-profit, member corporation under State law;
- 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 qualified health benefit plans 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;
- It must be in compliance with all the other requirements that other qualified health benefits plans must meet in any state, including solvency and licensure requirements, rules on payments to providers, rules on network adequacy, rates and form filing rules, and any applicable state premium assessments. Additionally, the organization would be required to coordinate with state insurance reforms described in Sec.2225(a)(2)(A); and
- 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.

S. 1796 would permit organizations 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. S. 1796 would 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 S. 1796, an organization receiving a grant or loan under the CO–OP program would qualify 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 non-profits 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.

## **Abortion**

Under S. 1796, a health benefits plan would not be required to provide coverage of either elective abortions or abortions that could be paid for with funds appropriated to the Department of Health and Human Services (“HHS”). Under current law, funds appropriated to 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 suffers from a physical disorder, physical injury, or physical illness that would endanger her life if an abortion is not performed.<sup>48</sup> S. 1796 indicates that the offeror of a health benefits plan would determine whether the plan would provide coverage of either type of abortion as part of its essential benefits package for the plan year.

S. 1796 would require the Secretary of HHS to ensure that in any exchange, at least one qualified health benefits plan provides coverage of both elective abortions and abortions for which funds appropriated to HHS are permitted. In addition, the Secretary would be required to ensure that in any exchange, at least one qualified health benefits plan does not provide coverage of elective abortions. If a state has one exchange covering both the individual and small group markets, the Secretary would have to provide the aforementioned assurances with respect to each market. A qualified health benefits plan would be treated as not providing coverage of elective abortions if it did not provide either type of abortion.

The offeror of a qualified health benefits plan that provides coverage of elective abortions could not use any amount attributable to a premium assistance credit or any cost-sharing subsidy to pay for such services. In addition, the offeror would be required to segregate from the aforementioned amount an amount equal to the actuarial value of providing elective abortions for all enrollees, as estimated by the Secretary. The Secretary would be required to estimate, on an average actuarial basis, the basic per enrollee, per month cost of including coverage of elective abortions. In making that estimate, the Secretary could take into account the impact of including such coverage on overall costs, but could not consider any cost reduction estimated to result from providing such abortions, such as prenatal care. The Secretary would be required to estimate the costs as if coverage were included for the entire covered population, but the costs could not be estimated at less than \$1 per enrollee, per month.

Under S. 1796, a qualified health benefits plan could not discriminate against any individual health care provider or health care facility because of its willingness or unwillingness to provide, pay for, provide coverage of, or refer for abortions. In addition, state laws regarding 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 would also not be affected by S. 1796. Finally, the rights and obligations of employees and employers under Title VII of the Civil Rights Act of 1964 would not be affected by the measure.

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<sup>48</sup> For additional information on the public funding of abortion, see CRS Report RL33467, *Abortion: Legislative Response*, by Jon O. Shimabukuro.

## Selected Revenue Provisions Relating to Private Health Insurance

The Senate Finance bill includes a number of provisions in Title VI 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 3** 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 \$304 billion in revenues over a 10-year period.

**Table 3. Selected Revenue Provisions in Title VI of S. 1796**

As Amended Through October 2, 2009

	Effective Date <sup>a</sup>	Increase in Revenues (Fiscal Years 2010-2019)
<b>Excise Taxes and Limitations On Employer Deductions</b>		
40% Excise Tax on High Cost Plans	Dec. 31, 2012	\$201.4 billion
Impose Annual Fee On Health Insurance Providers	January 1, 2010	\$60.4 billion
Eliminate Deductions for Expenses Allocable to Medicare Part D subsidy	December 31, 2010	\$5.4 billion
Limit deduction for compensation to \$500,000 for executives of health insurance companies	December 31, 2012 <sup>b</sup>	\$0.6 billion
<b>Modifications to Tax-Advantaged Accounts and Itemized Deductions Used for Health Care</b>		
Limit Health Flexible Spending Accounts (FSAs) to \$2,500	Dec. 31, 2010	\$14.6 billion
Raise penalty for non-qualified HSA withdrawals from 10% to 20%	Dec. 31, 2010	\$1.3 billion
Change the definition of medical expenses for FSAs and Health Savings Accounts (HSAs)	Dec. 31, 2009	\$5.4 billion
Raise 7.5% floor for itemized medical expenses to 10% for those under age 65.	Dec. 31, 2012	\$15.2 billion
<b>Total Revenues Relating To Private Health Insurance</b>	—	<b>\$304.3 billion</b>

**Source:** Joint Committee on Taxation, October 8, 2009, JCX-41-09

**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. Would apply to taxable years beginning after this date.
- b. Effective for remuneration paid in taxable years beginning after 2012 with respect to services performed after 2009.

