COMMISSION ON A HIGH PERFORMANCE HEALTH SYSTEM

AN ANALYSIS OF LEADING CONGRESSIONAL HEALTH CARE BILLS, 2007–2008: PART I, INSURANCE COVERAGE

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ABSTRACT: This report analyzes and compares leading bills of the 110th Congress aimed at expanding and improving health insurance coverage. Bills and proposals from members of Congress and President-elect Barack Obama include plans to fundamentally reform the health insurance system through mixed private–public approaches that build on our current system; a public insurance option available to the entire population; bills to change the tax treatment of employer benefits; federal–state partnership to provide grants to states to expand coverage; and bills that would expand coverage for children or disabled individuals, among others. Using analysis from the Lewin Group, the authors provide coverage and cost estimates for the proposed bills, which range from 48.9 million uninsured people gaining coverage to a net loss of coverage for 283,000 people; proposals could increase national health spending by as much as $64.1 billion or create savings of $58.1 billion.

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EXECUTIVE SUMMARY

This report—the first of a two-part series—analyzes and compares leading bills of the 110th Congress that are aimed at expanding and improving health insurance coverage.[1] The Commonwealth Fund commissioned the Lewin Group[*] to estimate the effect of the bills on stakeholder and health system costs and the projected number of people the bills would insure. The Fund also commissioned Health Policy R&D, a health policy firm, to create detailed side-by-side comparative analyses of the bills as well as summaries. The report also includes an analysis of the proposals outlined by President-elect Barack Obama and Senator Max Baucus (D-Mont.), focusing on the insurance coverage provisions of those proposals. Because President-elect Obama and Senator Baucus have proposed frameworks for expanding coverage that lack key details, Lewin provided an estimate of the Building Blocks proposal—published in a *Health Affairs* article by Cathy Schoen and colleagues at The Commonwealth Fund—which is similar to the Obama and Baucus plans.

Under the current laws, Lewin projects that the number of uninsured in the United States will rise to 48.9 million people in 2010 out of a total estimated population of 306.9 million; 15.9 percent of the total population will be uninsured. Among the plans analyzed, Lewin estimates that up to 48.9 million uninsured could be covered—under a bill proposed by Representative Pete Stark (D–Calif.). At the other end of the spectrum, a bill introduced by Representative Sam Johnson (R–Texas), would result in a net loss of coverage of 283,000. According to Lewin's cost estimates, total health spending could be as high as $64.1 billion—under a bill proposed by Senator Mike Enzi (R–Wyo.)—or we could see net savings of $58.1 billion under Rep. Stark's bill. All coverage and cost estimates are for 2010 and are based on the assumption of full implementation in 2010.

The bills and proposals to expand health insurance coverage take a variety of approaches to achieve incremental as well as more comprehensive expansions in coverage. They fall into four broad categories:

- fundamental reforms of the nation's health insurance system;
- expansions of existing public insurance programs;
- new options for small employers;
- expansions of health savings accounts.

[*] As disclosed more fully in note 6 on page 57, the Lewin Group is a wholly owned subsidiary of Ingenix which in turn is owned by UnitedHealth Group. The Lewin Group maintains editorial independence from its owners and is responsible for the integrity of any data that it produces for the Fund.

The proposals and bills covered in this report include:

Fundamental Reforms of the Nation's Health Insurance System

- **Building Blocks (similar to proposals by President-elect Obama, Senator Baucus)** Aims to achieve universal coverage through a mix of private and public group insurance with a shared responsibility for financing. Employers other than small employers would be required to offer coverage or contribute to the cost of their employees' coverage. Expands eligibility for Medicaid and the State Children's Health Insurance Program (SCHIP). Creates an insurance exchange or connector that would offer a choice of private plans and a public option modeled on Medicare, with premium subsidies for low- and moderate-income families and tax credits for small employers. Building Blocks and Senator Baucus's proposal include an individual requirement for insurance. Building Blocks, unlike President-elect Obama's or Senator Baucus's proposal, improves benefits for the Medicare population.

  Estimates of Coverage and Costs in 2010

Number of uninsured covered	44.9 million
Remaining uninsured	4.0 million
Total health spending	$17.8 billion
Federal	$103.9 billion
State and local	($32.7 billion)
Employers	$86.0 billion
Household	($139.4 billion)

- **Senator Ron Wyden's (D–Ore.) and Representative Brian Baird's (D–Wash.) "Healthy Americans Act" (S. 334 and H.R. 3163)** Establishes a requirement for non-elderly, non-disabled individuals to purchase private insurance, called Healthy Americans Private Insurance (HAPI). HAPI plans would be offered by private insurers through "Health Help Agencies" created by each state or territory, or through an employer under the Senate bill, or through the federal government if there were not a private plan available in a region. The income tax exclusion for employer health benefits would be eliminated and a standard tax deduction (Senate version) or tax credit (House version) would be substituted. Additional subsidies would be available for low-income individuals.

  Estimates of Coverage and Costs in 2010

Number of uninsured covered	46.0 million
Remaining uninsured	2.9 million
Total health spending	$13.7 billion
Federal	($39.6 billion)
State and local	($29.0 billion)
Employers	$98.4 billion
Household	($16.2 billion)

- **Senator Mike Enzi's (R–Wyo.) "Ten Steps to Transform Health Care in America Act" (S. 1783)**
  Promotes expanded health insurance coverage by replacing the income tax exclusion for employer health insurance with a standard income tax deduction and income-based, refundable, advanceable tax credits; setting standards for state insurance regulations; establishing an autoenrollment process; allowing coverage to be offered through small business health plans; and providing Medicaid and SCHIP beneficiaries with the option of using the value of benefits to purchase private health insurance. Creates a low-cost health plan option.

  Estimates of Coverage and Costs in 2010

Number of uninsured covered	26.9 million
Remaining uninsured	22.0 million
Total health spending	$64.1 billion
Federal	$176.4 billion
State and local	($21.2 billion)
Employers	($77.6 billion)
Household	($13.5 billion)

- **Senator Richard Burr's (R–N.C.) "Every American Insured Health Act" (S. 1886)**
  Replaces the income tax exclusion for employer health insurance with a refundable, advanceable flat tax credit for individuals to purchase qualified health insurance. The tax credit would only be available in states that establish a state health insurance exchange or a high-risk solution, such as a high-risk pool or reinsurance. The bill would establish a program for the certification of state health insurance exchanges. Creates a low-cost health plan option.

  Estimates of Coverage and Costs in 2010

Number of uninsured covered	22.3 million
Remaining uninsured	26.6 million
Total health spending	$31.1 billion
Federal	$161.3 billion
State and local	($52.9 billion)
Employers	$7.0 billion
Household	($84.3 billion)

- **Senator Jeff Bingaman's (D–N.M.) "Health Partnership Act" (S. 325)/ Representative Tammy Baldwin's (D–Wis.) "Health Partnership Through Creative Federalism Act" (H.R. 506)/ Senator Russ Feingold (D–Wis.) and Senator Lindsey Graham's (R–S.C.) "State-Based Health Care Reform Act" (S. 1169)**
  Establishes a commission to oversee demonstration grants to regions, states, or local governments to expand health insurance coverage and to improve health care quality and efficiency. The commission would provide states with a range of reform options, which might include expansion of public programs, tax credits,

purchasing pools, buy-ins to state and federal employee benefit programs, risk pools, single-payer systems, and health savings accounts. States would be required to provide a five-year target for reducing the number of uninsured. The commission would review state applications and determine grant amounts and submit to Congress a list of recommended applications and requests for grant funding.

Estimates of Coverage and Costs in 2010

(In these estimates, the Lewin Group assumed that 15 states would implement universal coverage plans similar to the Massachusetts law.)

Number of uninsured covered in the 15 states (out of 26.7 million uninsured in 2010 under current law)	21.1 million
Remaining uninsured in the 15 states	5.6 million
Remaining uninsured nationally	27.8 million
Total health system	$37.7 billion
Federal	$40.3 billion
State and local	$19.4 billion
Employers	$34.8 billion
Household	($56.7 billion)

- **Representative Pete Stark's (D–Calif.) "AmeriCare Health Care Act of 2007" (H.R. 1841) and Senator Edward Kennedy (D–Mass.) and Representative John Dingell's (D–Mich.) "Medicare for All Act" (S. 1218 and H.R. 2034)** Creates a new public health insurance program administered by the federal government to provide everyone with multiple choices for health coverage. Under the Stark bill (H.R. 1841), employers would either offer their employees coverage or pay into a fund to cover their employees through the new public program. Under the Kennedy and Dingell bills (S. 1218 and H.R. 2034), employers and their employees would help finance the expansion through new payroll taxes.

  Estimates of Coverage and Costs in 2010 (Rep. Stark's bill)

Number of uninsured covered	48.9 million
Remaining uninsured	0
Total health spending	($58.1 billion)
Federal	$188.5 billion
State and local	($83.6 billion)
Employers	$61.5 billion
Household	($224.5 billion)

Expansions of Existing Public Insurance Programs

- **Senator Bingaman and Representative Gene Green's (D–Texas) "Ending the Medicare Disability Waiting Period Act of 2007" (S. 2102 and H.R. 154)** Phases out the waiting period following the onset of a disability before a person under 65 may qualify to enroll in the Medicare program. The bill also would expand the list of specified fatal diseases that allow individuals to enroll in Medicare.

Estimates of Coverage and Costs in 2010

(In this estimate, the Lewin Group assumed the waiting period would be eliminated in 2010, rather than being phased out.)

Number of uninsured covered	299,200 currently in waiting period
Remaining uninsured	48.6 million
Total health spending	($0.6 billion)
Federal	$10.8 billion
State and local	($2.3 billion)
Employers	($4.3 billion)
Household	($4.9 billion)

- **Senator John Kerry (D–Mass.) and Representative Henry Waxman's (D–Calif.) "Kids Come First Act of 2007" (S. 95 and H.R. 1111)**
  Provides states with incentives to expand coverage for all children up to age 21 in families with incomes up to 300 percent of poverty through Medicaid and SCHIP, as well as incentives to simplify enrollment procedures. The bill would require employers offering coverage to provide a family option with coverage for dependents up to age 21 and would create a new refundable tax credit for coverage of a dependent child under certain circumstances. Any taxpayer, except those in the lowest tax brackets, with uninsured, dependent children would forfeit the personal tax exemption ordinarily available to individuals with dependent children.

  Estimates of Coverage and Costs in 2010

Number of uninsured covered	6.0 million children under age 21
Remaining uninsured	
Children under age 21	5.9 million
All uninsured	42.9 million
Total health spending	$2.0 billion
Federal	$27.0 billion
State and local	($15.7 billion)
Employers	($5.9 billion)
Household	($3.3 billion)

New Options for Small Employers

- **Representative Sam Johnson's (R–Texas) "Small Business Health Fairness Act of 2007" (H.R. 241)/ Representative Vern Buchanan's (R–Fla.) "Small Business Growth Act of 2007" (H.R. 1012)/ Representative Howard McKeon's (R–Calif.) "Working Families Wage and Access to Health Care Act" (H.R. 324)**
  Permits trade, industry, professional, or other similar associations to form association health plans, which could provide health benefits to employees of businesses that are members of the associations.

  Estimates of Coverage and Costs in 2010 (Rep. Johnson's bill)

Number of uninsured covered	(283,000)

Remaining uninsured	49.2 million
Total health spending	($0.4 billion)
Federal	$0.2 billion
State and local	$0.7 billion
Employers	($1.6 billion)
Household	$0.2 billion

- **Senator Richard Durbin (D–Ill.) and Representative Ronald Kind's (D–Wis.) "Small Business Health Options Program Act of 2008" (SHOP Act) (S. 2795 and H.R. 6210)**
  Creates a nationwide health insurance purchasing pool through which small businesses (100 employees or less) and self-employed individuals could purchase health insurance. The purchasing pool would offer a choice of private plans. Firms of fewer than 50 employees would be eligible for tax credits. An office within the Department of Health and Human Services would be created to administer the small business health options program, and a Small Business Health Board would be established to monitor the implementation of the program and make recommendations for improvements.

  Estimates of Coverage and Costs in 2010

Number of uninsured covered	1.7 million
Remaining uninsured	47.2 million
Total health spending	$15.6 billion
Federal	$27.2 billion
State and local	($1.2 billion)
Employers	($4.5 billion)
Household	($5.9 billion)

Expansions of Health Savings Accounts

- **Representative Eric Cantor's (R–Va.) "HSA Improvement and Expansion Act of 2007" (H.R. 3234)**
  The bill would allow health savings account (HSA) contributions to be used to pay health insurance premiums in the individual market, and would increase HSA contribution limits for individuals ($2,250 to $4,500) and families ($4,500 to $9,000) from current levels. More people would be eligible for HSAs, including those participating in certain flexible spending account and health reimbursement arrangement programs, Medicare Part A-only beneficiaries, and veterans receiving benefits from the Department of Veterans Affairs to cover health care expenditures for a service-related disability.

  Estimates of Coverage and Costs in 2010

Number of uninsured covered	5.8 million
Remaining uninsured	43.1 million
Total health spending	$3.7 billion

Federal	$19.2 billion
State and local	$4.5 billion
Employers	($39.1 billion)
Household	$19.1 billion

Findings

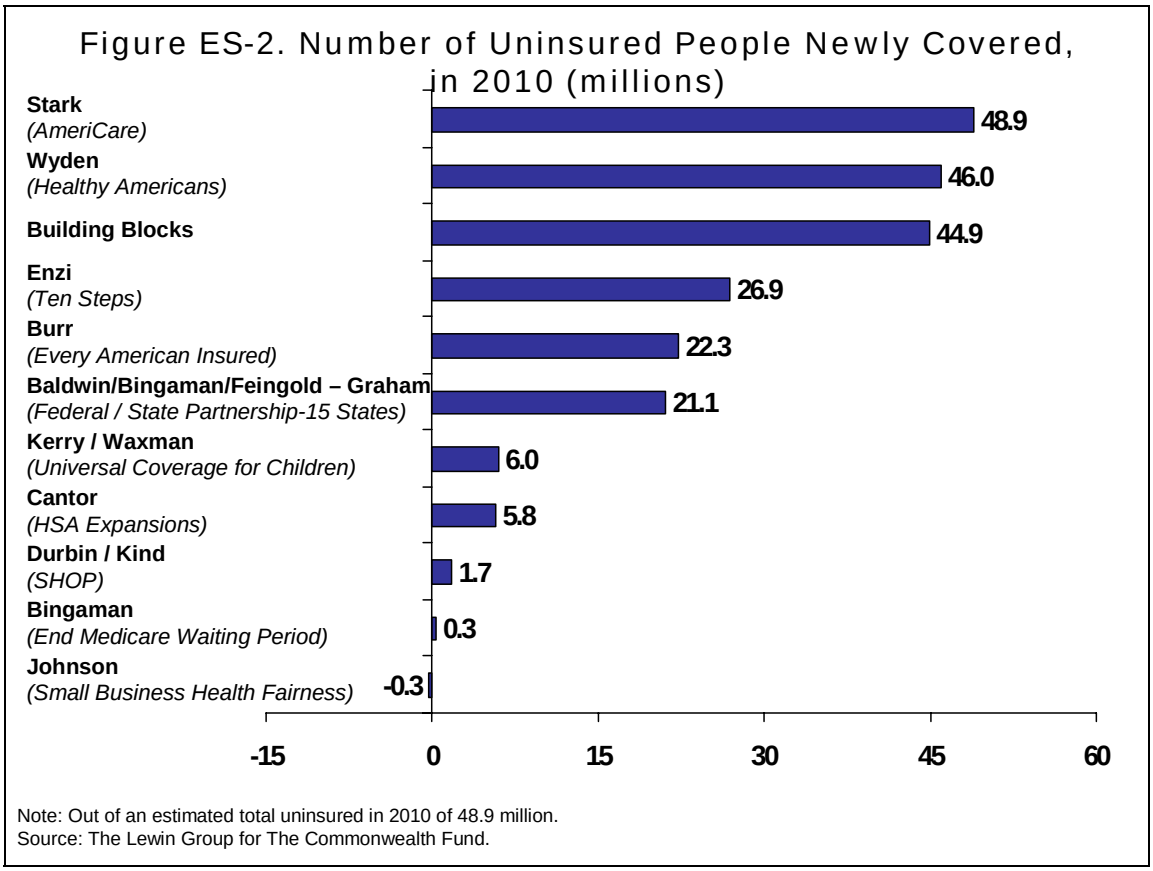
Reducing the Number of Uninsured

The bills and proposals that seek fundamental reform of the health insurance system have the most significant impact on reducing the number of uninsured (Figures ES-1 and ES-2). Within that category, bills that create new public insurance programs like Medicare that are open to the full population, such as Rep. Stark's proposal, or use a similar centralized financing mechanism, have the greatest potential to cover everyone. Mixed private–public approaches, like those of President-elect Obama and Sen. Baucus, also have potential to cover nearly everyone but would require an individual requirement for everyone to have insurance to achieve near-universal coverage. Sen. Wyden's and Rep. Baird's proposal to replace the income tax exclusion for employer benefits with an income tax deduction and premium subsidies, combined with new regional purchasing agencies and an individual and employer requirement to participate would also cover nearly everyone.

Figure ES-1. Summary of Insurance Coverage Proposals

	Uninsured Covered[1] (millions)	National Health Expenditures (billions)	Federal Spending (billions)	State/Local Spending (billions)	Employer Spending (billions)	Household Spending (billions)
Building Blocks	44.9	$17.8	$103.9	($32.7)	$86.0	($139.4)
Wyden *(Healthy Americans Act)*	46.0	$13.7	($39.6)	($29.0)	$98.4	($16.2)
Enzi *(Ten Steps)*	26.9	$64.1	$176.4	($21.2)	($77.6)	($13.5)
Burr *(Every American Insured)*	22.3	$31.1	$161.3	($52.9)	$7.0	($84.3)
Baldwin / Bingaman / Feingold – Graham *(Federal/State-15 States)*	21.1[2]	$37.7	$40.3	$19.4	$34.8	($56.7)
Stark *(AmeriCare)*	48.9	($58.1)	$188.5	($83.6)	$61.5	($224.5)
Bingaman *(End Medicare 2-yr Waiting Period)*	0.3[3]	($0.6)	$10.8	($2.3)	($4.3)	($4.9)
Kerry / Waxman *(Universal Coverage for Children)*	6.0[4]	$2.0	$27.0	($15.7)	($5.9)	($3.3)
Johnson *(Small Business Health Fairness)*	(0.3)	($0.4)	$0.2	$0.7	($1.6)	$0.2
Durbin / Kind *(SHOP)*	1.7	$15.6	$27.2	($1.2)	($4.5)	($5.9)
Cantor *(HSA Expansions)*	5.8	$3.7	$19.2	$4.5	($39.1)	$19.1

[1] Out of an estimated total uninsured in 2010 of 48.9 million. [2] Out of an estimated total uninsured in 2010 of 26.7 million in the 15 states. [3] Out of an estimated 0.3 million uninsured disabled people in 2010. [4] Out of an estimated 11.9 million uninsured children in 2010.
Source: The Lewin Group for The Commonwealth Fund.



While Senators Enzi and Burr also propose replacing the employer benefit tax exclusion with tax credits and new standard income tax deductions, the lack of a strong individual coverage requirement (Senator Enzi does include a process to autoenroll people without coverage), and less organized insurance markets than those proposed by Obama, Baucus, and Wyden reduce the effectiveness of their proposals to cover everyone.

The federal–state partnership bills (Baldwin, Bingaman, Feingold–Graham) that would provide grants to states to expand coverage would result in a varying degree of coverage, depending on the number of participating states, the amount of funding provided, and the reforms that states pursue. Assuming that 15 involved states would pursue a Massachusetts-style reform with an individual requirement to have health insurance, nearly everyone would become covered in those states.

Incremental reform bills cover far fewer people, but target high-risk groups. Sen. Kerry and Rep. Waxman's bill to expand coverage for children up to age 21, covers 6 million uninsured children and young adults out of an estimated 12 million uninsured. Though the bill is aimed at helping eligible children obtain and retain coverage, linking

the tax penalty for not covering dependent children in the bill to autoenrollment into default coverage could increase the number of children and young adults covered. Sen. Bingaman and Rep. Green's bill to phase out the two-year waiting period for Medicare for the disabled would be effective at covering everyone in that group, including the uninsured.

Rep. Johnson and Sen. Durbin's bills are focused on the affordability issues facing small companies that buy insurance in the small-group market. By allowing small businesses to effectively bypass state insurance regulations, the Johnson bill makes small-group coverage more affordable for companies with a young and healthy workforce but less affordable for those with an older or less healthy workforce, which would result in a net loss of coverage of 283,000 people. The Durbin bill seeks a different approach by establishing a national purchasing pool for small employers with regulations against rating on the basis of health and requiring participating states to regulate their small-group markets, therefore avoiding the adverse selection that affects the Johnson bill. While the Durbin bill provides relief to many small companies, the incentives are not sufficient to cause most non-insuring firms to offer coverage. About 1.7 million uninsured people would become insured under this bill.

Rep. Cantor's proposal to double the amount of pretax income that people can contribute to health savings accounts (HSAs) and allow people to use the funds, without tax penalty, to purchase health insurance in addition to covering out-of-pocket costs, is estimated to insure 5.8 million people. Currently, people can use HSA balances to pay for costs not covered by insurance but not for premiums.

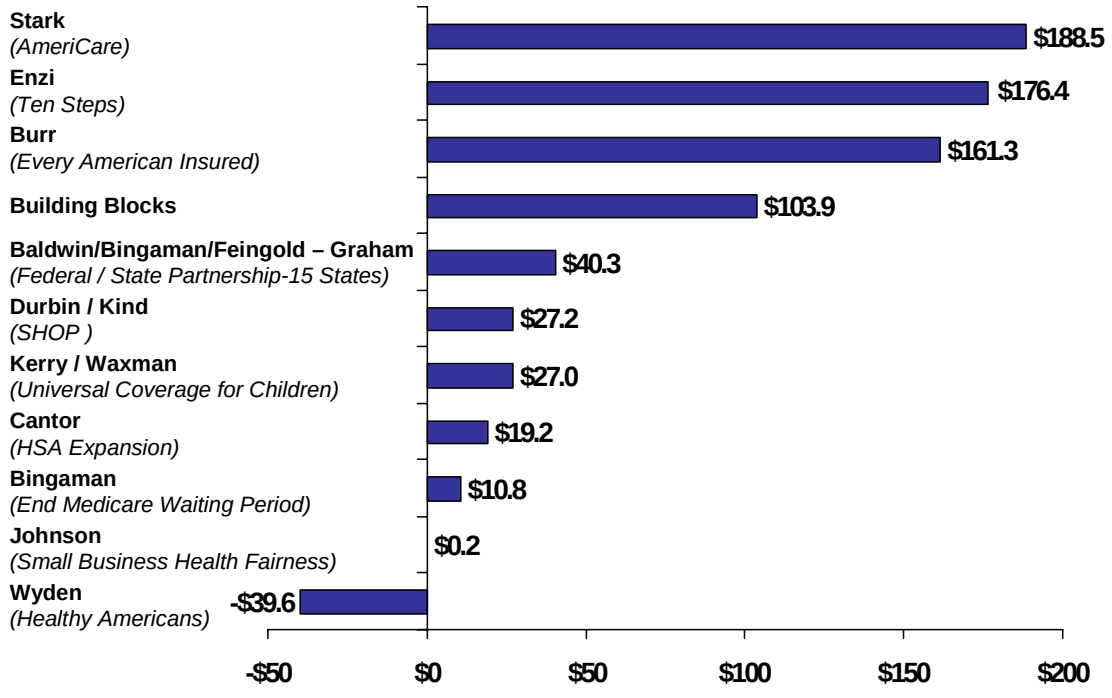
Improving the Quality of Health Insurance Coverage

Many of the bills and proposals aim to not only expand coverage but to set standards for covered benefits and out-of-pocket costs. Both President-elect Obama and Sen. Baucus are explicit about the need for defining benefit standards for both private and public health plans. To achieve this, Sen. Baucus would establish an Independent Health Coverage Council with members appointed by the President with advice and consent of the Senate that ensures coverage is affordable, clinically appropriate, ensures access to necessary services, and protects enrollees from high out-of-pocket costs.

Federal Health Expenditures

The bills that would fundamentally reform the health insurance system are estimated to be the most expensive to the federal government, with the exception of Sen. Wyden's bill (Figure ES-3).

Figure ES-3. Change in Federal Spending, in 2010 (billions)



Source: The Lewin Group for The Commonwealth Fund.

Under the current financial system, Rep. Stark's AmeriCare bill would cost the federal government about $188.5 billion in 2010. Though it would insure less than half the number as the Stark bill, Sen. Enzi's bill is estimated to cost the federal government nearly as much—$176.4 billion. Sen. Burr's bill would cost $161.3 billion.

The Building Blocks framework, an approach similar to that of President-elect Obama (but including a coverage requirement) and Sen. Baucus, has estimated federal costs in the first year of $103.9 billion, which also includes the cost of improving coverage for Medicare beneficiaries. Senator Wyden's bill, which is estimated to cost the federal government $1.2 trillion, raises sufficient revenue and offsets other spending through new income taxes, household and employer premium contributions, and the elimination of Medicaid to provide a net savings of $40 billion.

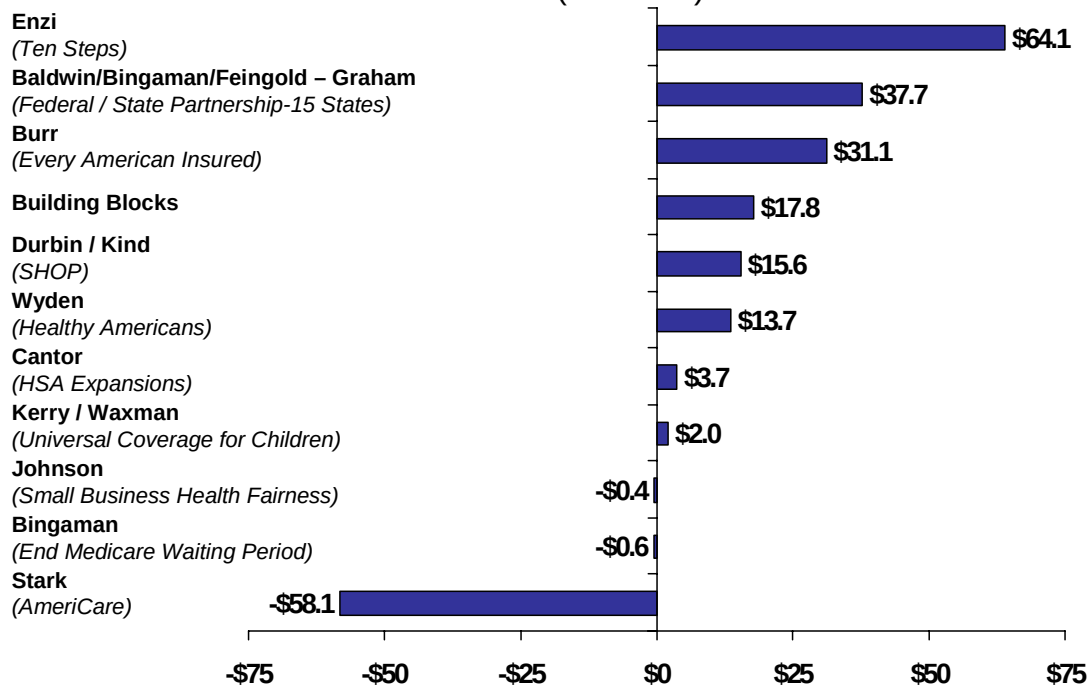
The federal cost of the federal–state partnership bills (Baldwin, Bingaman, Feingold–Graham) to provide grants to 15 states to implement Massachusetts-style universal coverage strategies is estimated at about $40 billion.

Incremental bills are less expensive to the federal government than most of the proposals for fundamental insurance reform but cover fewer people. The spending estimated in some incremental bills, such as Sen. Durbin's and Rep. Johnson's small business bills, mostly offers improved coverage and cost relief to people or businesses that already have coverage, rather than expanding coverage.

National Health Expenditures

Though Rep. Stark's AmeriCare bill is the most expensive to the federal government, it provides the biggest overall health savings, lowering projected national expenditures by $58 billion (Figure ES-4). It achieves this by significantly lowering the costs of insurance administration by covering most people through a program like Medicare, which has substantially lower administrative costs than private insurance. Savings are also accrued by paying all providers at Medicare reimbursement rates.

Figure ES-4. Change in National Health Expenditures, in 2010 (billions)



Source: The Lewin Group for The Commonwealth Fund.

Senator Enzi's bill increases national health spending by $64 billion. By insuring more people through the individual insurance market, where administrative costs average 25 percent to 40 percent of premium dollars, the bill increases administration costs by

$22 billion. In addition, the bill allows Medicaid beneficiaries to use the value of their benefits to purchase private health insurance. This feature increases provider payments by an estimated $17.3 billion because providers would be paid at private, rather than Medicaid, rates.

Conclusion

A great deal can be learned from the estimated impact on coverage and costs of the bills introduced in the 110th Congress, and much that will prove useful to Congress and the new Obama administration as they move forward in 2009 to develop new proposals to reform the health care system. The proposals to fundamentally reform the health system reveal the importance of an individual insurance requirement to bring most people into the system. Bills without an autoenrollment mechanism and individual requirement fall far short of universal coverage. The effectiveness of such a requirement, however, is contingent upon an enforcement mechanism and the ability to determine an appropriate level of benefits covered and cost-sharing that will improve health outcomes over the long term yet ensure affordability.

In the long run, it will not be productive to focus only on the impact of reform policies on federal, employers', or families' budgets. Instead, we must move forward while watching the number that really matters—the more than $2 trillion we spend collectively as a nation on health care each year. This ultimately determines the size and growth of all participants' budgets.

AN ANALYSIS OF LEADING CONGRESSIONAL HEALTH CARE BILLS, 2007–2008: PART I, INSURANCE COVERAGE

INTRODUCTION

Spiraling health care costs and slow income growth combined to increase the number of uninsured people in the United States—from 40 million to 46 million between 2001 and 2007.[2] In addition, by 2007, 25 million adults under age 65 had such high out-of-pocket costs relative to their income that they were considered "underinsured," 80 million adults reported not getting needed health care because of costs, and 72 million reported difficulty paying their medical bills.[3] Now, the worsening economy is certain to exacerbate these problems as employers shed jobs and trim wages and benefits.

The growing health care crisis played a central role in the 2008 presidential election with both President-elect Barack Obama and Senator John McCain (R–Ariz.), as well as primary candidates, presenting proposals to expand health insurance, improve quality, and lower costs.[4] In addition, several members of Congress introduced new bills during the 110th session aimed at reforming the health system. Following the election, Senator Max Baucus (D–Mont.) released a white paper outlining an approach to health care reform similar to the one proposed by President-elect Obama during the campaign. Senator Edward Kennedy (D–Mass.) has also indicated he is working on a proposal.

This report analyzes and compares leading bills of the 110th Congress that are aimed at expanding and improving health insurance coverage.[5] It also includes an analysis of the proposals outlined by President-elect Obama and Sen. Baucus, focusing on the insurance coverage provisions of those proposals. To be included, the bills met at least one of the following criteria: a) potential to significantly affect the problem; b) reflective of ideas proposed by the Bush Administration or the 2008 presidential candidates; c) bipartisan support; or d) unique or innovative.

The Commonwealth Fund commissioned the Lewin Group, a health care policy research and management consulting firm, to estimate the effect of the bills on stakeholder and health system costs and the projected number of people the bills would insure. The Fund also commissioned Health Policy R&D, another health policy firm, to create detailed side-by-side comparative analyses of the bills as well as summaries. The side-by-side analyses appear in Tables A-1 through A-9.

The bills and proposals to expand health insurance coverage take a variety of approaches to achieve incremental, as well as more comprehensive expansions, in coverage. They fall into four broad categories:

- fundamental reforms of the nation's health insurance system;
- expansions of existing public insurance programs;
- new options for small employers; and
- expansions of health savings accounts.

The Commonwealth Fund Commission on a High Performance Health System identified several key principles for moving the health system toward high performance. They include:

- provision of equitable and comprehensive insurance for all;
- provision of benefits that cover essential services with appropriate financial protection;
- premiums, deductibles, and out-of-pocket costs are affordable relative to family income;
- health risks are broadly pooled;
- the proposals should be simple to administer, with coverage that is automatic and continuous;
- dislocation should be kept to a minimum—people could choose to keep the coverage they have; and
- financing should be adequate, fair, and shared across stakeholders.

To help assess the bills and proposals based on these criteria, the Lewin Group used its Health Benefits Simulation Model to estimate the number of people who would gain coverage and the effects on national health care expenditures overall, as well as on principal stakeholders, including federal and state governments, employers, and households. All estimates are for 2010 and are based on the assumption of full implementation in that year. Under the current laws, Lewin projects that the number of uninsured in the U.S. will rise to 48.9 million people in 2010, out of a total estimated population of 306.9 million; 15.9 percent of the total population will be uninsured. According to the latest census estimates, this represents an increase from 45.7 million in 2007 or 15.3 percent of the total population.[6]

Among the plans analyzed, Lewin estimates that up to 48.9 million uninsured could be covered—under a bill proposed by Representative Pete Stark (D–Calif.). At the other end of the spectrum, a bill proposed by Representative Sam Johnson (R–Texas) would result in a net loss of coverage of 283,000 According to Lewin's cost estimates, total health spending could be as high as $64.1 billion—under a bill proposed by Senator Mike Enzi (R–Wyo.)—or we could see net savings of $58.1 billion under Rep. Stark's bill.

The Lewin Group developed two sets of estimates for the analysis. One set assumes that changes in employer costs, such as for premiums, are passed on to workers as changes in wages. The other set excludes this wage adjustment. Because of the uncertainty about how long it will take for these market adjustments to occur, and the degree to which costs are fully offset by wage changes, the report focuses on the cost impacts for employers and workers and the federal government without this wage adjustment.

COMPREHENSIVE REFORM

Mixed Private–Public Insurance with a Shared Responsibility for Financing: President-elect Obama, Senator Baucus, and Building Blocks

As a candidate, President-elect Obama proposed a plan for universal coverage that would build on the current system of mixed private and public group insurance (Figure 1). Many features are similar to the universal coverage law being implemented in Massachusetts. All employers—other than small businesses—would be required to offer health insurance to their employees or contribute to the cost of employees' coverage. Eligibility for Medicaid and the State Children's Health Insurance Program (SCHIP) would be expanded. Small businesses, self-employed individuals, and people who do not have coverage through their employers, Medicaid, or SCHIP could purchase a plan through a health insurance exchange. Through this exchange, people could choose a private plan or a new public plan similar to the one offered to federal employees and members of Congress. All insurance carriers would be required to offer plans to all applicants and could not charge premiums based on health status. Small businesses would be eligible for tax credits to offset their premium costs and individuals would be eligible for income-based premium subsidies. All children would be required to have coverage.

Sen. Baucus introduced a similar proposal in his November 2008 white paper, "Call to Action: Health Reform 2009."[7] Sen. Baucus's proposal differs from President-elect Obama's in a few regards, most notably in its requirement for everyone to have health insurance once it is deemed affordable and its provision to allow older adults under age 65 to buy in to Medicare until the insurance exchange is established.

Both President-elect Obama and Sen. Baucus propose measures aimed at improving the quality and efficiency of the health care delivery system and at lowering costs. These include expanding the use of health information technology; creating a new institute to conduct and disseminate comparative effectiveness research; reforming the way providers are paid, including new incentives for better coordinated care and medical homes; and eliminating excess payments to Medicare Advantage plans.

The two proposals are similar to a framework for universal coverage outlined by The Commonwealth Fund's Cathy Schoen and colleagues in *Health Affairs* in May 2008.[8] Like Sen. Baucus' proposal, this framework, entitled Building Blocks, requires everyone to have health insurance. The Lewin Group modeled cost and coverage estimates of a revised version of the Building Blocks approach for the *Health Affairs* article. Those estimates are updated for 2010 in the following analysis.

President-elect Obama, Senator Baucus, and Building Blocks

Overall Approach: Aims to achieve universal coverage through a mix of private and public group insurance with a shared responsibility for financing. Employers, with the exception of small employers, would be required to offer coverage or contribute to the cost of their employees' coverage. Expands eligibility for Medicaid and SCHIP. Creates an insurance exchange or connector, which would offer a choice of private plans and a public plan option. Would offer premium subsidies for low- and moderate-income families and tax credits for small employers.

Individual Requirement for Coverage: Under President-elect Obama's plan, only children would be required to have health insurance. Under Sen. Baucus's plan, all people would be required to have health insurance once it is determined that affordable coverage is available. The requirement under Sen. Baucus' plan would be enforced through the tax system or another point of contact between individuals and government. Building Blocks would also require that everyone have coverage and would enforce the requirement through the tax code.

Benefit Packages: President-elect Obama's public plan option would be similar to FEHBP. All plans offered by private carriers through the exchange would be required to be at least as generous as FEHBP. Under Sen. Baucus's plan, the exchange would include a public plan option similar to Medicare. Private plan options in the insurance exchange would have high, medium, and low benefit package options. All benefit structures within benefit categories would be required to be actuarially equivalent. Participating insurers would be required to charge the same amount for the same benefit packages inside and outside the exchange. Building Blocks would create an enhanced Medicare option called Medicare Extra, offered through the exchange and to Medicare beneficiaries. Like President-elect Obama's proposal, all plans offered through the exchange (or connector) would be at least as generous. Participating providers would be paid at Medicare rates.

Premiums and Cost-Sharing: The federal government would provide income-related premium assistance for people buying insurance through the connector. Under Sen. Baucus's plan, refundable tax credits would be available to all individuals and families with

incomes up to 400 percent of the federal poverty level who purchase coverage through the exchange. Building Blocks would provide refundable tax credits for premium costs equal to 10 percent or more of income or 5 percent or more for lower-income households.

Financing: Shared financial responsibility would include an individual requirement to have coverage and a requirement that employers provide coverage or contribute a percent of payroll to an insurance fund. Building Blocks would require a payroll tax of 7 percent of earnings up to $1.25 per hour. A similar requirement would only apply to large firms under President-elect Obama and Sen. Baucus. Small firms would receive a tax credit to offset premium costs. Sen. Baucus would base the credit on firm size and earnings per employee. The smallest firms with the lowest average earnings would be eligible for a tax credit equivalent to half of the average premium for employer coverage in the firm's state. The tax credit would be phased out for larger and higher wage companies. Sen. Baucus proposes a small assessment on premiums to help fund the exchange. Building Blocks also places a 4 percent assessment on hospital gross revenues and 2 percent on physician gross revenues.

Regulation: Private insurers offering coverage both inside and outside the exchange would be required to offer the same coverage for all people regardless of pre-existing conditions. Sen. Baucus would establish an Independent Health Coverage Council, with members appointed by the President, with advice and consent of the Senate, to ensure coverage is affordable, clinically appropriate, provides access to necessary services, and protects enrollees from high out-of-pocket costs. It would set standards for chronic care management and quality reporting.

Medicare: Sen. Baucus's plan would temporarily expand Medicare to older adults, ages 55 to 64, until the insurance exchange is fully implemented. The two-year waiting period for Medicare coverage for disabled people would be phased out. Building Blocks would create an enhanced Medicare option called Medicare Extra that would be available through the exchange as well as to Medicare beneficiaries. Building Blocks would end the two-year waiting period for disabled people.

Medicaid and SCHIP: All three approaches would expand eligibility for Medicaid and SCHIP. Sen. Baucus would expand Medicaid and SCHIP to adults up to 100 percent of poverty and children up to 250 percent of poverty and increase federal matching rates during economic downturns. Building Blocks would expand eligibility to 150 percent of poverty, increase provider payment rates to Medicare levels, and increase federal matching rates to SCHIP levels.

Quality and Efficiency: System reforms would promote prevention and wellness, management of chronic conditions, patient-centered medical homes, coordinated care, health information technology (with President-elect Obama's plan spending $10 billion per year), and comparative effectiveness research.

Reinsurance and Risk Adjustment: Under President-elect Obama's plan, reinsurance would be provided to employer plans for catastrophic costs. Sen. Baucus's plan would give the exchange authority to ensure that plans enrolling sicker than average people would not be financially disadvantaged relative to plans that enroll healthy people.

Lewin Group Estimates of Coverage and Costs in 2010

Building Blocks approach

Number of uninsured covered	44.9 million
Remaining uninsured	4.0 million

Net change in costs in 2010	
Total health spending	$17.8 billion
Federal	$103.9 billion
State and local	($32.7 billion)
Employers	$86.0 billion
Household	($139.4 billion)

What the Estimates Mean

The Lewin Group estimates that 44.9 million people would become newly insured in 2010 under the Building Blocks approach (Figure 2).[9] An estimated 59.4 million people would purchase coverage through the national insurance connector/exchange, including 18.6 million previously uninsured people, 28.9 million people who previously had employer insurance, 8.9 million people who had private non-group insurance, and 3 million people who previously had public insurance (Figure 3). The number of people covered by employer insurance would decrease from an estimated 161.5 million to 150.4 million under the proposal, as many individuals and small businesses would shift to coverage through the connector/exchange. Medicaid/SCHIP enrollment would increase by 8 million to 45.3 million. About 4 million people, or 1 percent of the population, primarily non tax-filers, would be left uninsured.

The Lewin Group estimates that the Building Blocks proposal would increase total health spending in 2008 by $17.8 billion (Figure 4). This includes a $48.7 billion increase in health services expenditures, largely due to increased utilization of health care by newly insured people and increased utilization due to improved coverage (Figure 5). Provider reimbursement is estimated to decrease by a net $20.2 billion: provider reimbursement rates drop to Medicare levels for the Medicare Extra plan offered through the connector and Medicaid reimbursement rates are increased to current Medicare levels. The costs of insurance administration would decrease by $13.1 billion.