## **Excise Taxes and Limitations on Employer Deductions**

S. 1796 would impose excise taxes on health insurers and health plan administrators.<sup>49</sup> 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, S. 1796 would limit the deductibility of compensation for health insurance executives. The bill also would affect employers who currently provide retiree health insurance and would limit their ability to deduct federal subsidies for retiree prescription drug coverage from their taxable income.

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

S. 1796 would impose an excise tax of 40% on health insurance coverage that exceeds certain thresholds in 2013. The thresholds are \$8,000 for single coverage and \$21,000 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 age 55 and older, 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.<sup>50</sup> 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.

S. 1796 would impose additional reporting requirement on employers providing health insurance coverage. Specifically, under the proposal, 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,

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<sup>49</sup> There is also an excise tax on health care manufacturers (e.g. medical devices and branded prescription drugs). See CRS Report R40886, *Public Health, Workforce, Quality, and Other Provisions in the America's Healthy Future Act (S. 1796)*, for a discussion of the revenue provisions on health care manufacturers.

<sup>50</sup> 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.

- 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 \$201 billion in revenues from 2010 to 2019 and would be levied on nearly one-third of health plans by 2019.<sup>51</sup>

### **Annual Fee on Health Insurance Plans**

In addition to an excise tax on high cost plans, S. 1796 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.<sup>52</sup> The fee would not apply to self-insured plans or federal, state or government entities. However, it would apply to companies or organizations that underwrite these government-funded insurance (i.e. Medicaid managed care plans, Federal Employee Health Benefit Plans [FEHBP]). According to the JCT, this fee is expected to raise \$60.4 billion over a 10-year period (see **Table 3**).

### **Limitation on Deduction for Executive Compensation of Health Insurers**

The Senate Finance bill 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 3**).

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

Under current law, employers providing prescription drug coverage to retirees that meet 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. S. 1796 would require

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<sup>51</sup> Joint Committee on Taxation, October 8, 2009, JCX-41-09.

<sup>52</sup> 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.

employers to coordinate the subsidy and the deduction for retiree prescription drug coverage. In this provision, 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 3**).

## **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 VI of S. 1796.

### *Modifications to Tax-Advantaged Accounts*

S. 1796 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.<sup>53</sup>

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.<sup>54</sup> About one-third of workers in 2007 have access to an FSA.<sup>55</sup> Under current law, it is at the discretion of each employer to set their limits on FSA contributions. In 2008, the average FSA contribution was \$1,350.<sup>56</sup> S. 1796 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 3**).

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.<sup>57</sup> 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. S. 1796 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 3**).

In addition to the specific provisions in S. 1796 that would directly modify these tax-advantaged plans, this proposal 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

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<sup>53</sup> See CRS Report RL33505, *Tax Benefits for Health Insurance and Expenses: Overview of Current Law and Legislation*, by Janemarie Mulvey.

<sup>54</sup> See CRS Report RL32656, *Health Care Flexible Spending Accounts*, by Janemarie Mulvey.

<sup>55</sup> Bureau of Labor Statistics, *Table 24. Pretax benefits: Access, private industry workers*, National Compensation Survey, March 2007.

<sup>56</sup> Mercer Human Resources Consulting, *National Survey of Employer-Sponsored Health Plans 2008*.

<sup>57</sup> See CRS Report RL33257, *Health Savings Accounts: Overview of Rules for 2009*, by Janemarie Mulvey.

medications. S. 1796 would restrict this practice and excludes over-the-counter prescriptions (except those prescribed by a physician) as a qualified medical expense. According to the JCT, this provision would increase revenues by \$5.4 billion over 10 years (see **Table 3**).

### *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.<sup>58</sup> Taxpayers with adjusted gross income below \$50,000 accounted for 52% of those taking this itemized deduction for medical expenses.<sup>59</sup> S. 1796 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 still be subject to the 7.5% limit under current law. According to the JCT, this provision would raise revenues by \$15.2 billion over 10 years (see **Table 3**).

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<sup>58</sup> Internal Revenue Service, Statistics of Income, *Table 1.3: All Returns: Source of Income, Adjustments, Deductions, Credits and Tax Items, by Marital Status, Tax Year 2007*.

<sup>59</sup> Joint Committee on Taxation, *Tax Expenditures: Compendium of Background Material on Individual Provisions*, December 2008.