Spending by the federal government is estimated to increase by a net $103.9 billion in 2010, because of tax credits and increased Medicaid eligibility for the under-65 population and the enhanced benefits of Medicare Extra for the Medicare population (Figure 4). Enhanced benefits for the Medicare population are not included in either the Obama or Baucus proposal. State and local government spending is expected to decrease by $32.7 billion, primarily from savings to the safety net. Private employer spending would increase by $86 billion under the proposal. Costs are expected to increase by $27.3 billion for employers that currently provide coverage and by $58.7 billion for employers that do not currently provide coverage.

Household spending is estimated to decrease by $139.4 billion under the proposal as a result of premium subsidies and declines in out-of-pocket spending.

Figure 1. Features of Mixed Private–Public Reform Proposals

	President-elect Obama	Senator Baucus (D-Mont.)	Building Blocks
Coverage Expansion			
Aims to cover everyone	X	X	X
Individual requirement to have insurance	Children only	X	X
Employer shared responsibility	X	X	X
Small business tax credit	X	X	
New insurance exchange or connector	X	X	X
Medicare/public plan option for < 65	X	X	X
Subsidies/tax credits for low- to moderate-income families	X	X	X
Regulation of insurance markets	X	X	X
Improves Medicare benefits for > 65			X
Medicare buy-in for older adults and phase out waiting period for disabled		X (buy-in available until Exchange is created)	X
Medicaid/SCHIP expansion	X	X	X
System Improvements			
Expanded use of health IT	X	X	X
Medical effectiveness research	X	X	X
Pay providers for performance	X	X	X
Reduced Medicare Advantage payments	X	X	X
Federally negotiated Medicare Rx prices	X		X
Primary care and care coordination	X	X	X

Source: Commonwealth Fund analysis of health reform proposals.

Figure 2. Major Features of Health Insurance Expansion Bills and Impact on Uninsured, National Expenditures

	Building Blocks	Wyden	Enzi	Burr	Baldwin / Bingaman / Feingold – Graham	Stark
Aims to cover all people	X	X				X
Individual requirement/ auto-enrollment	X	X	Partial mandate		X	X
Employer shared responsibility	X	X			X	X
Insurance exchange or connector	X	X	X	Certification program	For low-income families, small businesses	
Public program expansion	X			(Medicaid HSAs expanded)	X	X
Subsidies for lower-income Families	X	X	X	X	X	X
Risk pooling	X	X	X			X
Standard benefit package	X	X	For low-income families			X
Quality and efficiency measures	X	X	X			X
Uninsured covered in 2010[1] (in millions)	44.9	46.0	26.9	22.3	21.1[2]	48.9
Net health system cost in 2010 (in billions)	$17.8	$13.7	$64.1	$31.1	$37.7	(58.1)
Net federal budget cost in 2010 (in billions)	$103.9	($39.6)	$176.4	$161.3	$40.3	188.5

[1]Out of an estimated total uninsured in 2010 of 48.9 million. [2]Out of an estimated total uninsured in 2010 of 26.7 million in the 15 states.
Note: Wyden's proposal is the Healthy Americans Act (S.334); Enzi's proposal is Ten Steps (S.1783); Burr's proposal is the Every American Insured Act (S.1886); Bingaman/Baldwin/Feingold/Graham's proposals is Federal/State Partnership Act (S. 325, H.R.506, S.1169); and Stark's proposal is AmeriCare (H.R.1841).
Source: The Lewin Group for The Commonwealth Fund.

Figure 3. U.S. Population by Primary Source of Insurance, Under Current Law and Proposals, 2010

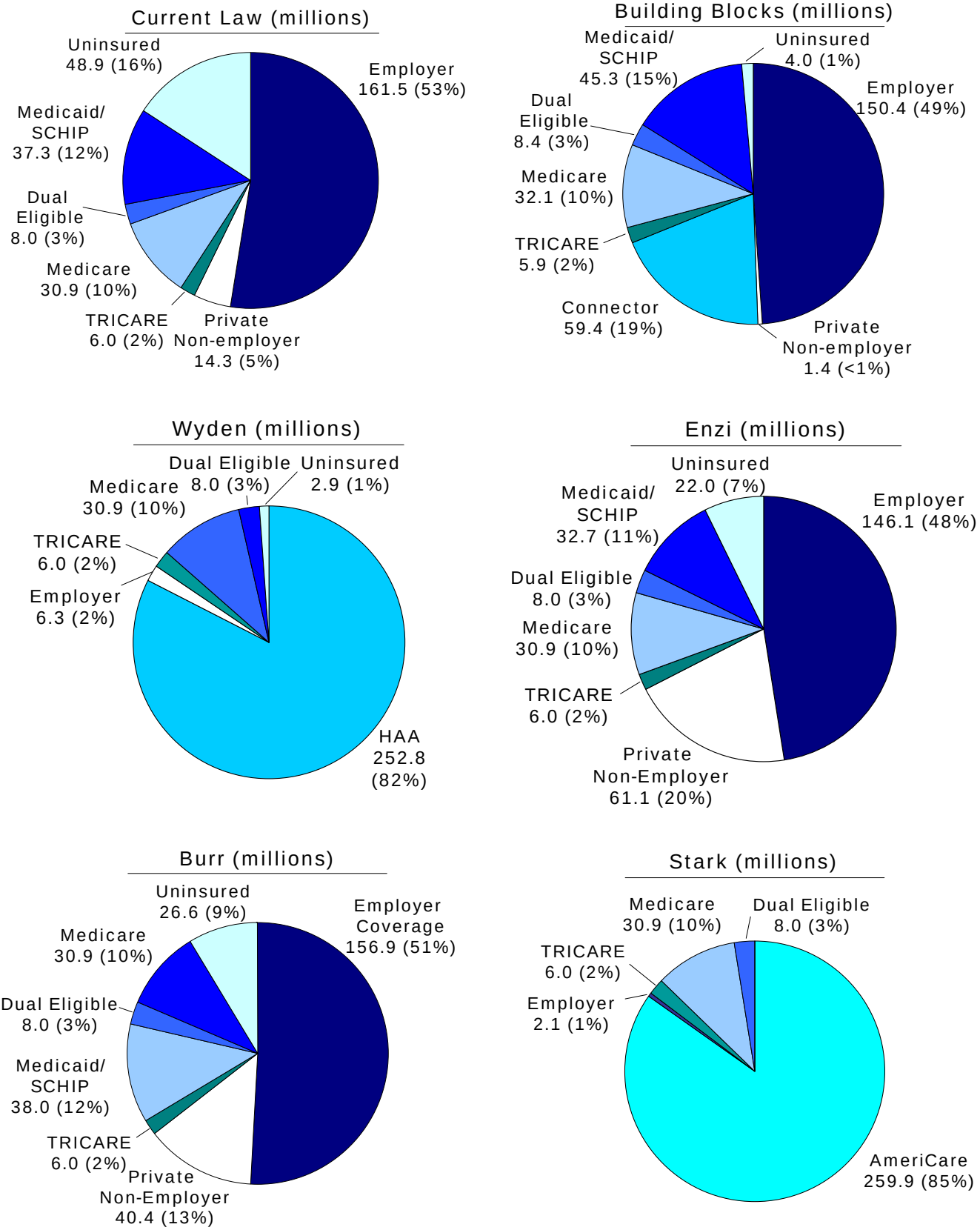


Figure 4. Health Insurance Expansion Bills Change in Health Spending by Stakeholder Group, Billions of Dollars, 2010

	Building Blocks	Wyden	Enzi	Burr	Baldwin / Bingaman / Feingold – Graham	Stark
Total uninsured covered, millions	44.9	46.0	26.9	22.3	21.1	48.9
Federal government	$103.9	($39.6)	$176.4	$161.3	$40.3	$188.5
State and local government	($32.7)	($29.0)	($21.2)	($52.9)	$19.4	($83.6)
Private employers	$86.0	$98.4	($77.6)	$7.0	$34.8	$61.5
Households	($139.4)	($16.2)	($13.5)	($84.3)	($56.7)	($224.5)
Net health system cost in 2010 (in billions)	$17.8	$13.7	$64.1	$31.1	$37.7	($58.1)
Total uninsured not covered,[1] Millions	4.0	2.9	22.0	26.6	5.6[2]	0

[1]Out of an estimated total uninsured in 2010 of 48.9 million. [2]Out of an estimated total uninsured in 2010 of 26.7 million in the 15 states.
Note: Wyden's proposal is the Healthy Americans Act (S.334); Enzi's proposal is Ten Steps (S.1783); Burr's proposal is the Every American Insured Act (S.1886); Bingaman/Baldwin/Feingold/Graham's proposal is Federal/State Partnership Act (S. 325, H.R.506, S.1169); and Stark's proposal is AmeriCare (H.R.1841).
Source: The Lewin Group for The Commonwealth Fund.

Figure 5. Changes in National Health Spending Under the Building Blocks Proposal in 2010 (in billions)

Change in Health Services Expenditures		$48.7
Change in utilization for newly insured	$47.1	
Change in utilization due to improved coverage	$1.6	
Reimbursement Effects		($20.2)
Medicare rates for connector program and Medicare Extra	($32.2)	
Increased Medicaid rates to Medicare levels	$31.1	
Provider assessment [1]	($48.0)	
Payments for uncompensated care	$34.9	
Eliminate federal Medicare and Medicaid DSH payments	($19.5)	
Increased cost shifting [2]	$13.5	
Change in Administrative Costs		($10.7)
Insured administration	($13.1)	
Administration of subsidies [4]	$2.4	
Total Change in Health Spending		$17.8

Note: DSH = disproportionate-share hospital.
[1] Provider assessment of 4% of hospital gross revenues and 2% of physician revenues. This amount is counted as a reduction in provider revenue. [2] Assumes 40% of change in provider payment rates is passed on to health plans. [3] Impact of Connector Plan on Private Insurance Market. Assumes 8% reduction for people remaining in the privately insured market who are not currently in an HMO. [4] Assumes IRS budget increased by 25% for income eligibility determination.
Source: The Lewin Group for the Commonwealth Fund.

Elimination of the Employer Benefit Tax Exclusion

Senator Ron Wyden's (D–Ore.) and Representative Brian Baird's (D–Wash.) "Healthy Americans Act" (S. 334 introduced in January 2007 and H.R. 3163 introduced in July 2007, respectively) would end the current tax exemption for employer-provided health benefits and provide personal income tax deductions for people who buy insurance coverage (Figure 2). It would create a large risk-pooling mechanism in the form of regional insurance exchanges through which most people would purchase health insurance. The Lewin Group estimated Sen. Wyden's bill.

Sen. Wyden's and Rep. Baird's "Healthy Americans Act"
(S. 334 and H.R. 3163) (for more detail see Table A-1)

Overall Approach: Establishes a requirement for non-elderly, non-disabled persons to purchase private insurance, called Healthy Americans Private Insurance (HAPI). Individuals covered by Medicare, the military, employee benefit plans from former employers, the Veterans Administration, or the Indian Health Service would be exempt. For a maximum of seven years (nine years in the House bill) after the implementation of HAPI plans, individuals currently covered by health insurance through a "qualified collective bargaining agreement" would also be exempt.

Coverage policies would be available from "Health Help Agencies" (HHAs) created by each state or territory or, under the Senate bill, through an employer. Policies would conform to regulations established by the Department of Health and Human Services (HHS). The income tax exclusion for employer health benefits would be eliminated and employers that offer coverage would either pay the value of their employee premium contribution as higher wages to workers in the first two years of the proposal or pay the difference between the premium contribution and subsequent annual wage increases to the U.S. Treasury. After that, all employers would make a shared responsibility payment equal to a percent of the national average premium per full-time employee. People would purchase their own health insurance through an HHA.

HAPI plans would be offered by private or public insurers. Each HHA would ensure that at least two HAPI plans exist in each "coverage area." If there is only a single plan, HHS would offer a "fallback" plan in the area. Policies would be purchased by individuals. The exclusion of employer paid health insurance premiums from employees' taxable incomes would be eliminated and a standard tax deduction (Senate version) or tax credit (House version) substituted. Additional subsidies would be available for low-income persons.

Benefit Package: Each HAPI plan would be required to offer benefits equivalent to the standard FEHBP plan as of January 1, 2007, plus certain preventive services and other benefits specified by HHS. The Senate bill would allow—and the House bill would require—at least one HAPI plan in each coverage area to offer additional supplemental benefits. The House bill also includes benefit parity requirements for mental health and substance abuse services.

Premiums and Cost-Sharing: The full HAPI plan premium would be paid by the individual. Employed persons would pay premiums through payroll deductions. Employer contributions would be counted as income for income and payroll taxes. Subsidies equal to the lesser of the premium paid or the weighted average premium of all plans would be provided for persons with modified adjusted gross income (MAGI) less than the federal poverty level. Partial premium subsidies would be available on a sliding scale for persons

with MAGI between 100 percent and 400 percent of poverty. Individuals selecting more expensive plans would be responsible for the difference between the subsidy and the selected plan's premium. Under the Senate version, individuals with MAGI above 100 percent of poverty would be able to deduct the lesser of premiums actually paid or a standard deduction related to income. The allowable deduction would increase with MAGI between 100 percent and 400 percent of poverty as premium subsidies decline. The deduction would be phased out for persons with MAGI above $62,500 for individuals or $125,000 for couples filing jointly. The House version would provide a refundable tax credit with the same MAGI limits, but does not link the credit to actual premiums paid.

Cost-sharing (called a "personal responsibility contribution" and encompassing deductibles, coinsurance, and copayments) could be similar to the deductibles, coinsurance, and copayments in the standard FEHBP Blue Cross Blue Shield Plan, as of January 1, 2007. However, no cost-sharing would be allowed for preventive items or services, early disease detection, or chronic care. Additionally, individuals with income below 100 percent of poverty would be eligible for a full cost-sharing subsidy, and those with income above 100 percent of poverty could be eligible for cost-sharing subsidies at the discretion of an HHA.

Financing: The exclusion of employer-paid health insurance premiums from employees' taxable incomes would be eliminated. Employers would be required to contribute a shared-responsibility payment to a fund providing subsidies for low-income persons. The employer shared-responsibility payments per worker would be between 2 percent and 25 percent of the nationwide average annual premium once the program is fully operational. The percentage would depend on the type of employer, the number of employees, and revenue per employee. Employer contributions would be tax-deductible for the employer, would not be counted as wages for the purposes of the payroll tax, and would not be counted as ordinary income for employees.

Under the Senate bill, self-insured employers would not be required to use adjusted community rating principles and would not be prohibited from varying premiums based upon employee risk factors such as age, gender, industry, health status, or claims experience. However, self-insured HAPI plans would be subject to "a risk adjustment mechanism used to spread risk across all health plans." Additionally, under the Senate bill, employers with fewer than 10 employees would not be required to withhold HAPI premiums from employee paychecks.

Medicare: The Senate version of the legislation would expand the Medicare hospice benefit to allow coverage for curative care in conjunction with palliative care. The Senate version would require the federal government to play a role in price negotiations for Medicare Part D drugs in Part D "fallback" plans, would authorize HHS to participate in Part D drug price negotiations on behalf of Medicare Advantage prescription drug plans, and would allow beneficiaries to switch Part D plans upon reaching the coverage gap. Both the Senate and House versions would add primary care and chronic care benefits to the Medicare program.

Medicare and Medicaid DSH: The bills would terminate the Medicare disproportionate share hospital (DSH) program and reduce by 90 percent the funds available to the federal Medicaid DSH program. The money currently allocated to Medicare DSH would be frozen, inflation-adjusted, and contributed to the Medicare Hospital Insurance Trust Fund. The federal Medicaid DSH amounts would be frozen and inflation adjusted. Ninety percent would be allocated to premium and coinsurance subsidies for lower income families and as bonus payments to states that enact medical malpractice reform (Senate version only). Any excess from a given federal fiscal year would be used to pay down any national budget deficit or returned to the general fund of the U.S. Treasury. Ten percent of federal Medicaid DSH funds would remain available for the Medicaid DSH program.

Medicaid and SCHIP: These bills would essentially terminate the Medicaid and SCHIP programs. However, to ensure that benefits are not decreased because of the bill, the legislation would allow the Medicaid and SCHIP programs to maintain supplemental coverage for children, people who are disabled, and elderly enrolled in the programs, at the levels that are in place on the December 31 immediately preceding when HAPI plans go into effect. Additionally, the Medicaid program would continue to cover cost-sharing and premium subsidies for low-income Medicare beneficiaries. In the Senate version, each state's Medicaid program would be authorized to institute a long-term care plan for individuals who meet long-term care facility coverage eligibility requirements under the Medicaid State Plan or under a section 1115 or 1915 waiver.

Lewin Group Estimates of Coverage and Costs in 2010
Senator Wyden's "Healthy Americans Act"

Number of uninsured covered	46.0 million
Remaining uninsured	2.9 million
Net change in costs in 2010	
Total health spending	$13.7 billion
Federal	($39.6 billion)
State and local	($29.0 billion)
Employers	$98.4 billion
Household	($16.2 billion)

What the Estimates Mean

The Lewin Group estimates that, under Senator Wyden's Healthy Americans Act, 46 million people would become newly insured through HHAs in 2010 (Figure 3). In addition, most people currently insured under employer plans, and everyone insured through Medicaid, SCHIP, or private non-group coverage also would become enrolled in the new program. Because employers would be allowed to continue offering coverage, about 6.3 million people would be insured under employers' plans. People with coverage through Medicare, the military, and those dually eligible for Medicare and Medicaid would retain their current coverage. Enrollment in HHAs would total 252.8 million in 2010.

Lewin estimates that the federal government's expenditures on health care would fall by a net $39.6 billion in 2010 (Figure 6). Total federal costs (before offsets) for the program total $1,207 billion and include those for benefits ($962 billion), the cost of the new tax deduction ($151 billion), the costs of private insurance administration and profits ($34 billion), the administration of the HHAs ($31 billion), the wage cash out and premium contributions for federal employees ($27 billion), and the administration of premium collections and subsidies through the tax code ($2 billion) (data not shown).

These costs are more than offset by household premiums net of premium subsidies ($675 billion); savings from Medicaid, disproportionate share payments, state payments for savings realized by the elimination of Medicaid (state maintenance of effort payments) ($207 billion); premium payments from employers ($120 billion); and savings from ending FEHBP ($23 billion). Lewin assumed that employers who offer coverage "cash-out" their employee premium contributions as taxable wages in the first two years of the program. Employers would also contribute more through Social Security and Medicare taxes. This would have the effect of increasing income tax revenues for the federal government by $125 billion and Social Security and Medicare taxes by $84 billion. Additional tax revenues are gained from elimination of the current health care cost deduction ($6 billion) and tax preferred health reimbursement and savings accounts ($6 billion). Total revenues and offsets amount to $1,247 billion.

State and local spending on health care would decline by a net $29.0 billion (Figure 4). These savings are primarily the result of a decline in uncompensated care at safety-net institutions.

Even though they would have a substantially reduced role in the provision of health benefits, employers would continue to share in the costs of covering workers. Employer spending on health care would climb by $98.4 billion in 2010 because of the requirement that employers that do not offer coverage make shared responsibility payments (Figure 4). Lewin assumed that employers with fewer than 50 employees would pay a fee equal to 3 percent to 11 percent of the national average premium per full-time employee. Employers with 51 to 200 workers would pay an additional 0.1 percent for each additional employee. Companies with 200 or more employees would contribute 18 percent to 26 percent of the average premium. Nonprofits, state and local governments, and companies reporting no revenues in the prior year would pay between 2 percent and 17 percent, depending on size.

Lewin estimates that households in the aggregate would see their health care bill drop by $16.2 billion (Figure 4). But because of the premium subsidies and structure of the new standard tax deduction, spending would rise with income. Families earning less than $10,000 a year would see their average spending on health care decline by $982 per year (Figure 7). At the other end of the income scale, families earning $150,000 or more would see their health care spending climb by about $1,890, on average.

National health expenditures are estimated to increase by a net $13.7 billion. New health care expenditures among newly insured people are estimated to be $48.4 million

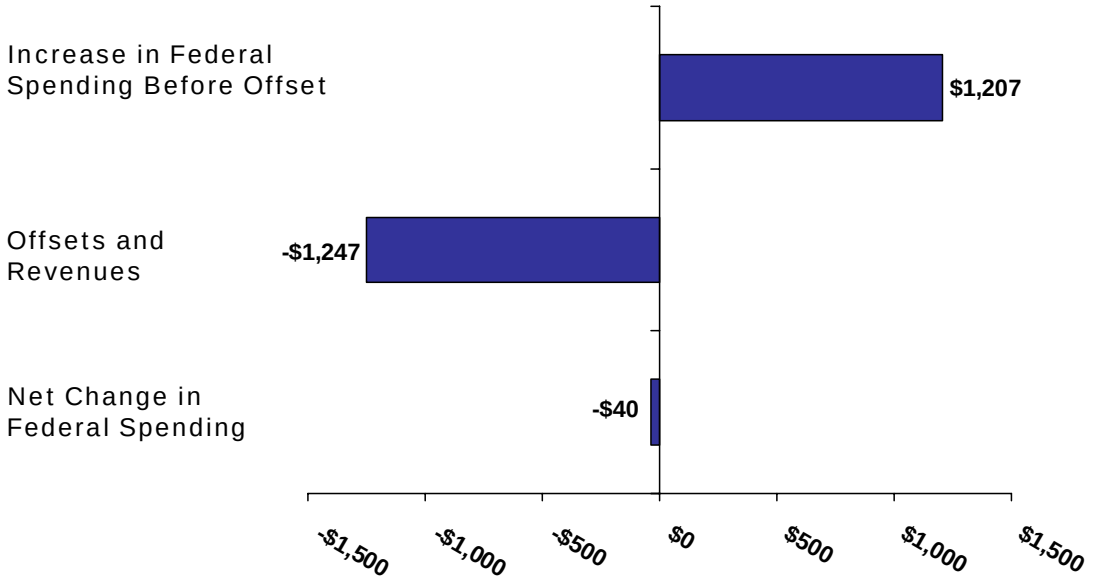
(Figure 8). They would be partly offset by incentives to decrease health care utilization among both the currently insured and uninsured: because people would face the full price of the premium, albeit with subsidies and tax deductions for most, it is likely individuals would choose lower-cost products. Lewin assumes most would select HMOs and estimates a consequent reduction on spending of about $37 billion as a result of the new incentives.

The biggest increase in spending under the Healthy Americans Act is the increase in provider reimbursement as a result of the elimination of the Medicaid program. Providers who now provide services to Medicaid beneficiaries would see their rates rise to commercial insurance levels.

One of the largest sources of savings in national health care expenditures is a reduction in the cost of insurance administration. Senator Wyden's bill would create new group regional purchasing pools and impose restrictions on individual underwriting. The regional pools, established and administered by the HHAs, would be expected to pool risks more broadly than do the individual and small-group insurance markets. Insurance administration costs are projected to drop by a net $41 billion, even after accounting for the new administrative costs of the HHAs and the cost of administering subsidies (Figure 8).

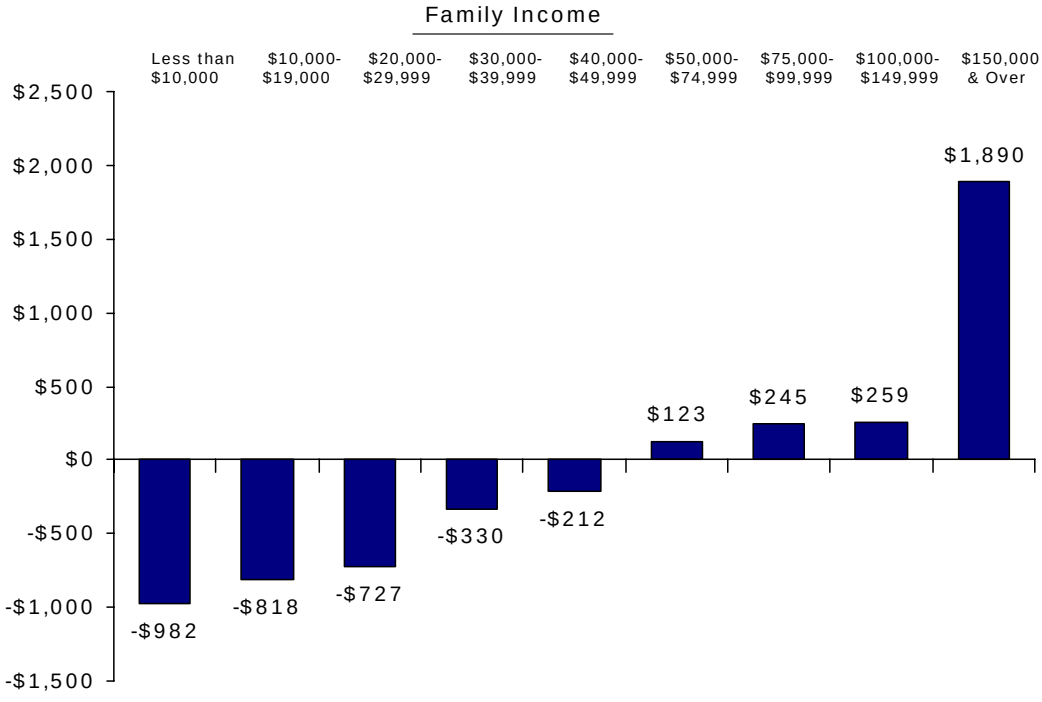
Senator Mike Enzi (R–Wyo.) introduced "Ten Steps to Transform Health Care in America Act" (S. 1783) in July 2007. This proposal would change the tax treatment of health insurance, establish an autoenrollment mechanism, allow coverage to be offered through small business health plans, and provide Medicaid and SCHIP beneficiaries with the option of using the value of their benefits to purchase private health insurance.

Figure 6. Change in Federal Health Expenditures Under Wyden's Healthy Americans Act in 2010 (in billions)



Source: The Lewin Group for The Commonwealth Fund.

Figure 7. Change in Average Family Health Spending by Income Group Under Wyden's Healthy Americans Act in 2010



Source: The Lewin Group for The Commonwealth Fund.

Figure 8. Changes in National Health Spending Under Wyden's Healthy Americans Act in 2010 (in billions)

Change in Health Services Expenditures		$16.6
Change in utilization for newly insured	$48.4	
Change in utilization due to improved coverage	$4.7	
Consumer incentives and Insurer price competition	($36.5)	
Reimbursement Effects		$38.1
Change in provider income net of reduce cost-shift		
Payments for formerly uncompensated care	$27.8	
Use of commercial payment rates for all in program	$55.6	
Eliminate Disproportionate Share Hospital (DSH) Payments		
Medicare	($10.4)	
Medicaid	($9.5)	
Reduced cost shifting (Assumes 40 percent passed to payers)	($29.0)	
Net Change in Administrative Costs		($41.0)
Insured administration	($74.3)	
Health Help Agencies administration	$30.9	
Administration of subsidies	$2.4	
Total Change in Health Spending		$13.7

Source: The Lewin Group for the Commonwealth Fund.

Senator Enzi's "Ten Steps to Transform Health Care in America Act" (S. 1783) (for more detail see Table A-2)

Overall Approach: Promotes expanded health insurance coverage by: modifying the tax treatment of health insurance; setting standards for state insurance regulations; establishing an autoenrollment mechanism; allowing coverage to be offered through small business health plans; and providing Medicaid and SCHIP beneficiaries with the option of using the value of benefits to purchase private health insurance. The bill also includes provisions related to: promoting health information technology; promoting quality improvement; supporting health professions education and the health care workforce; tort reform demonstrations; and other topics, such as advanced directives, community based long-term care and Medicaid coverage of clinics.

Tax Treatment: The bill would eliminate the exclusion of employer-paid health insurance premiums for individual tax purposes. The bill would create an above-the-line standard tax deduction for qualified health care insurance premiums equal to $7,500 for individuals and $15,000 for families. It would also create an income-based advanceable, refundable, assignable tax credit for qualified health insurance coverage for households earning less than 300 percent of the federal poverty level. The full tax credits of $2,500 for individuals and $5,000 for families would be available to households with incomes at poverty or less and would phase out between 100 percent and 300 percent of the poverty level. No one can take both a standard deduction and a tax credit.

Insurance Regulation: The bill would require the creation of uniform rules for the individual and group insurance markets. It would establish requirements regarding benefit mandates, premium variation, and allowable cost-sharing. The bill also would establish national harmonized standards related to form and rate filing, market conduct reviews, internal reviews, and prompt payment of claims. Additionally, other standards regulating insurers would be created to require insurers to offer qualified core plans (QCPs) subject to certain benefit and premium requirements and permitting insurers to offer one or more certified qualified core compatible plans (QCCPs) meeting certain requirements. The standard premium for coverage under a qualified core plan for the initial plan year would be $2,500 for individual coverage and $5,000 for family coverage. Qualified core plans would be subject to limitations on cost-sharing and would not be permitted to impose cost-sharing requirements on basic preventive items or services. States would be required to establish risk adjustment mechanisms to correct for risk selection among the QCPs and QCCPs. All carriers selling in the newly combined market would be required to participate in the risk adjustment mechanism.

Automatic Enrollment: People who do not indicate having health insurance on their tax forms, or who access a provider without health insurance, would be automatically enrolled into a QCP, and Medicaid and SCHIP, if eligible. State insurance commissioners would work with the federal government to develop notification procedures for people who indicate a lack of coverage on tax returns or when they access a provider. The bill does not address non-payment of premiums by those automatically enrolled in plans.

Small Business Health Plans: Small business health plans and other organizations would be able to offer health insurance through small business health plans. Small business health plans would be allowed to operate across state lines subject to oversight by a single state. The bill would require the plans to cover mandated benefits applicable under the law. Premiums would be based on the experience of the pool.

Other: The bill would also provide individuals the option of converting the value of Medicaid and SCHIP program benefits into support for purchasing private health insurance.

Lewin Group Estimates of Coverage and Costs in 2010
Senator Enzi's "Ten Steps to Transform Health Care in America Act"

Number of uninsured covered	26.9 million
Remaining uninsured	22.0 million
Net change in costs in 2010	
Total health spending	$64.1 billion
Federal	$176.4 billion
State and local	($21.2 billion)
Employers	($77.6 billion)
Household	($13.5 billion)

What the Estimates Mean

The Lewin Group modeled cost and coverage estimates for the Ten Steps proposal based on the coverage portion of the bill only. Under the proposal, an estimated 26.9 million

uninsured people would become insured in 2010 (Figure 3). About 10 million would get coverage through the individual market, and another 10.7 million would get coverage through a qualified core plan (QCP). About 6.7 million previously uninsured people would gain coverage through Medicaid and SCHIP as a result of the autoenrollment mechanism. Slightly fewer than 2 million previously uninsured people would gain coverage through a small business plan or other employer based plan. Twenty-two million people would remain uninsured in 2010 under this proposal.

There are significant shifts in coverage as a result of the change in taxation of employer-provided benefits and the provision that allows Medicaid and SCHIP beneficiaries to convert their benefits to the individual market. About 17 million people are estimated to move out of employer-based coverage, as many employers are expected to drop coverage and some employees of insuring firms would use their tax credits or deductions to purchase coverage on the individual market. Of these, nearly 8 million would gain coverage through the individual market, 5.4 million would enroll in a QCP, 1.5 million would enroll in Medicaid or SCHIP, and 2.6 million would become uninsured. About 13 million Medicaid and SCHIP beneficiaries are expected to take the value of their benefits and the tax credit and purchase coverage in the individual market. Lewin assumes beneficiaries would be required to purchase comparable benefits.

The Lewin Group estimates that this proposal would increase total health spending in 2010 by $64.1 billion (Figure 9). This includes an increase in spending on health services for the newly and currently insured ($19 billion). Payments to providers would increase by a net $20.9 billion, partly as a result of some current Medicaid and SCHIP beneficiaries switching to private insurance and, subsequently, higher reimbursement rates. The shift from employer-based coverage and Medicaid/SCHIP to the individual and small-group markets increases the cost of insurance administration by $22 billion. The provision to increase adoption of health information technology would create savings of almost $100 million in the first year.

The federal government's spending on health care is estimated to increase by a net $176.4 billion in 2010 under the proposal (Figure 10). The federal share of program costs would be $391 billion, which includes the new standard deduction for private health insurance ($313 billion), tax credits ($47 billion), new enrollment in the Medicaid program ($21 billion), and subsidizing costs of the QCPs ($10 billion). The program costs will be partially offset by savings and revenues of $215 billion, which include revenue from taxing employer health benefits ($194 billion), elimination of the current out-of-pocket deduction for health care ($9 billion), elimination of the tax exclusion for

medical flexible spending accounts ($5 billion), savings from some federal employees opting out of FEHBP to buy individual coverage ($5 billion), and savings on other federal health programs due to the new incentives ($2 billion).

State and local government spending is expected to decrease by $21.2 billion (Figure 4). State and local governments would experience increases in spending due to higher enrollment in the Medicaid program. State income tax revenues would decline as the costs of the new income tax deduction would exceed the increase in the revenues from eliminating the employer benefit tax exclusion. However, this may change over time if the deduction is pegged to consumer price inflation, which grows more slowly than health care costs. State and local governments would experience savings from many state and local government workers choosing to buy their own coverage and from savings to safety net and other programs.

Private employers could see their health expenditures fall by approximately $77.6 billion as many employers and their employees drop employer coverage. It is estimated that households would experience a decrease in spending of $13.5 billion. Most families would see their average spending on health care decline in the first year of implementation. Families with incomes less than the poverty level would benefit from the full amount of the tax credit. Because the tax credit is phased out between 100 percent and 300 percent of the poverty level, savings decline as income rises. The new income tax deduction for premiums provides the greatest savings to families in the highest tax brackets.

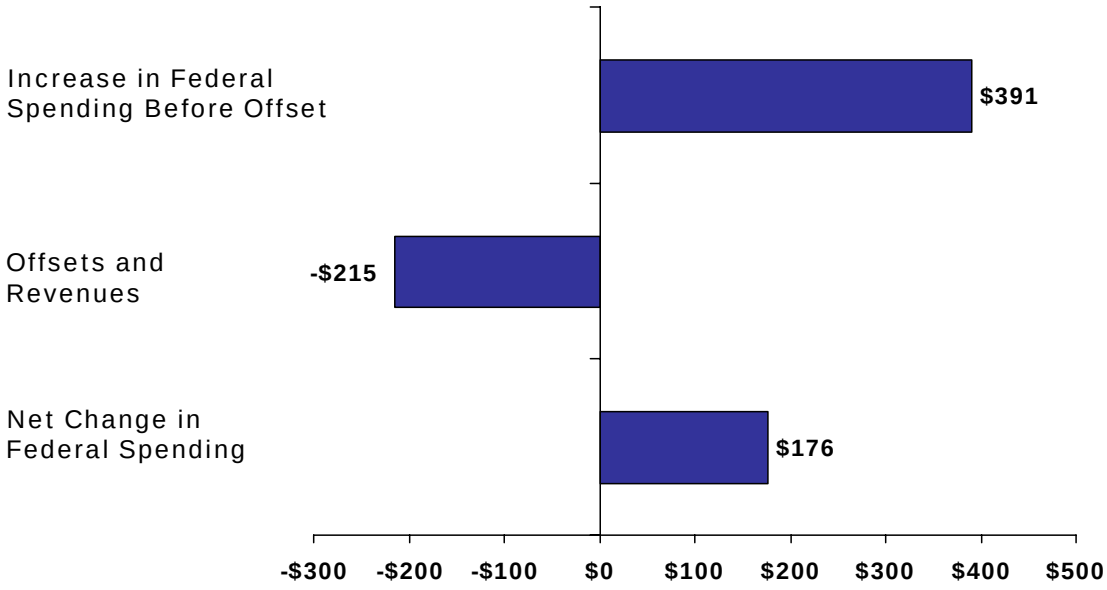
Two bills introduced in 2007 would eliminate the employer benefit income tax exclusion and replace it with tax credits for people to purchase private health insurance (Figure 2). Senator Richard Burr (R–N.C.) introduced the “Every American Insured Health Act” (S. 1886), and Senator Tom Coburn (R–Okla.) introduced the “Universal Health Care Choice and Access Act” (S. 1019). The Lewin Group modeled Sen. Burr’s bill.

Figure 9. Changes in National Health Spending Under Enzi's Ten Steps to Transform Health Care Act in 2010 (in billions)

Change in Health Services Expenditures		$19.0
Change in utilization for newly insured	$29.9	
Change in utilization for currently insured	$3.9	
Effect of new incentives on currently insured	($14.8)	
Reimbursement Effects [1]		$20.9
Payments for previously uncompensated care	$17.6	
Increased provider payment levels for Medicaid beneficiaries moving to private insurance [1]	$17.3	
Reduced cost shifting [2]	($14.0)	
Savings to Health Spending [3]		($0.1)
Increase adoption of health information technology	($0.1)	
Change in Administrative Cost of Programs and Insurance		$24.3
Change in insurer administration	$22.0	
Administration of subsidies [4]	$2.3	
Total Change in National Health Spending		$64.1

[1] Includes increased payment rates for people previously covered under Medicaid, who take the buy-out and purchase private insurance. [2] Assumes 40% of change in provider payments are passed on to health plans. [3] Proposal appropriates $139 million in 2008 and 1009 to increase rate of HIT adoption. We estimate this results in net health system savings of $1.2 billion over 10 years.
[4]Assumes IRS budget is increased by 25% to administer tax credits and subsidies.
Source: The Lewin Group for the Commonwealth Fund.

Figure 10. Change in Federal Health Expenditures Under Enzi's Ten Steps to Transform Health Care Act in 2010 (in billions)



Source: The Lewin Group for The Commonwealth Fund.

Senator Burr's "Every American Insured Health Act" (S. 1886)

(for more detail see Table A-3)

Overall Approach: Establishes a refundable, advanceable flat tax credit for individuals to purchase qualified health insurance. The tax credit would only be available in states that met the refundability requirements established by HHS. States could meet the requirement by establishing a state health insurance exchange or establishing a high-risk solution, such as a high-risk pool or reinsurance that makes affordable coverage available. The bill would establish a program for the certification of state health insurance exchanges, which would serve as a pooling mechanism for consumers purchasing private health insurance. It would also repeal the current exclusion of employer-paid health insurance premiums from employee income. The bill also would allow all states to establish Medicaid health opportunity accounts, which are similar to health savings accounts.

Eligibility: An individual in a state deemed to meet the refundability requirements would be eligible for the refundable health insurance tax credit if the person is covered under qualified health insurance as of the first day of the month. Certain individuals, such as people entitled to Medicare, enrolled in Medicaid, SCHIP, or entitled to military coverage, would not be eligible for the tax credit. Persons in states not meeting the refundability requirements would also be ineligible for the tax credit, but could deduct premiums paid to the extent allowable under current laws.

Tax Credit: The annual tax credit in 2009 would be $2,160 for adult individuals, $1,620 for children and a maximum amount of $5,400 for a household or filing unit. If the amount of the tax credit exceeds the cost of a qualified health plan, the excess funds would be deposited into a designated account, including a health savings account, an Archer Medical Savings Account (MSA), which is similar to a health savings account but limited to self-employed people or employees of small firms, or a health insurance reserve account.

Affordability: The bill would require that both certified state health insurance exchanges and states meeting the refundability requirements through a high-risk solution have at least one plan with an average premium for individuals that does not exceed 6 percent of the state's median income. States could use their own funds to subsidize the premium of the lowest cost plan to meet this requirement, but could not set premiums for any product offered through a health insurance exchange.

Benefit Package: Qualified health insurance for the purpose of the health insurance tax credit would be any health insurance comprising medical care that has a reasonable annual and lifetime benefit maximum and provides coverage for inpatient and outpatient care, emergency benefits, and physician care. Health insurance plans participating in a certified state health insurance exchange would be subject to Health Insurance Portability and Accountability Act limitations on pre-existing condition exclusions as if the plan was a group health plan.

Lewin Group Estimates of Coverage and Costs in 2010
Senator Burr's "Every American Insured Health Act"

Number of uninsured covered	22.3 million
Remaining uninsured	26.6 million
Net change in costs in 2010	
Total health spending	$31.1 billion

Federal	$161.3 billion
State and local	($52.9 billion)
Employers	$7.0 billion
Household	($84.3 billion)

What the Estimates Mean

The Lewin Group assumed that all states would take steps to meet the refundability requirements: establish a health insurance exchange or a high risk pool and develop a low-cost plan option to meet the requirement that at least one plan costs no more than 6 percent of the state's median income.

Under the proposal, 24.5 million of the projected 48.9 million uninsured people in 2010 would become covered (data not shown). Of those, 19.2 million would use their tax credits to purchase insurance through the individual market, 3.3 million would apply their credits to their employer-sponsored insurance, and 2 million would purchase a low-cost plan offered by their state. Many employers would drop coverage because of the change in the tax treatment of employer provided benefits. About 8.3 million people would either lose employer coverage or choose to apply their tax credits to individual market coverage. About 2.2 million of those previously insured through an employer would become uninsured. Thus an estimated 26.6 million people would remain uninsured under the proposal (Figure 3).

Total national health spending under the proposal would increase by $31.1 billion in 2010, including an increase of $9.6 billion for administrative costs (Figure 11).

The federal government would experience an increase in spending of $161.3 billion in 2010 (Figure 12). The federal share of program costs would be $388 billion, which includes an increase in spending due to the tax credits ($385 billion) and an increase in spending on the Medicaid program ($3 billion). The program costs will be partially offset by savings and revenues of $226 billion, which include new revenues from taxing employer-based benefits ($210 billion), elimination of the current out-of-pocket deduction for health care ($9 billion), elimination of the tax exclusion for medical flexible spending accounts ($5 billion), savings on workers and their dependents under FEHBP ($1 billion), and savings on other federal health programs due to new incentives ($1 billion).

State and local government spending would fall by $52.9 billion (Figure 4). Savings would largely accrue from lower expenditures on health insurance for state and

local government workers and from revenue from taxing employer-sponsored insurance benefits. Some local governments are expected to drop coverage and many workers are expected to select lower cost health plans.