## Appendix. Timeline of Implementation Dates of Private Health Insurance Provisions Under Title I of S. 1796 Prior to Full Implementation on July 1, 2013

Implementation date	Section in S. 1796	Provision
"as soon as practicable after the date of enactment"	Sec. 1001 "Sec. 2225(b)(2)" "Sec. 2235(c)"	Each state that planned to implement the private health insurance requirements of the new Title XXII of the Social Security Act would establish an interim exchange to offer coverage during the period beginning January 1, 2010 and ending June 30, 2013. For each state that did not set up an interim exchange, the Secretary would contract with a nongovernmental organization to do so.
After 2009	Sec. 1201 "Sec. 2233(a)"	Health benefits plans in the large or small group markets would be prohibited from imposing unreasonable annual or lifetime limits.
After December 31, 2009	Sec. 1502	Each health benefits plan offeror would report to the Secretary the share of premiums collected that is used to for payments other than for medical care. Each hospital would establish and update a list of standard charges for items and services provided by the hospital, including for each diagnosis-related group category established under the Medicare program.
Not later than 90 days after enactment	Sec. 1001 "Sec. 2216"	The Secretary would establish a temporary reinsurance program to reimburse participating employment-based health plans for a share of the cost of providing health coverage to retirees.
Not later than 3 months after enactment	Sec. 1401 "Sec. 2251"	The Comptroller General would appoint the original members of the CO-OP program's advisory board, which would provide recommendations to the Secretary regarding the awarding of loans and grants under such program.
Not later than 12 months after enactment	Sec. 1001 "Sec/ 2225(a)"	The NAIC would develop and promulgate "Model Regulations" to implement the private health insurance requirements specified under the new Title XXII for health benefits plans offered within a state.
Not later than 12 months after enactment	Sec. 1503	The NAIC would develop and submit to the Secretary standards applicable to outline documents that accurately describe the coverage offered by health insurance issuers to be provided to plan enrollees. Not later than 60 days after standards are submitted, the Secretary would promulgate regulations to implement such standards. Not later than 24 months after enactment, health insurance issuers or the Secretary (with respect to public coverage programs) would provide an outline of coverage to each insurance applicant, enrollee, and policyholder.
Not later than 1 year after enactment	Sec. 1001 "Sec. 2215"	The Secretary would establish one or more high risk pools to provide health insurance coverage that does not impose any coverage exclusions for pre-existing health conditions to all eligible persons.
Not later than 24 months after enactment	Sec. 1102	The Secretary would submit to Congress a report on methods that could be employed by plans offered in the exchange to encourage use of electronic health records, and recommendations for legislation or administrative action as deemed appropriate.
Not later than January 1, 2012	Sec. 1401 "Sec. 2251"	The Secretary would award loans and grants under the CO-OP program to facilitate the creation of qualified nonprofit health insurance issuers to offer qualified health benefits plans in the individual and small group markets. The bill would appropriate \$6 billion for the CO-OP program.
Not later than 2012	Sec. 1001 "Sec. 2227(b)"	The NAIC would develop model rules for the offering of national QHBPs.
Not later than July 1, 2012	Sec. 1001 "Sec. 2227(a)"	The NAIC would develop model rules for the creation of health care choice compacts under which two or more states may enter into agreement under which a qualified health benefits plan could be offered in multiple states but subject to the laws and regulations of the state in which the plan was issued.

Implementation date	Section in S. 1796	Provision
Not later than July 1, 2012	Sec. 1101(b)	With respect to the establishment of qualified health benefit plan exchanges, the Secretary would submit a report to Congress regarding processes to ensure (1) the confidentiality of taxpayer information, (2) employee access to QHBP coverage through an exchange, and (3) employer access to information and due process, including any recommendations for legislative changes.
Not later than July 1, 2012	Sec. 1201 "Sec. 2242(e)"	The Secretary would define the benefit categories regarding the minimum services to be covered under the "minimum benefit package" for qualified health benefits plans in the individual market, and specify the covered treatments, items, and services within each category.
March 1, 2013	Sec. 1101 "Sec. 2236"	The initial open enrollment period, for coverage offered through the exchange would be from March 1 to May 31, 2013.

**Source:** CRS analysis of S. 1796 as ordered reported by Senate Finance Committee

**Notes:** CO-OP: Consumer Operated and Oriented Plan program. NAIC: National Association of Insurance Commissioners. QHBP: qualified health benefits plan.

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## Acknowledgments

Jon O. Shimabukuro contributed to the section on abortion. In addition, Ruth Ellen Wasem made contributions to this report.