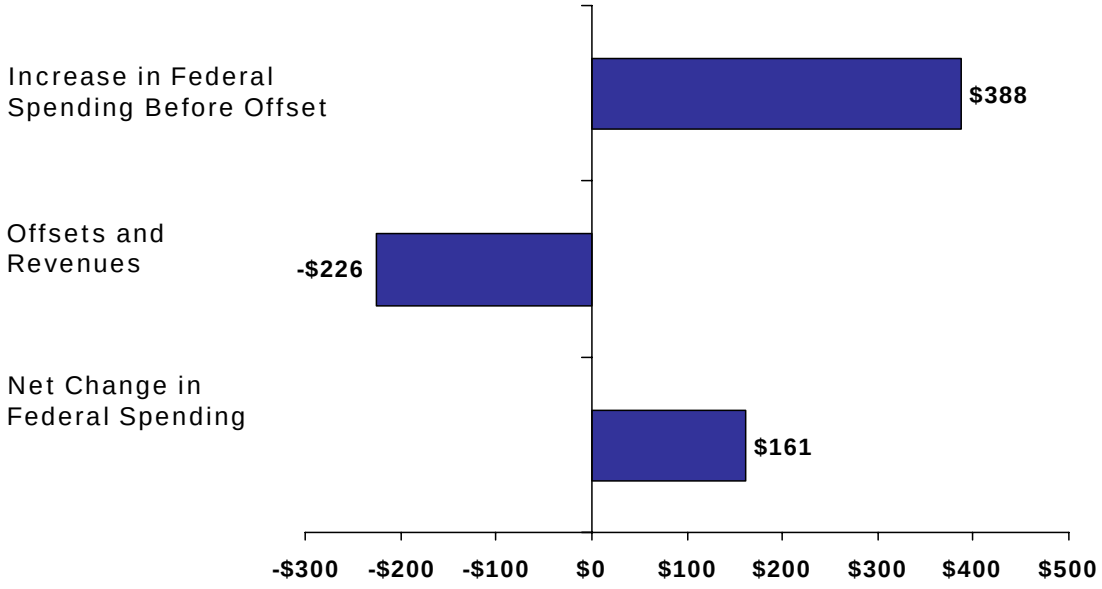
Spending by private employers would increase by a net $7 billion. While some employers would drop coverage as a result of the new tax credits, employer costs would rise in the aggregate as a result of an increase in payroll taxes. Family health spending would decrease by $84.3 billion in 2010. Although premium and out-of-pocket expenses would increase, federal income and payroll taxes would decrease as a result of the tax credits, resulting in an overall decrease in household spending. Middle- and high-income families would realize the largest savings. Lower-income families would realize smaller savings on health care expenses.

Figure 11. Changes in National Health Spending Under Burr's Every American Insured Act in 2010 (in billions)

Change in Health Services Expenditures		$14.3
Change in utilization for newly insured	$24.8	
Change in utilization for currently insured	$4.0	
Effect of new incentives on currently insured	($14.5)	
Reimbursement Effects		$7.2
Payments for previously uncompensated care	$12.0	
Reduced cost shifting[1]	($4.8)	
Change in Administrative Cost of Programs and Insurance		$9.6
Change in insurer administration	$9.6	
Total Change in National Health Spending		$31.1

[1] Assumes 40% of change in provider payments are passed on to health plans.
Source: The Lewin Group for the Commonwealth Fund.

Figure 12. Change in Federal Health Expenditures Under Burr's Every American Insured Act in 2010 (in billions)



Source: The Lewin Group for The Commonwealth Fund.

Federal–State Partnerships to Expand Health Insurance

Several congressional bills seek to underscore the momentum building at the state level—for instance, in states like Maine, Massachusetts, Vermont, and others that have proposed or initiated health reform—to expand health insurance by providing grants to states that propose promising plans. Senator Jeff Bingaman (D–N.M.) reintroduced the "Health Partnership Act" (S. 325) in January 2007. At the same time, Representative Tammy Baldwin (D–Wis.) reintroduced the "Health Partnership Through Creative Federalism Act" (H.R. 506). In April 2007, Senators Russ Feingold (D–Wis.) and Lindsey Graham (R–S.C.) introduced the "State-Based Health Care Reform Act" (S. 1169).

Senator Bingaman's "Health Partnership Act" (S. 325)/ Representative Baldwin's "Health Partnership Through Creative Federalism Act" (H.R. 506)/ Senators Feingold and Graham's "State-Based Health Care Reform Act" (S. 1169) (for more detail see Table A-4)

Overall approach: Establishes a commission to oversee demonstration grants to regions, states, or local governments to expand health insurance coverage and to improve health care quality and efficiency. The commission would provide states with a range of reform options, which might include expansion of public programs, tax credits,

purchasing pools, buy-ins to state and federal employee benefit programs, risk pools, single-payer systems, and health savings accounts. States would be prohibited from changing eligibility criteria for state public insurance programs and would be required to maintain the pre-grant level of expenditures for health care coverage.

States would be required to provide a five-year target for reducing the number of uninsured. The commission would review state applications and determine grant amounts and submit to Congress a list of recommended applications and requests for grant funding. Each bill sets forth procedures for congressional consideration of the recommended applications and requests for funding. These procedures would provide for consideration of the recommendations by Congress on an expedited basis.

Benefit package: The Baldwin and Feingold–Graham bills (H.R. 506 and S. 1169) suggest that the minimum benefit package would be equivalent to a SCHIP benchmark package. All the bills generally would restrict states from implementing reform options that include exclusions for pre-existing conditions.

Affordability: The Feingold-Graham bill specifies protections for lower-income families. Families with incomes below the poverty level would have no premiums and cost-sharing would not exceed 0.5 percent of income, families with incomes between 100 percent and 200 percent of the federal poverty level would pay no more than 3 percent of their income on premiums and no more than 5 percent on premiums plus cost-sharing, and families with incomes between 200 percent and 300 percent of poverty would pay no more than 5 percent of income on premiums and no more than 7 percent on premiums plus cost-sharing.

Financing: States that receive congressional approval would receive federal grants. Size of the grants would be determined by Congress, likely based on the recommendation of the commission. The Feingold–Graham bill caps expenditures on grants and administration at $40 billion over 10 years, and includes a set of suggested spending offsets.

Efficiency and Quality Improvement: Along with their coverage plans, states would be required—or encouraged in the Baldwin bill—to submit a plan to improve health care quality and efficiency.

The state–federal partnership bills introduced to date would request proposals from states for demonstrations to expand health insurance. By definition, the bills do not provide sufficient details to permit cost and coverage estimates like those performed for other bills in this report. To illustrate how a state–federal partnership might work and what the federal and state cost might be if the federal government helped finance expansions of coverage to lower-income families, the Lewin Group assumed a hypothetical model for this set of bills. Lewin assumed that 15 states would propose coverage plans based on Massachusetts' Commonwealth Care Program. States were selected to provide regional and population diversity, variation in numbers of uninsured residents, and a range of income eligibility limits in Medicaid and SCHIP. The 15 states are: Arizona, California, Georgia, Illinois, Iowa, Kansas, Louisiana, Montana, New Mexico, New York, Ohio, Pennsylvania, South Carolina, Texas, and Wisconsin. Lewin assumed that each state would expand SCHIP for children in families with incomes up to 300 percent of poverty and Medicaid to adults up to 100 percent of poverty. Adults with incomes between 100 percent and 300 percent of poverty would purchase subsidized coverage through a new

insurance “connector” or exchange. Small employers with fewer than 100 employees could also buy coverage through the connector. All state residents would be required to have insurance. However, people with incomes between 300 percent and 600 percent of poverty could opt out of the program if premiums are deemed unaffordable. Employers with more than 10 workers would be required to either offer comprehensive coverage and contribute at least 75 percent of the premium and cover at least 80 percent of their workers, or pay 7 percent of payroll into a state fund. Employers would be required to allow young adults under age 26 to be covered on their parents’ plans. Employers with more than 10 employees must offer section 125 that enable workers to purchase coverage with pretax dollars.

Lewin assumed that federal grants to states would take the form of the current federal Medicaid match for adults to 100 percent of poverty and the federal SCHIP match for children to 300 percent of poverty. All estimates are based on the current demographics in each state.

It is important to note that Representative Baldwin’s bill would require that a set of approved applications in a given year be budget-neutral at the end of their five-year demonstration period. That is, the state plans would not collectively increase federal expenditures at the end of five years. Senators Feingold and Graham would allocate up to $40 billion over 10 years for state grants and administration of the program.

Lewin Group Estimates of Coverage and Costs in 2010
Federal–State Partnership to Expand Health Insurance

Number of uninsured covered in the 15 states	21.1 million
(out of 26.7 million uninsured in 2010 under current law)	
Remaining uninsured	
In the 15 states	5.6 million
All uninsured	27.8 million
Net change in costs in 2010	
Total health system	$37.7 billion
Federal	$40.3 billion
State and local	$19.4 billion
Employers	$34.8 billion
Household	($56.7 billion)

What the Estimates Mean

The Lewin Group projects that 26.7 million people in the 15 states are estimated to be uninsured in 2010, about half of the total number of people without coverage nationally (Figure 13). Of those, Lewin estimates that 21.1 million would become newly insured if those states implemented a Massachusetts-style approach to expanding coverage. Of those gaining coverage, 12.3 million would buy plans through the newly established insurance connectors in each state, and 8.8 million would enroll in Medicaid and SCHIP. Overall, 21.9 million people in the 15 states are estimated to buy coverage through connectors, and Medicaid and SCHIP enrollment would grow by 10 million. Employer-based coverage is estimated to decline by 7.7 million people.[10] The number of people enrolled in the individual non-group market would decline by 3.1 million.

The net costs to the federal government under the program are estimated to be $40.3 billion in 2010, unless offset by cost savings (Figure 4). These costs are mainly the result of the matching funds provided to states for the expansions to Medicaid and SCHIP, subsidized premiums for people who buy coverage through the connectors with incomes of less than 300 percent of poverty, and tax revenue loss from the provision of section 125 plans for all employees.

The 15 state governments are estimated to see a net increase in spending of $19.4 billion in 2010. This increase is driven by the increase in Medicaid and SCHIP enrollment (offset by the federal share of those costs) and the state share of the premium subsidies and cap on out-of-pocket costs in the connectors. State costs would be offset by tax revenues from employers that do not offer coverage and savings to safety-net institutions.

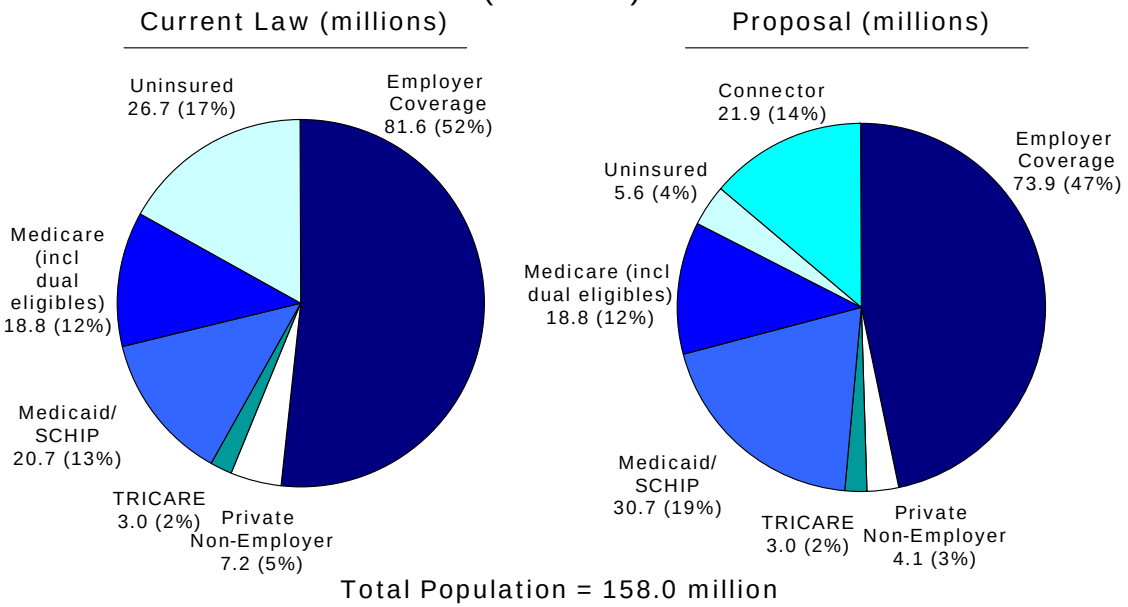
Lewin estimates that employers in the 15 states would incur a net increase in costs of $34.8 billion. Upgrading benefit packages to the standards required under the program is estimated to cost employers $22.7 billion. There are also new costs associated with covering workers who previously had declined coverage or had not been eligible for employer plans, such as part-time workers. Increasing the dependent age to 25 would increase employer costs by $400 million. Some lower-wage firms would drop coverage to allow employees to take full advantage of the new subsidies available through the connectors. Non-insuring firms would see their costs increase by the new payroll tax.

Health spending by families in the 15 states is estimated to decline by $56.7 billion. Premium expenditures would decline as a result of an overall decrease in premiums due to regulation against rating on the basis of health status and other factors, premium subsidies, and caps on cost-sharing. With more people covered under

comprehensive plans, overall out-of-pocket spending would decline. Households also realize savings from the use of pre-tax income for premiums in section 125 plans.

The Lewin Group estimates that total health expenditures in the 15 states would increase by a net $37.7 billion in 2010 (Figure 14). This is primarily driven by new health care use by previously uninsured and underinsured families. The costs of insurance administration are projected to rise by $7 billion, because many people will receive private insurance coverage through the connector. Including a public plan option in the connector would help reduce administrative costs as it does in the Building Blocks estimates. The provision of premium subsidies is estimated to increase administrative costs by an additional $0.9 billion.

Figure 13. Distribution of People by Primary Source of Insurance, Under Current Law and Sens. Bingaman, Feingold, Graham and Rep. Baldwin's Proposals (Federal-State Partnership Acts), 2010: For the 15 Affected States Only (millions)



Source: The Lewin Group for The Commonwealth Fund.

Figure 14. Changes in Statewide Health Spending Under Baldwin / Bingaman / Feingold – Graham's Federal-State Partnership Acts in 2010: For 15 Affected States Only (billions)

Change in Health Services Expenditures		$22.7
Change in utilization for newly insured	$20.5	
Change in utilization for currently insured	$2.2	
Reimbursement Effects		$7.1
Payments for previously uncompensated care	$11.8	
Reduced cost shifting [1]	($4.7)	
Change in Administrative Cost of Programs and Insurance		$7.9
Connector administration [2]	$2.5	
Change in insurer administration	$4.5	
Administration of subsidies [3]	$0.9	
Total Change in National Health Spending		$37.7

[1] Assumes 40% of change in provider payments are passed on to health plans.
[2] Assumes purchasing pool administrative costs of 4.5 percent of claims in the pool.
[3] Assumes eligibility determination expense of $190 per application. Assumes federal match on eligibility determination for parents in the Connector.
Source: The Lewin Group for The Commonwealth Fund.

Coverage Through Medicare or Centralized Financing

People of all ages would be eligible to enroll in Medicare or a Medicare-like program under three bills introduced in 2007. Senator Edward Kennedy (D-Mass.) and Representative John Dingell (D–Mich.) introduced the "Medicare for All Act" in April 2007 (S. 1218 and H.R. 2034), and Representative Pete Stark (D–Calif.) introduced the "AmeriCare Health Care Act of 2007" (H.R. 1841) in March 2007. In addition, two bills would cover everyone through a central financing or "single-payer" mechanism. Under Representative John Conyers' (D–Mich.) "United States National Health Insurance Act," introduced in January 2007 (H.R. 676), the federal government would collect payroll and income taxes to finance a system of health insurance under which all residents would be eligible for a set of covered benefits. Representative Jim McDermott's (D–Wash.) "American Health Security Act of 2007," introduced in February 2007 (H.R. 1200), would use a similar financing mechanism. The federal government would distribute tax revenues to states, which would design their own programs subject to national benefit and regulatory guidelines. The Lewin Group estimated the coverage and cost impact of Rep. Stark's bill.

Representative Stark's "AmeriCare Health Care Act of 2007" (H.R. 1841) and Senator Kennedy and Representative Dingell's "Medicare for All Act" (S. 1218 and H.R. 2034) (for more detail see Table A-5)

Overall Approach: Creates a new public health insurance program administered by the federal government to provide everyone with multiple choices for health coverage. Under the Stark bill (H.R. 1841), employers would either offer their employees coverage or pay into a fund to cover them through a new public program. Under the Kennedy and Dingell bills (S. 1218 and H.R. 2034), employers and their employees would help finance the expansion through new payroll taxes.

Benefit Package: Enrollees would have two choices: 1) a fee-for-service option under Medicare Parts A and B, enhanced with additional benefits such as pregnancy-related services, well-child care, and a drug benefit package similar to that in the most popular FEHBP plan; and 2) a choice of private plans that contract with the federal government and provide a standard benefit package.

Cost-Sharing: Under the Medicare fee-for-service option in the Stark bill, cost-sharing would include: deductibles equal to $350 for individuals and $500 for families; 20 percent coinsurance; and an out-of-pocket cap of $2,500 for individuals and $4,000 for families. Premiums would be established by HHS based on cost of coverage and enrollment class (e.g. individual, couple, or family). Enrollees would pay cost-sharing under the Kennedy and Dingell bills, although the bills do not specify the amounts.

Affordability: Under the Stark bill, there would be no cost-sharing for children and young adults under age 24, pregnant women, and people with incomes less than 200 percent of poverty. People with incomes of less than 200 percent of poverty would not pay premiums. Families with incomes between 200 percent to 300 percent of poverty would receive a premium subsidy and would pay no more than 5 percent of income on total out-of-pocket spending, including premiums. Families with incomes between 300 percent to 500 percent of poverty would pay no more than 7.5 percent of income on total out-of-pocket costs, including premiums. The Stark bill would require employers to make a premium contribution on behalf of their enrolled employees. Under the Kennedy and Dingell bills, people with low incomes would pay reduced cost-sharing with amounts at least as protective as the cost-sharing levels for qualified Medicare beneficiaries under Medicaid.

Financing: The bills establish a new trust fund, modeled on the existing Medicare Trust Fund. Under the Stark bill, employers would either offer their employees coverage and pay 80 percent of their premiums or pay 80 percent of the AmeriCare premium into the trust fund, with employees paying the remaining 20 percent subject to premium subsidies and out-of-pocket cost caps. States would contribute into the new trust fund an amount equal to the amounts they would have contributed to Medicaid and SCHIP. Under the Kennedy and Dingell bills, employers would pay a 7 percent payroll tax and employees would pay a 1.7 percent wage tax on wages in excess of $25,000, both of which would go to the trust fund.

Automatic Enrollment: People would automatically be enrolled at birth under the bills. Under the Stark bill, people with employer coverage with equivalent benefits would be able to opt-out of the AmeriCare program.

Phase-In: The Kennedy and Dingell bills would phase in coverage by age, with children and older adults covered first.

Efficiency and Quality Improvement: Under the Stark bill, HHS would be required to negotiate prescription drug prices with pharmaceutical manufacturers. HHS would also establish standards for uniform claims and electronic medical records and create an electronic claims database.

Lewin Group Estimates of Coverage and Costs in 2010
Representative Stark's "AmeriCare Health Care Act of 2007"

Number of uninsured covered	48.9 million
Remaining uninsured	0
Net change in costs in 2010	
Total health spending	($58.1 billion)
Federal	$188.5 billion
State and local	($83.6 billion)
Employers	$61.5 billion
Household	($224.5 billion)

What the Estimates Mean

The Lewin Group assumed that all people who are either currently uninsured or have private individual health insurance would become enrolled in AmeriCare, without the ability to opt out. Under these assumptions, the bill would achieve universal coverage (Figure 2). Lewin also assumed that all employers would ultimately stop offering health insurance. Ultimately, most people under age 65 would become insured through AmeriCare, with 260 million people eventually enrolled in the program (Figure 3).

The costs to the federal government from the expansion and enhanced benefits to existing Medicare beneficiaries would be $188.5 billion in 2010 (Figure 4). Lewin assumed that the benefits and effect of drug price negotiation would also extend to current Medicare beneficiaries.

There are potentially large estimated savings to the overall health system from insuring everyone through Medicare. The Lewin Group estimates that overall national health care spending would decline by $58 billion in 2010 (Figure 15). This is driven, in part, by the substantial administrative savings accrued by enrolling everyone in a single risk pool: the total costs of health insurance administration would decline by $73.4 billion in 2010. Currently, Medicare has significantly lower administrative costs per premium dollar than employer or individual market insurance—2 percent compared with approximately 10 percent for employer group coverage and 25 percent to 40 percent for the individual insurance market.[11]

Additional declines in spending arise from allowing the federal government to negotiate discounted prescription drug prices for enrollees. The Lewin Group estimates that this provision would amount to a decline in national spending on prescription drugs of $38.2 billion in 2010. This is based on the assumption that the government would negotiate prices for AmeriCare and Medicare and they would ultimately fall midway between current average Medicaid prescription drug prices and those currently negotiated on behalf of federal programs.

In addition, paying Medicare rates to all providers would lower national spending by an additional $79.9 billion in 2010. This is based on estimated differences in provider payment levels that existed in 2007 between Medicaid, Medicare, and private payers: Medicaid hospital payment rates are approximately 88 percent of Medicare rates and Medicaid physician rates are 69 percent of Medicare rates. In contrast, private payers reimburse hospitals, on average, at 135 percent of Medicare rates and physicians at 120 percent of Medicare rates.[12]

Households would see a dramatic drop in health care expenditures of $224.5 billion (Figure 4). This results both from people becoming insured as well as from new protections against out-of-pocket costs and premiums, which would benefit families who are currently insured but have high out-of-pocket costs and premiums relative to income. The average decrease in annual health care expenditures for a household would range from $1,094 to $2,017, depending on income (data not shown). All employers would be required to pay 80 percent of their employees' premiums, with the employee share subject to subsidies and out-of-pocket spending caps. If the federal government were to finance the program in part through higher taxes, household savings might be less. Because the Medicaid and SCHIP programs are rolled into AmeriCare, states would see a decline in costs of $83.6 billion per year.

Figure 15. Changes in National Health Spending Under Stark's AmeriCare Health Act in 2010 (in billions)

Change in Health Services Expenditures		$16.1
Change in utilization for newly insured	$50.6	
Change in utilization due to improved coverage	$3.7	
HHS negotiated Rx discounts	($38.2)	
Reimbursement Effects		($19.0)
Payments for previously uncompensated care	$48.3	
Medicare payment rates	($79.9)	
Increased cost shifting[1]	$12.6	
Change in Administrative Costs		($55.2)
Insurance administration	($73.4)	
Administration of subsidies[2]	$18.2	
Total Change in National Health Spending		($58.1)

[1]Assumes 40% of change in provider payment rates is passed on to health plans.
[2]Assumes eligibility determination expense of $171 per application, which is based upon the average cost of eligibility determination programs in New York.
Source: The Lewin Group for The Commonwealth Fund.

Eliminating the Medicare Two-Year Waiting Period for Disabled People

Under two proposed bills, people who are unable to work because of a disability would no longer have to wait 24 months before becoming eligible for Medicare. Senator Jeff Bingaman (D–N.M.) and Representative Gene Green (D–Texas) in September 2007 and January 2007, respectively, introduced "Ending the Medicare Disability Waiting Period Act of 2007" (S. 2102 and H.R. 154) (Figure 16). These bills would phase out the waiting period by approximately two months per year over a 10-year period and immediately eliminate it for people with life-threatening diseases. For modeling purposes, The Lewin Group assumed that the bill would immediately eliminate the waiting period for everyone.

Senator Bingaman and Representative Green's "Ending the Medicare Disability Waiting Period Act of 2007" (S. 2102 and H.R. 154)
(for more detail see Table A-6)

Overall Approach: Phases out the waiting period following the onset of a disability before a person under 65 may qualify to enroll in Medicare. The bill would expand the list of specified fatal diseases that trigger eligibility for Medicare.

Expansion of Coverage: Medicare currently requires a person to have been disabled for at least 24 months before becoming eligible to enroll. The 24-month period would be reduced annually, to 18 months in the first year, and then by one, two, or three months each year. The waiting period would be completely eliminated by 2017. The bill would also add fatal diseases, identified by HHS, to the list of medical conditions that trigger eligibility for Medicare.

Additional Provisions: Requires HHS to commission and submit to Congress a study on the range of disability conditions that could be delayed or prevented if individuals were to receive access to and coverage of health care services before the condition renders the individual disabled.

Lewin Group Estimates of Coverage and Costs in 2010
Senator Bingaman's "Ending the Medicare Disability Waiting Period Act of 2007"

Number of uninsured covered	299,200 currently in waiting period
Remaining uninsured	48.6 million
Net change in costs in 2010	
Total health spending	($0.6 billion)
Federal	$10.8 billion
State and local	($2.3 billion)
Employers	($4.3 billion)
Household	($4.9 billion)

What the Estimates Mean

There are an estimated 1.6 million people who are disabled and in the Medicare waiting period (Figure 17). Of those, about one-third have coverage through a former employer under the Consolidated Omnibus Budget Reconciliation Act (COBRA) or through a spouse's employer, slightly more than one-quarter are covered by Medicaid, and one-tenth purchase coverage through the individual market. About 19 percent of the 1.6 million, or nearly 300,000 people, have no health insurance. The Lewin Group assumes that all those in the waiting period would enroll in Medicare if the waiting period were eliminated. The cost to the federal government of those newly enrolled would be about $10.8 billion in 2010 (Figure 18). This annual cost might decline over time, as there would be fewer people enrolling at once and less pent-up demand for health services as a result of being uninsured or underinsured during the waiting period. States are estimated to save about $2 billion in 2010 because Medicare would become the first payer for those currently enrolled in Medicaid, with Medicaid providing wraparound benefits. States also would save money from uncompensated care provided to those currently without insurance coverage. Employers currently providing benefits to early retirees in the

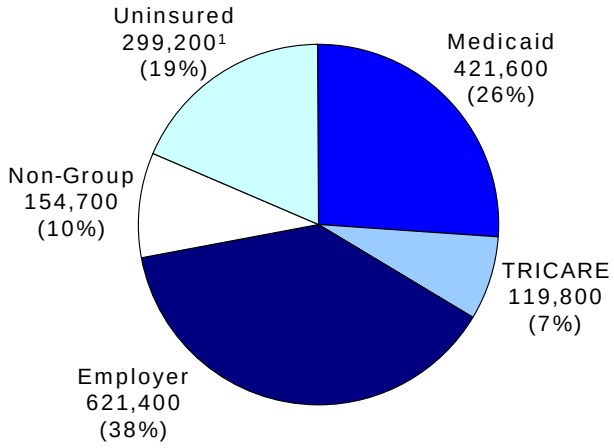
waiting period would save about $4.3 billion as these early retirees move to Medicare. Households would see premiums and out-of-pocket spending decline by $4.9 billion. The overall effect of the change would be a decline in national health care spending of $600 million in 2010.

Figure 16. Major Features of Health Insurance Expansion Bills and Impact on Uninsured, National Expenditures

	Bingaman / Green	Kerry / Waxman
Aims to cover all people		
Individual requirement/auto-enrollment		Tax penalty
Employer shared responsibility		
Insurance exchange or connector		
Public program expansion	X	X
Subsidies for lower-income families		X
Risk pooling	X	X
Comprehensive benefit package	X	X
Quality and efficiency measures		X
Uninsured Covered in 2010[1] (in millions)	0.3	6.0
Net Health System Cost in 2010 (in billions)	($0.6)	$2.0
Net Federal Budget Cost in 2010 (in billions)	$10.8	$27.0

[1]Out of an estimated total uninsured in 2010 of 48.9 million.
Note: Bingaman & Green's proposal is the Ending Medicare Waiting Period Act (S.2102); Kerry & Waxman's proposal is the Kids Come First Act (S.95, H.R.1111).
Source: The Lewin Group for The Commonwealth Fund.

Figure 17. Disabled People in the Medicare Waiting Period in 2010, by Source of Coverage



Total people currently in waiting period[2] = 1,616,700

Note: Number of people in the waiting period was estimated using an analysis of 2005 through 2007 Current Population Survey data for non-workers receiving Social Security income and who do not have Medicare.
[1]Other studies have estimated 25 percent to 33 percent of people in the waiting period as being uninsured (Riley, G. 2006. Health Insurance and Access to Care among Social Security Disabled Insurance Beneficiaries during the Medicare Waiting Period. Inquiry, 43: 222-230; Berg Dale, S and Verdier, JM, 2003).
[2]We assume that the number of people in the waiting period remains unchanged between January 2008 and January 2010.
Source: The Lewin Group for The Commonwealth Fund.

Figure 18. Health Insurance Expansion Bills Change in Health Spending by Stakeholder Group, Billions of Dollars, 2010

	Bingaman / Green	Kerry / Waxman
Total Uninsured Covered, Millions	0.3	6.0
Federal government	$10.8	$27.0
State and local government	($2.3)	($15.7)
Private employers	($4.3)	($5.9)
Households	($4.9)	($3.3)
Net Health System Cost in 2010 (in billions)	($0.6)	$2.0
Total Uninsured Not Covered,[1] Millions, Disabled and Children	0 (Disabled uninsured)	5.9 (Children uninsured)

[1]Out of an estimated total uninsured in 2010 of 48.9 million.
Note: Bingaman & Green's proposal is the Ending Medicare Waiting Period Act (S.2102); Kerry & Waxman's proposal is the Kids Come First Act (S.95, H.R.1111).
Source: The Lewin Group for The Commonwealth Fund.

Universal Coverage of Children

Two bills introduced in 2007 propose to expand health insurance to children under age 21. Senator John Kerry (D–Mass.) and Representative Henry Waxman (D–Calif.) introduced bills that would offer states incentives to expand Medicaid and SCHIP and require employers and carriers to offer dependent coverage—the "Kids Come First Act of 2007" (S. 95 and H.R. 1111). The Lewin Group modeled Senator Kerry's and Representative Waxman's bills (Figure 16).

Senator Kerry and Representative Waxman's "Kids Come First Act of 2007" (S. 95 and H.R. 1111) (for more detail see Table A-7)

Overall Approach: Provides states with incentives to expand coverage for all children up to age 21 in families with incomes up to 300 percent of the poverty level through Medicaid and SCHIP. Would also simplify enrollment procedures. The bill would require employers offering coverage to provide a family option for dependents up to age 21 and would create a new refundable tax credit for coverage of a dependent child under certain circumstances. Any taxpayer, except those in the lowest tax brackets, with uninsured, dependent children would forfeit the personal tax exemption ordinarily available to individuals with dependent children.

Medicaid and SCHIP Expansion: The federal government would pay the full cost of covering children in poverty under Medicaid and would no longer cap SCHIP funding. In turn, states would agree to: cover children in families with incomes up to 300 percent of the poverty level in Medicaid or SCHIP, allow children in families with incomes of 300 percent of poverty or more to buy in to SCHIP as either full or supplemental (wraparound) coverage, and adopt several measures to streamline enrollment.

State Options: States would have the option to finance private coverage for children up to 300 percent of poverty as long as the health plan had comparable benefits; to enroll low-income children of state employees in SCHIP; include legal immigrant children without a five-year waiting period; and allow passive renewal of eligibility.

Benefit Package: Current Medicaid and SCHIP benefits.

Affordability: The new refundable tax credit would apply to the cost of coverage that exceeded 5 percent of family income.

Financing: The Senate bill would partially roll back the tax cuts instituted since 2000 for the highest federal income tax bracket.

Auto Enrollment: People would have to demonstrate coverage of dependent children at tax filing or lose their personal tax exemption.

Measures to Increase and Stabilize Enrollment: To qualify for increased federal matching rates, states would have to agree to several measures that would remove enrollment and re-enrollment barriers, including: adoption of 12-month continuous eligibility rules (i.e., eligibility for assistance under Medicaid and SCHIP could not be redetermined more than once every year for children); presumptive eligibility; allowing families to self-declare income; acceptance of eligibility determinations for other assistance programs such as Food Stamps and the School Lunch Program; not requiring face-to-face interviews at enrollment or re-enrollment; no waiting period prior to enrollment.

Lewin Group Estimates of Coverage and Costs in 2010
Senator Kerry and Representative Waxman's "Kids Come First Act of 2007"

Number of uninsured covered	6.0 million children under age 21
Remaining uninsured	
Children under age 21	5.9 million
All uninsured	42.9 million
Net change in costs in 2010	
Total health spending	$2.0 billion
Federal	$27.0 billion[13]
State and local	($15.7 billion)
Employers	($5.9 billion)
Household	($3.3 billion)[14]

What the Estimates Mean

The Lewin Group projects that there will be 11.9 million uninsured children under age 21 in 2010 (Figure 19). Of those, 71 percent are in families with incomes under 300 percent of poverty. Under the Kids Come First Act, Lewin estimates that 6 million, or 51 percent, would gain coverage: 4.6 million would become enrolled through Medicaid or SCHIP and 1.4 would enroll in private health plans (Figure 20). About 5.9 million children are estimated to remain uninsured.

Historically, complex application processes and onerous re-enrollment rules in state public insurance programs have contributed to millions of children going without health insurance or experiencing gaps in insurance, even though their families' incomes make them eligible for public coverage. The Kids Come First bill would institute several provisions aimed at simplifying enrollment and re-enrollment processes. The Lewin Group estimates these provisions would help enroll about 1.4 million children eligible for coverage (data not shown). Still, about 3.2 million children up to age 21 who would be eligible for Medicaid and SCHIP under the bill remain uninsured, accounting for about half of the remaining uninsured children (Figure 20). This finding highlights the potential limits to expanding coverage by targeted approaches in the absence of a more comprehensive system of national health insurance coverage. Under a system that provides options for the entire population, combined with an individual requirement to have insurance and autoenrollment, enrollment into particular forms of coverage could be achieved more systematically.

Among the 3.5 million uninsured children under age 21 in families with incomes over 300 percent of poverty, about 2.1 million would remain uninsured (Figure 19, 20). The subsidy for dependent children in families above 300 percent of poverty is a

refundable tax credit equal to the amount paid for qualified private health insurance that exceeds 5 percent of adjusted gross income. For many families with incomes close to 300 percent of poverty, the credit might be too small to substantially affect their decision to take up coverage.

Though the bill includes a tax penalty—a loss of personal income tax exemption—for failure to demonstrate a child's insurance coverage at tax filing, it does not link this to autoenrollment into default coverage. Such an autoenrollment mechanism would likely increase coverage under the bill.

Overall, enrollment in Medicaid and SCHIP would increase by 11.1 million children under age 21 (data not shown). The Lewin Group estimates that about 6 million children with dependent coverage under employer plans would become enrolled in the expanded program.

The Lewin Group estimates that the costs to the federal government in 2010 would be $27 billion (Figure 18). Senator Kerry would fund his proposal by partially or fully eliminating the Bush Administration's tax cuts to income earners in the top tax bracket.

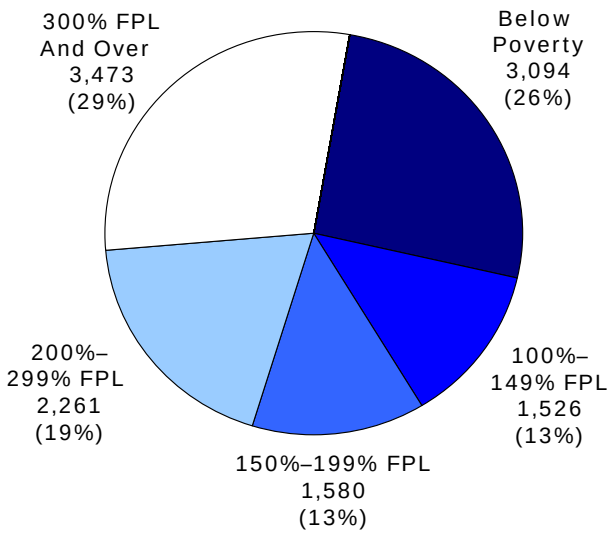
Households would save about $3.3 billion in spending, mostly through reduced out-of-pocket costs for health care as their children gain coverage (Figure 18). The Lewin Group estimates that rolling back the tax cuts would offset such savings for those families in higher-income tax brackets.

State and local governments could experience a drop in spending of about $15.7 billion in 2010 (Figure 18). This is primarily because the federal government would fully fund children in the Medicaid program in families with incomes of less than 100 percent of poverty, in exchange for expanding SCHIP and streamlining enrollment. The Lewin Group assumes that all states would do this and receive the new matching funds.

Employer costs could potentially decline as well, falling by an estimated $5.9 billion in 2010, reflecting the shift of children currently enrolled in employer plans to Medicaid and SCHIP.

National spending overall is estimated to increase by $2 billion in 2010, driven by an increase in health care utilization by newly insured children and costs of administering the program subsidies. However, these new expenditures would be offset somewhat by savings from children receiving care from providers who are paid Medicaid rates, which are lower, on average, than private payment rates.

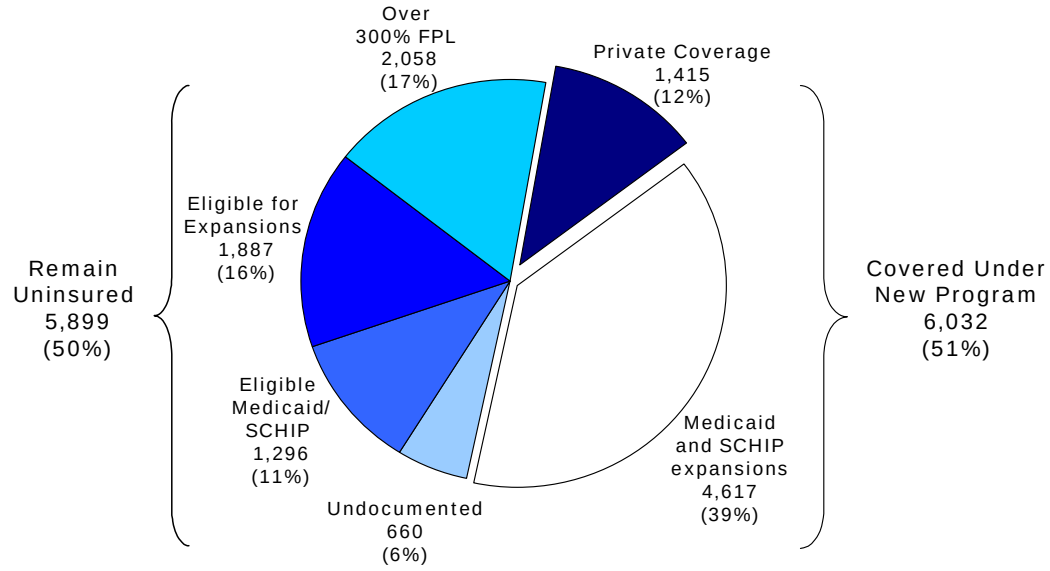
Figure 19. Poverty Distribution of Uninsured Children Under Age 21 Under Current Law, by Poverty Level, in 2010 (in thousands)



All uninsured children under age 21 (under current law, in thousands): 11,934

Source: The Lewin Group for the Commonwealth Fund.

Figure 20. Estimated Effect of Sen. Kerry's and Rep. Waxman's Proposal (Kids Come First Act) on Uninsured Children in 2010 (in thousands)



All uninsured children under age 21 (current law, in thousands): 11,934

Note: Numbers may not sum to 100% due to rounding.
Source: The Lewin Group for the Commonwealth Fund.

Improving the Affordability of Coverage for Small Businesses

Among employers, small businesses face the greatest challenge in offering affordable and comprehensive health insurance for their employees. The Congressional Budget Office estimates that administrative costs as a share of premiums are nearly 30 percent for companies with fewer than 25 employees compared to about 7 percent for firms with 1,000 or more employees.[15] A 2006 study by Jon Gabel and colleagues found that, when premiums were adjusted for the amount of medical bills for which a health plan would pay, companies with fewer than 10 workers pay about 18 percent more for employee health insurance than do companies with 1,000 or more employees.[16] It isn't surprising, therefore, that the greatest erosion in employer health insurance coverage is occurring among the smallest firms. Less than half (49 percent) of companies with fewer than 10 employees offered coverage in 2008, down from 57 percent in 2000.[17]

To help reduce the costs of coverage for small business, Representative Sam Johnson (R–Texas) has proposed allowing trade, industry, or professional associations to create association health plans (AHPs) to provide health insurance to their member employers (Figure 21). His "Small Business Health Fairness Act of 2007" (H.R. 241) was introduced in January 2007. Representative Vern Buchanan (R–Fla.) and Representative Howard McKeon (R–Calif.) introduced similar bills, the "Small Business Growth Act of 2007" (H.R. 1012) and the "Working Families Wage and Access to Health Care Act" (H.R. 324).

Representative Johnson's "Small Business Health Fairness Act of 2007" (H.R. 241)/ Representative Buchanan's "Small Business Growth Act of 2007" (H.R. 1012)/ Representative McKeon's "Working Families Wage and Access to Health Care Act" (H.R. 324) (for more detail see Table A-8)

Overall Approach: Permits trade, industry, professional, or other similar associations to form association health plans (AHPs), which could provide health benefits to employees of businesses that are members of the associations.

State Insurance Regulations: AHPs could offer fully-insured plans (those issued by a state-licensed insurer) or self-funded plans. Self-insured AHPs would be certified under the Employee Retirement Income Security Act of 1974 (ERISA), which means that self-insured AHPs generally would not be subject to state insurance regulations.

Fully-insured AHPs would be subject to oversight only by the state in which the AHP initially was established, but could operate in other states as well. All other states would have to accept the approved plan. AHPs would not have to comply with state insurance benefit requirements, although they would have to open the plan to all association members and comply with state rules regarding coverage of specific diseases. Self-insured AHPs would be required to maintain certain reserves and comply with other solvency requirements.

Premiums: AHPs would not have to follow benefit requirements under state insurance laws, but states could require fully-insured AHPs to cover some diseases and conditions.

Rates for small employers would not be permitted to vary on the basis of health status or on the employer's type of business or industry. However, rates could vary based on the claims experience of the plan or to the extent that rates would be allowed to vary under state laws and regulations. Self-insured plans would be required to have rates sufficient—as determined by the opinion of a qualified actuary—to provide for the payment of all obligations and the maintenance of required reserves, including reserves for unearned contributions, benefit liabilities (including administrative costs, other plan obligations, a margin of error, and other fluctuations) and the establishment of aggregate and specific excess and stop-loss insurance and solvency indemnification.

Financing: Self-insured plans, in addition to maintaining stop-loss coverage and a minimum surplus as well as claims reserves, would be required to pay $5,000 annually to the federal government, which the Department of Labor could use to maintain excess and stop-loss coverage and indemnification insurance coverage to cover claims in the event that an AHP becomes insolvent.

Lewin Group Estimates of Coverage and Costs in 2010
Representative Johnson's "Small Business Health Fairness Act of 2007"

Number of uninsured covered	(283,000)
Remaining uninsured	49.2 million
Net change in costs in 2010	
Total health spending	($0.4 billion)
Federal	$0.2 billion
State and local	$0.7 billion
Employers	($1.6 billion)
Household	$0.2 billion

What the Estimates Mean

States regulate the sale of health insurance in their small-group (i.e., firms with fewer than 50 employees) and individual insurance markets. To ensure that small companies and individuals have access to coverage, regardless of their health or demographic profiles, some states prevent carriers from varying premiums by health status, age, gender, or other factors. Many states require that carriers provide certain benefits or cover particular diseases or health conditions. While such regulations have lowered the cost and increased the comprehensiveness of coverage for older people or those with health conditions, they have also had the effect of increasing premiums for healthier or younger people relative to the premiums of those living in states with few or no regulations.

The most important implication of the Small Business Health Fairness Act is that it would enable AHPs to avoid state insurance regulations by selling policies across state lines.[18] For example, an AHP in Delaware, which allows carriers to vary premiums by

health status, age, and other factors, could sell policies to small groups in New York, which has full community rating, meaning that premiums cannot vary by health status or age. Consequently, companies in New York with healthier employees could go outside the state's small-group market and buy a cheaper policy from the Delaware-based AHP. Over time, New York would have an increasing share of companies in the small-group market with less healthy or older workers, which would cause premiums to climb. Thus, while the establishment of AHPs might encourage small companies that do not currently offer coverage to buy health plans from the AHP, other small firms that offer coverage might be tempted to drop it, due to the adverse effect on premiums in the small-group market. The Lewin Group assumed that some AHPs would use the exception from the state benefit mandates to offer lower cost products.

The Lewin Group estimates that the lower premiums offered by AHPs will cause 2.7 million workers and dependents in firms that do not currently offer coverage to gain employment-based insurance through their companies. Of those, 2 million are currently uninsured, 302,000 have coverage in the individual market, and 398,000 are currently enrolled in Medicaid or SCHIP (Figure 22). But the adverse effect of AHPs on premiums in the small-group market is estimated to cause 2.8 million workers and dependents who currently have employer benefits to lose coverage. Of those, 2.1 million would become uninsured, 405,000 would buy coverage in the individual market, and 296,000 would become covered by Medicaid or SCHIP. The number of uninsured under the Small Business Health Fairness Act is therefore estimated to increase by a net 283,000.

The bill is estimated to have only a minor effect on national health spending and on spending among most stakeholders (Figure 23). The overall net change in spending across targeted small employers would be a decline of $1.6 billion, as more firms would drop coverage because of higher premiums than would take up coverage, and those that dropped coverage would have higher premiums on average than those firms that take up coverage under the bill. There would be little net change in household spending on premiums because approximately equal numbers of people would lose employer coverage as would gain it. Out-of-pocket spending among affected workers and their families would rise by a net $723 million (data not shown).

Purchasing pools such as associations have been proposed as a means of reducing administrative costs and accumulating bargaining power to negotiate discounts with providers. However, there is little evidence that this has been a successful strategy, when attempted.[19] Small groups continue to be costly to administer, even in pools. Administrative costs tend to shift to the pools in the form of administrative functions

normally performed by insurers. The cost of performing these administrative tasks is then passed on to participating groups as an administrative surcharge.[20]

Using another approach, Senator Richard Durbin (D–Ill.) and Representative Ronald Kind (D–WI) introduced the "Small Business Health Options Program Act of 2008" (S. 2795, H.R. 6210), which would create a new purchasing pool through which small businesses and self-employed individuals could purchase health insurance (Figure 21). Representative Thomas Allen (D–Maine) introduced a similar bill, the "Small Business Health Plans Act of 2007" (H.R. 2132), which would allow states to set up group pooling arrangements for small businesses through grants provided by the federal government. The Lewin Group modeled Durbin and Kind's bill.

Figure 21. Major Features of Health Insurance Expansion Bills and Impact on Uninsured, National Expenditures

	Johnson	Durbin / Kind[2]	Cantor
Aims to cover all people			
Individual requirement/auto-enrollment			
Employer shared responsibility		X	
Insurance exchange or connector		X	
Public program expansion			
Subsidies for lower-income families or small business		X	
Risk pooling		X	
Comprehensive benefit package		X	
Quality and efficiency measures		X	
Uninsured Covered in 2010[1] (in millions)	(0.3)	1.7	5.8
Net Health System Cost in 2010 (in billions)	($0.4)	$15.6	$3.7
Net Federal Budget Cost in 2010 (in billions)	$0.2	$27.2	$19.2

[1]Out of an estimated total uninsured in 2010 of 48.9 million. [2]Modeling assumed that firms with under 100 employees are eligible; reinsurance of 90% of costs over $50,000.
Note: Johnson's proposal is the Small Business Health Fairness Act (H.R. 241); Durbin & Kind's proposal is the SHOP Act (S.2795, H.R.6210); Cantor's proposal is HSA Improvement, Expansion (H.R.3234).
Source: The Lewin Group for The Commonwealth Fund.

Figure 22. Summary Impact of Rep. Johnson's Proposal (Small Business Health Fairness Act), in 2010[1]

	Changes in Insurance Coverage Including Exemption from Mandatory Benefits (1,000s)
Change in Uninsured	
Formerly uninsured people who gain employer coverage	(1,973)
People who lose employer coverage and become uninsured	2,118
People with non-group insurance who become uninsured [2]	138
Net increase in uninsured	283

[1] Estimates show changes in coverage resulting from premium changes with and without the premium effects of the exemption from mandatory benefits.
[2] The shift of older and sicker people from employer coverage to non-group market would increase premiums in the non-group market resulting in some loss of coverage.
Source: The Lewin Group for the Commonwealth Fund.

Figure 23. Health Insurance Expansion Bills Change in Health Spending by Stakeholder Group, Billions of Dollars, 2010

	Johnson	Durbin / Kind[2]	Cantor
Total Uninsured Covered, Millions	(0.3)	1.7	5.8
Federal government	$0.2	$27.2	$19.2
State and local government	$0.7	($1.2)	$4.5
Private employers	($1.6)	($4.5)	($39.1)
Households	$0.2	($5.9)	$19.1
Net Health System Cost in 2010 (in billions)	($0.4)	$15.6	$3.7
Total Uninsured Not Covered,[1] Millions	49.2	47.2	43.1

[1]Out of an estimated total uninsured in 2010 of 48.9 million. [2]Modeling assumed that firms with under 100 employees are eligible; reinsurance of 90% of costs over $50,000.
Note: Johnson's proposal is the Small Business Health Fairness Act (H.R. 241); Durbin & Kind's proposal is the SHOP Act (S.2795, H.R.6210); Cantor's proposal is HSA Improvement, Expansion (H.R.3234).
Source: The Lewin Group for The Commonwealth Fund.

Senator Durbin and Representative Kind's "Small Business Health Options Program Act of 2008" (SHOP Act) (S. 2795 and H.R. 6210)

Overall Approach: Creates a nationwide health insurance purchasing pool through which small businesses (100 employees or fewer) and self-employed individuals could purchase health insurance. The purchasing pool would offer a choice of private plans. Firms of fewer than 50 employees would be eligible for tax credits. An office within HHS would be created to administer the small business health options program. A Small Business Health Board would be established to monitor the implementation of the program and make recommendations to HHS for improvements. This Board would be comprised of 13 individuals with expertise in benefits, financing, economics, actuarial science, and other related fields.

Premiums and Cost-Sharing: Employers would pay at least 60 percent of the premium and would collect premium payments from their employees through payroll deductions. Self-employed and small employers of fewer than 50 employees would receive a per-employee tax credit to help pay the premium amount for qualified employee health insurance. The full tax credits are equal to $1,200 for individuals and $2,400 for families and are available for firms of fewer than 11 employees. The credits gradually phase out by firm size up to 50 employees. Insurers would not be allowed to vary premium rates based on health status, gender, class of business, or claims experience. Premiums could differ based on age (not more than five age brackets for individuals under age 65), geographic area, industry, tobacco use, and individual/family status. Premiums for any age bracket under 65 could not exceed 300 percent of the rate for the lowest age bracket, and premiums for any industry could not exceed 115 percent of the rate for the industry with the lowest premium.

Regulation: Private insurers offering coverage through the purchasing pool would not be allowed to refuse to provide coverage to any eligible individual. Insurers offering coverage would be allowed to include a pre-existing condition exclusion under which coverage of a pre-existing condition would begin no later than six months after the coverage begins. However, this period would be reduced or eliminated by the number of days of previous creditable insurance coverage.

Benefit Package: The administrator of the program will work with the Institute of Medicine to establish a minimum benefit package for nationwide plans.

Risk Adjustment: Insurers with above average benefit costs, excluding administration, are compensated by the pool. Insurers with below average benefit costs pay into the pool.

Other: The administrator would develop and implement a public education campaign to provide information to employers and employees about the purchasing pool. An interactive Web site would provide descriptions of the coverage plans available in each state and comparative information on premiums, index rates, benefits, quality, and consumer satisfaction.

Lewin Group Estimates of Coverage and Costs in 2010
Senator Durbin and Representative Kind's "Small Business Health Options Program Act of 2008"

Number of uninsured covered	1.7 million
Remaining uninsured	47.2 million

Net change in costs in 2010	
Total health spending	$15.6 billion
Federal	$27.2 billion
State and local	($1.2 billion)
Employers	($4.5 billion)
Household	($5.9 billion)

What the Estimates Mean

The Lewin Group assumed that the program is implemented in all states and that states reform their small-group markets to meet the program requirements. Benefits are assumed to be equivalent to the FEHBP Blue Cross Blue Shield standard plan. Lewin assumes that many small companies and self-employed individuals who currently offer or have coverage would switch to the pool based on the expected lower premiums inside the pool compared with those outside the pool. It also assumes that some small companies and self employed people who do not currently offer or purchase coverage would decide to do so based on the lower premiums in the pool. Premiums in the pool would be lower than those outside the pool because they are based on modified community rating for the minimum benefit package minus the amount of the tax credits, which Lewin assumed would only be applied to coverage sold through the pool.

Under this proposal, 31.1 million people would be covered under the small group pools in 2010 (data not shown). Of those, 29 million were previously insured. Only 1.7 million uninsured people would gain coverage under this proposal. This is primarily because the tax credits are too small to entice most small employers who do not offer coverage and self-employed people who are uninsured to purchase coverage. About 47 million people would remain uninsured.

National health care spending under the proposal would increase by a net $15.6 billion in 2010. This includes increases of $6.8 billion in spending by the newly insured and those with improved coverage and $7.2 billion in administrative costs of the purchasing pool and by insurers (Figure 24). Small groups continue to be costly to administer even when purchased through a pool.

The federal government would face a $27.2 billion increase in spending, largely due to the tax credits (Figure 23). Employers that currently offer insurance would realize nearly $20 billion in savings from the tax credits. Overall, employers would experience a decrease in health spending of $4.5 billion in 2010.

State and local government spending would fall by a net $1.2 billion, due to a savings of $1.4 billion from safety net and other programs.

Household spending would fall by a net $5.9 billion. Improved coverage would reduce out-of-pocket expenses by $12 billion and tax credits for the self-employed would reduce household premium costs by $6.2 billion. This would offset higher premium payments for some healthy individuals and families by $12.3 billion as a result of new regulations that prevent insurers from rating policies on the basis of health status.

Figure 24. Changes in National Health Spending Under Durbin and Kind's SHOP Act, in 2010 (billions)

Change in Health Services Expenditures		$6.8
Change in utilization for newly insured	$2.7	
Change in utilization for currently insured	$4.1	
Reimbursement Effects		$1.6
Payments for previously uncompensated care	$2.7	
Reduced cost shifting [1]	($1.1)	
Change in Administrative Cost of Programs and Insurance		$7.2
Purchasing pool administration [2]	$5.3	
Change in insurer administration	$1.9	
Total Change in National Health Spending		$15.6

[1] Assumes 40% of change in provider payments are passed on to health plans.
[2] Assumes purchasing pool administrative costs of 4.5 percent of claims in the pool.
Source: The Lewin Group for the Commonwealth Fund.

Expansion of Health Savings Accounts

Health savings accounts (HSAs) are currently only available to people purchasing HSA-qualified high-deductible health plans (HDHPs). In July 2007, Rep. Eric Cantor (R–Va.) introduced the "HSA Improvement and Expansion Act of 2007" (H.R. 3234). This bill would amend the Internal Revenue Code to increase eligibility for HSAs.

Representative Cantor's "HSA Improvement and Expansion Act of 2007" (H.R. 3234) (for more detail see Table A-9)

Overall Approach: Expands the population potentially eligible to benefit from HSAs and increases the contribution limits to HSAs.

Eligibility: This bill would expand the pool of individuals potentially eligible to contribute to an HSA to include individuals participating in certain flexible spending account (FSA) and health reimbursement arrangement (HRA) programs, provided that the total annual HSA, FSA and HRA

contributions do not exceed the total annual deductible and out-of-pocket requirements of the HSA's underlying HDHP, excluding premiums. The bill also would allow two new groups of individuals to contribute to HSAs: Medicare Part A-only beneficiaries, and veterans receiving benefits from the Department of Veterans Affairs (VA) to cover health care expenditures exclusively for a service-connected disability. Receiving other VA benefits that cover health care expenditures would disqualify the individual.

Benefits: The bill would allow HSA contributions to be used to pay health insurance premiums and would increase contribution limits for individuals ($2,250 to $4,500) and families ($4,500 to $9,000) from current levels. They would be inflation adjusted from a 2007 base year. Employers would have greater freedom to convert unused FSA or HRA contributions into a one-time HSA deposit on behalf of the HSA beneficiary. Spouses age 55 or older with a single HSA between them would be allowed to double catch-up contributions to the HSA. HSAs and HDHPs could become effective on any date (rather than the first day of the month following the effective date) if coverage does not begin on the first day of the month. Additionally, for any HSA beneficiary, any health expenses incurred within the first 60 days of joining an HDHP but prior to establishing a HSA would be treated as "qualified medical expenses" and would be reimbursable out of the HSA.

Lewin Group Estimates of Coverage and Costs in 2010
Representative Cantor's "HSA Improvement and Expansion Act of 2007"

Number of uninsured covered	5.8 million
Remaining uninsured	43.1 million
Net change in costs in 2010	
Total health spending	$3.7 billion
Federal	$19.2 billion
State and local	$4.5 billion
Employers	($39.1 billion)
Household	$19.1 billion

What the Estimates Mean

The proposal would allow people to use HSA funds to pay premiums for qualified HDHPs in the individual market, which would lead to lower costs for health insurance. This is estimated to result in 7.1 million previously uninsured Americans purchasing insurance in the private non-group market. However, this would reduce the tax advantage of employer-sponsored insurance, so some employers are expected to discontinue offering coverage. The number of people covered by employer coverage would decrease by 3.4 million under the proposal, and 1.4 million would become uninsured. The bill thus results in a net decrease in uninsured people of 5.8 million. About 43 million people would remain uninsured under this proposal.

The increase in the contribution limit and the removal of the restriction on combining HSAs with FSAs and HRAs would create further tax incentives for workers to

establish HSAs. The Lewin Group assumed that workers would either increase their contribution to an existing HSA or establish an HSA, allowing them to add to the amounts they are already saving under other tax-exempt retirement savings mechanisms. Lewin assumes that workers would be most likely to adopt an HSA if they are already at the maximum contribution level under an existing retirement savings plan (401k, IRA, or other), and that people who are currently contributing the maximum amount to an existing HSA would increase their contribution amount. The Lewin Group assumed an average contribution of $3,500 per worker over what they are currently contributing to an HSA or retirement plan.

National health spending under this proposal would increase by $3.7 billion, including an increase of $2.2 billion on insurer administration (Figure 25). Health care utilization would increase for the newly insured, but the high cost-sharing of HDHPs would also dampen health care use. The federal government is estimated to increase spending by $19.2 billion, and state and local governments would increase spending by $4.5 billion (Figure 23). Household spending would rise by a net $19.1 billion. The tax benefits of the HSAs would be offset by higher premiums and out-of-pocket costs for households. Employer spending would decrease by $39.1 billion as a result of dropping coverage and lower premium costs of the HDHPs.

Figure 25. Changes in National Health Spending Under Rep. Cantor's HSA Improvement and Expansion Act in 2010 (in billions)

Change in Health Services Expenditures		$0.3
Change in utilization for newly insured	$4.8	
Change in utilization for currently insurer	$0.1	
Effect of new incentives on utilization [1]	($4.6)	
Reimbursement Effects		$1.2
Payments for previously uncompensated care	$1.9	
Reduced cost shifting [2]	($0.7)	
Change in Administrative Cost of Programs and Insurance		$2.2
Change in insurer administration	$2.2	
Total Change in National Health Spending		$3.7

[1] The HSA model creates incentives for enrollees to conserve on their expenditures for health care. Based upon a review of the literature on HSAs, we assume a savings of 4 percent for people newly enrolled in an HSA.
[2] Assumes 40% of change in provider payments are passed on to health plans.
Source: The Lewin Group for the Commonwealth Fund.

SUMMARY OF FINDINGS

Reducing the Number of Uninsured

The bills and proposals that seek fundamental reform of the health insurance system have the most significant impact on reducing the number of people without health insurance (Figures 26 and 27). Within that category, bills that open Medicare or a Medicare-like program to the full population— such as Rep. Stark's proposal—or use a similar centralized financing mechanism have the greatest potential to cover everyone. Mixed private–public approaches, such as that of President-elect Obama and Sen. Baucus, also have potential to cover nearly everyone, but an individual requirement that everyone have insurance is critical to achieving near-universal coverage.

Sen. Wyden's proposal to replace the income tax exclusion for employer benefits with an income tax deduction and premium subsidies, combined with new regional purchasing agencies and an individual and employer requirement to participate would also cover nearly everyone. While Sen. Enzi and Sen. Burr also propose replacing the employer benefit tax exclusion with tax credits and new standard income tax deductions, the lack of an individual requirement for coverage and less organized insurance markets than those proposed by President-elect Obama and Senators Baucus and Wyden reduces the effectiveness of their proposals.

When considering the federal–state partnership bills (Baldwin, Bingaman, Feingold-Graham) that would provide grants to states to expand coverage, the impact on coverage would depend on the number of participating states, the amount of funding provided, and the reforms that states pursue. Assuming that 15 states would pursue a Massachusetts-style reform with an individual requirement for health insurance, nearly everyone would become covered in those states.

Incremental reform bills cover far fewer people, but target high risk groups. For example, Sen. Kerry and Rep. Waxman's bill to expand coverage for children up to age 21 would cover 6 million uninsured children and young adults, out of an estimated 12 million uninsured. The bill includes several measures aimed at helping eligible children obtain and retain coverage, but linking the tax penalty for not covering dependent children in the bill to autoenrollment into default coverage might increase the number of children and young adults covered. Sen. Bingaman and Rep. Green's bill to phase out the two-year Medicare waiting period for the disabled would be effective at covering all those eligible, including the uninsured.

Rep. Johnson and Sen. Durbin's bills target small businesses and illustrate the difficulty of attempting to fix the affordability crisis that is plaguing small companies that buy insurance in the small-group market. By allowing small businesses to effectively

bypass state insurance regulations, the Johnson bill makes small-group coverage more affordable for companies with a young and healthy workforce but less affordable for those with an older or less healthy workforce. The reform would result in a net loss of coverage of 283,000. The Durbin bill seeks a much different approach, establishing a national purchasing pool for small employers with regulations against rating on the basis of health and requiring participating states to regulate their small-group markets with equivalent rules, therefore avoiding the adverse selection that plagues the Johnson bill. While the Durbin bill provides relief to many small companies that currently offer coverage through the change in the rating rules and new tax credits, the incentives are not sufficient to cause most non-insuring firms to offer coverage. About 1.7 million uninsured people become insured under the bill.

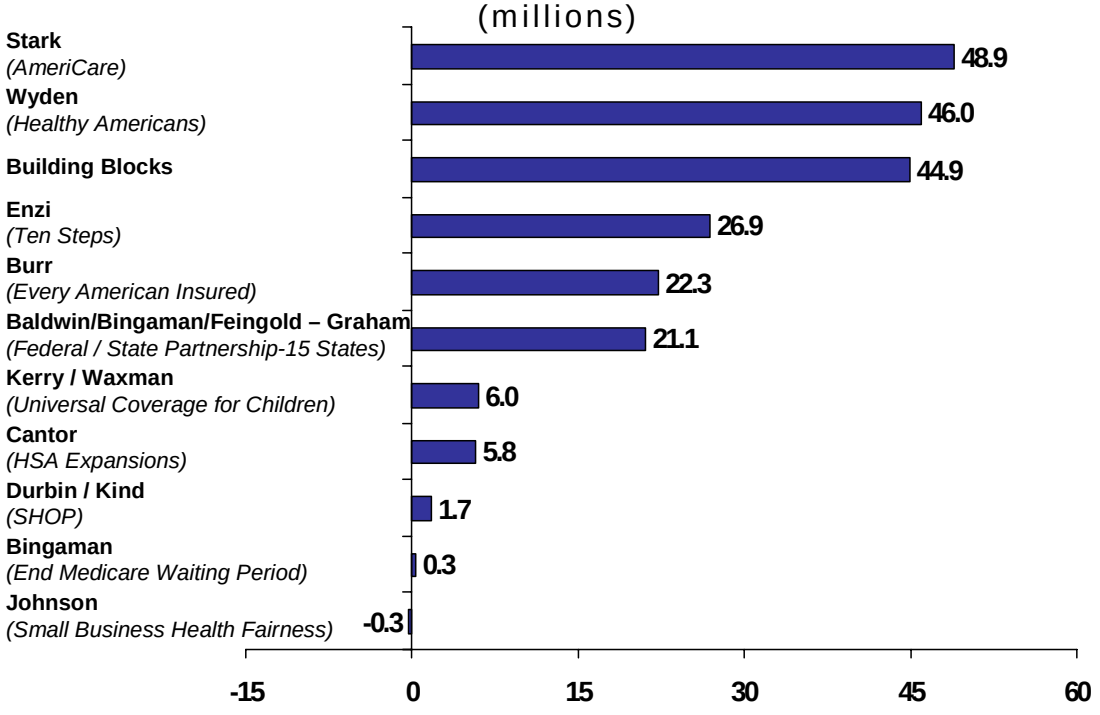
Rep. Cantor's proposal would double the amount of pretax income that people can contribute to health savings accounts (HSAs) and allow people to use the funds, without tax penalty, to purchase health insurance in addition to cover out-of-pocket costs. It is estimated to increase the number of people with health insurance by about 5.8 million. Currently, people can use HSA balances to pay for costs not covered by health insurance but not for health insurance premiums.

Figure 26. Summary of Insurance Coverage Proposals

	Uninsured Covered[1] (millions)	National Health Expenditures (billions)	Federal Spending (billions)	State/Local Spending (billions)	Employer Spending (billions)	Household Spending (billions)
Building Blocks	44.9	$17.8	$103.9	($32.7)	$86.0	($139.4)
Wyden *(Healthy Americans Act)*	46.0	$13.7	($39.6)	($29.0)	$98.4	($16.2)
Enzi *(Ten Steps)*	26.9	$64.1	$176.4	($21.2)	($77.6)	($13.5)
Burr *(Every American Insured)*	22.3	$31.1	$161.3	($52.9)	$7.0	($84.3)
Baldwin / Bingaman / Feingold – Graham *(Federal/State-15 States)*	21.1[2]	$37.7	$40.3	$19.4	$34.8	($56.7)
Stark *(AmeriCare)*	48.9	($58.1)	$188.5	($83.6)	$61.5	($224.5)
Bingaman *(End Medicare 2-yr Waiting Period)*	0.3[3]	($0.6)	$10.8	($2.3)	($4.3)	($4.9)
Kerry / Waxman *(Universal Coverage for Children)*	6.0[4]	$2.0	$27.0	($15.7)	($5.9)	($3.3)
Johnson *(Small Business Health Fairness)*	(0.3)	($0.4)	$0.2	$0.7	($1.6)	$0.2
Durbin / Kind *(SHOP)*	1.7	$15.6	$27.2	($1.2)	($4.5)	($5.9)
Cantor *(HSA Expansions)*	5.8	$3.7	$19.2	$4.5	($39.1)	$19.1

[1] Out of an estimated total uninsured in 2010 of 48.9 million. [2] Out of an estimated total uninsured in 2010 of 26.7 million in the 15 states. [3] Out of an estimated 0.3 million uninsured disabled people in 2010. [4] Out of an estimated 11.9 million uninsured children in 2010.
Source: The Lewin Group for The Commonwealth Fund.

Figure 27. Number of Uninsured People Newly Covered, in 2010 (millions)



Note: Out of an estimated total uninsured in 2010 of 48.9 million.
Source: The Lewin Group for The Commonwealth Fund.

Improving the Quality of Health Insurance Coverage

With the number of underinsured people climbing from 16 million in 2003 to 25 million in 2007, many of the bills and proposals attempt to not only expand coverage but to set standards for covered benefits and out-of-pocket costs. For example, both President-elect Obama and Sen. Baucus are explicit about the need for defining benefit standards that private and public health plans must meet. To achieve this, Sen. Baucus would establish an Independent Health Coverage Council with members appointed by the President, with advice and consent of the Senate, to ensure coverage is affordable and clinically appropriate, and that it ensures access to necessary services and protects enrollees from high out-of-pocket costs.

Federal Health Expenditures

The bills that would fundamentally reform the health insurance system are estimated to be the most expensive to the federal government, with the exception of Sen. Wyden's bill (Figure 28). As currently financed, in 2010, Rep. Stark's "AmeriCare" bill is estimated to cost the federal government about $188.5 billion. Sen. Enzi's bill would cost the federal government $177 billion—nearly as much as the Stark proposal—but it would insure less than half the number of uninsured covered under the Stark bill. Sen. Burr's bill would cost $161 billion.

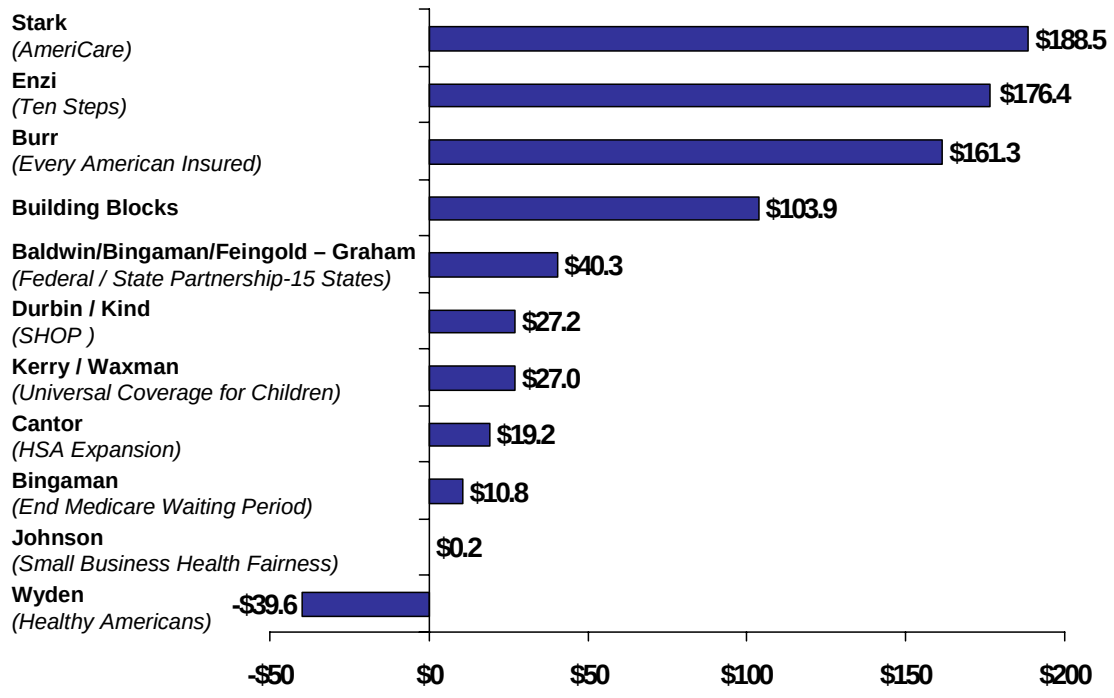
The Building Blocks framework, an approach similar to that of President-elect Obama (but including a coverage requirement) and Sen. Baucus has estimated federal estimated federal costs in the first year of $103.9 billion. This would include the cost of improving coverage for Medicare beneficiaries.

Sen. Wyden's bill, which is estimated to cost the federal government $1.2 trillion, raises sufficient revenue and offsets other spending through new income taxes, household and employer premium contributions, and the elimination of Medicaid to provide a net savings of $40 billion.

If the federal–state partnership bills (Baldwin, Bingaman, Feingold-Graham) provided grants to 15 states that implemented Massachusetts-style universal coverage strategies, the federal cost is estimated at about $40 billion.

Incremental bills are less expensive to the federal government than most of the proposals for fundamental insurance reform but cover fewer people. The spending estimated in some incremental bills, such as Sen. Durbin's and Rep. Johnson's small business bills, mostly offers improved coverage and cost relief to people or businesses that already have coverage, rather than expanding coverage.

Figure 28. Change in Federal Spending, in 2010 (billions)



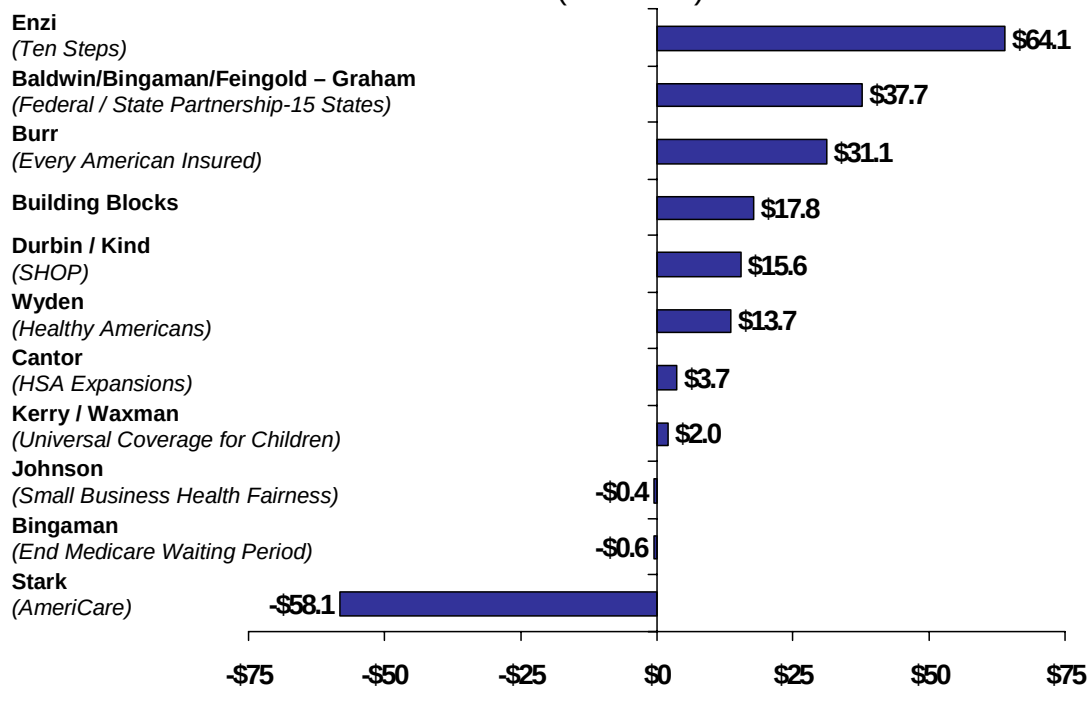
Source: The Lewin Group for The Commonwealth Fund.

National Health Expenditures

Although Rep. Stark's "AmeriCare" bill is the most expensive to the federal government, it provides the biggest savings to overall health spending, lowering projected national expenditures by $58 billion (Figure 29). Stark's bill would achieve this by significantly lowering the costs of insurance administration by covering most people through a program like Medicare, which has substantially lower administrative costs than private insurance. It also achieves substantial savings by paying all providers at Medicare reimbursement rates.

Senator Enzi's bill increases national health spending by $64 billion. By insuring more people through the individual insurance market, where administrative costs average 25 percent to 40 percent of premium dollars, the bill increases the costs of insurance administration by $22 billion. In addition, the bill allows Medicaid beneficiaries to use the value of their benefits to purchase private health insurance. This increases provider payments by an estimated $21 billion because providers would be paid at private rates, rather than Medicaid rates.

Figure 29. Change in National Health Expenditures, in 2010 (billions)



Source: The Lewin Group for The Commonwealth Fund.

Conclusion

A great deal can be learned from the estimated impact on coverage and costs of bills introduced in the 110th Congress, and much that will prove useful to Congress and the new Obama administration as they move forward in 2009 to develop new proposals to reform the health care system. Proposals that would fundamentally reform the health system reveal the importance of an individual insurance requirement to bring most people into the system. The bills that do not include an autoenrollment mechanism and an individual insurance requirement fall far short of universal coverage. The effectiveness of such a requirement, however, will depend upon an enforcement mechanism and an ability to determine an appropriate level of benefits covered and cost-sharing that will improve health outcomes over the long term, yet ensure the affordability for low- and moderate-income families.

All health care reform bills will have an effect on federal expenditures, making it important to identify financing sources and potential savings offsets. But, in the long run, it will not be productive to focus only on the impact of reform policies on federal, employers', or families' budgets. Instead, we must move forward while watching the number that really matters—the more than $2 trillion we spend collectively as a nation on health care each year. This ultimately determines the size and growth of all participants' budgets.

NOTES

[1] Part II of the series will analyze and compare congressional bills and recent proposals that seek to improve health care quality and efficiency.

[2] C. DeNavas-Walt, B. D. Proctor, and J. C. Smith, *Income, Poverty, and Health Insurance Coverage in the United States: 2007* (Washington, D.C.: U.S. Census Bureau, Aug. 2008).

[3] S. R. Collins, J. L. Kriss, M. M. Doty, and S. D. Rustgi, *Losing Ground: How the Loss of Adequate Health Insurance Is Burdening Working Families—Findings from the Commonwealth Fund Biennial Health Insurance Surveys, 2001–2007* (New York: The Commonwealth Fund, Aug. 2007); M. M. Doty, S. R. Collins, S. D. Rustgi, and J. L. Kriss, *Seeing Red: The Growing Burden of Medical Bills and Debt Faced by U.S. Families* (New York: The Commonwealth Fund, Aug. 2008); C. Schoen, S. R. Collins, J. L. Kriss, and M. M. Doty, "How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007," *Health Affairs* Web Exclusive, June 10, 2008: w298–w309.

[4] S. R. Collins, J. L. Nicholson, S. D. Rustgi, and K. Davis, *The 2008 Presidential Candidates' Health Reform Proposals: Choices for America* (New York: The Commonwealth Fund, Oct. 2008); S. R. Collins and J. L. Kriss, *Envisioning the Future: The 2008 Presidential Candidates' Health Reform Proposals* (New York: The Commonwealth Fund, Jan. 2008).

[5] Part II of the series will analyze and compare congressional bills and recent proposals that seek to improve health care quality and efficiency.

[6] The Commonwealth Fund contracts with The Lewin Group to provide the estimates in this report of the impact and costs of different health reform options, based on that firm's health system modeling capacity. The Lewin Group is a wholly-owned subsidiary of Ingenix, which is in turn a subsidiary of UnitedHealth Group. Through extensive due diligence examinations, the Fund has ascertained that The Lewin Group modeling team functions as an independent analytic group without owner interference, and that data security and confidentiality protections are in place. The Lewin Group has complete responsibility for the reliability and integrity of its estimates.

[7] M. Baucus, *Call to Action: Health Reform 2009*, Nov 12, 2008.

[8] C. Schoen, K. Davis, and S. R. Collins, "Building Blocks for Reform: Achieving Universal Coverage with Private and Public Group Health Insurance," *Health Affairs*, May/June 2008 27(3):646–57; K. Davis, C. Schoen, and S. R. Collins, *The Building Blocks of Health Reform: Achieving Universal Coverage and Health System Savings* (New York: The Commonwealth Fund, May 2008).

[9] Ibid.

[10] In Lewin's estimates, workers in small firms whose employers offer them coverage through the Connector and their dependents are counted as having Connector coverage instead of employer coverage; however, if they were to be counted as having employer coverage, the number of people with employer-based coverage would increase by about 4 million under the proposal.

[11] K. Davis, B. S. Cooper, and R. Capasso, *The Federal Employee Health Benefits Program: A Model for Workers, Not Medicare* (New York: The Commonwealth Fund, Nov. 2003); J. Gabel, K. Dhont, H. Whitmore et al., "Individual Insurance: How Much Financial Protection Does It Provide?" *Health Affairs* Web Exclusive, Apr. 17, 2002:w172–w181.

[12] Based on Lewin Group analysis of MedPAC 2006 Reports, American Hospital Association 2004 Survey of Hospitals, Kaiser StateHealthFacts (http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=compare&category=Medicaid+%26+SCHIP&subcategory=Medicaid+Physician+Fees&topic=Medicaid%2dto%2dMedicare+Fee+Index%2c+2003).

[13] The bill's proposal to eliminate the tax reduction in the highest federal income tax bracket would provide $18 billion in revenue to offset federal spending.

[14] The bill's proposal to eliminate the tax reduction in the highest federal income tax bracket would increase taxes for people in that income category by $18 billion.

[15] Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals* (Washington, D.C.: CBO, Dec. 2008).

[16] J. Gabel, R. McDevitt, L. Gandolfo et al., "Generosity and Adjusted Premiums in Job-Based Insurance: Hawaii Is Up, Wyoming Is Down," *Health Affairs,* May/June 2006 25(3):832–43.

[17] Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits, 2008 Annual Survey* (Washington, D.C.: KFF and HRET, 2008).

[18] See also the Congressional Budget Office analysis of H.R. 525: Congressional Budget Office, H.R. 525 Small Business Health Fairness Act of 2005 (Washington, D.C.: CBO, Apr. 8, 2005).

[19] S. H. Long and M. S. Marquis, "Pooled Purchasing: Who Are the Players?" *Health Affairs*, July/Aug. 1999 18(4):105–11; J. M. Yegian, T. C. Buchmueller, J. C. Robinson et al., *Health Insurance Purchasing Alliances for Small Firms: Lessons from the California Experience* (Oakland, Calif.: California HealthCare Foundation, May 1998).

[20] The Lewin Group, Cost and Coverage Impacts: Small Business Health Fairness Act of 2007, Draft Report, Nov. 13, 2008.

TABLE A-1. ANALYSIS OF THE "HEALTHY AMERICANS ACT"

Bill Name	Healthy Americans Act	Healthy Americans Act
Bill number(s)	S. 334	H.R. 3163
Bill sponsor(s)	S. 334 is sponsored by Senator Wyden and has 14 cosponsors.	H.R. 3163 is sponsored by Representative Baird and has 3 cosponsors.
Latest Congressional action	S. 334 was referred to the Senate Finance Committee on January 18, 2007. On April 24, 2008, an amendment was proposed by Senator Wyden and referred to the Committee on Finance. This summary incorporates the provisions of that amendment.	H.R. 3163 was referred to the House Energy and Commerce Committee Subcommittee on Health, the House Committee on Ways and Means, the House Oversight and Government Reform Committee, and the House Education and Labor Committee on July 24, 2007, and was referred to its Subcommittee on Health, Employment, Labor, and Pensions on September 19, 2007.
Basic structure of coverage expansion	Requires all adults over the age of 19 to enroll in health insurance coverage through state Health Help Agencies (HHAs) that oversee Healthy Americans Private Insurance (HAPI) plans administered by private insurers. Individuals could purchase a plan offered by their employer (other than the federal government) provided it meets HAPI plan standard coverage and benefit requirements. Individuals would purchase coverage directly. The exclusion of employer paid health insurance premiums from employees' taxable incomes would be eliminated. Failure to enroll in HAPI insurance would result in a penalty of 115 percent of the weighted average HAPI plan premium in the area in which the individual resides. Persons with coverage from Medicare, TRICARE, an employee benefit plan through a former employer, the Veterans Administration, the Indian Health Service or during a 7-year transition period under a qualified collective bargaining agreement would be exempt. Low income individuals would be eligible for premium and cost-sharing subsidies. A standard deduction for HAPI premiums paid would be available with a phase-out for persons with higher incomes. Employers would be required to make "shared responsibility payments" to the fund providing subsidies. The Federal Employees Health Benefits Program (FEHBP) would be prohibited from	Identical to S. 334, except the bill would: • Provide a refundable tax credit for Healthy Americans Private Insurance (HAPI) premiums instead of the standard deduction; • Prevent plans from imposing more restrictive limits on substance abuse and mental health benefits as compared to other health benefits; • Allow individuals to retain coverage through qualified collective bargaining agreements for up to 9 years instead of 7 years; and • Retain current Medicaid coverage options for long-term care. In addition, the bill would not allow employers to offer HAPI plans directly to employees, i.e., if an employer wished to offer a HAPI plan, it would be required to do so through a Health Help Agency (HHA).

Bill Name	Healthy Americans Act	Healthy Americans Act
	covering any federal employees once HAPI plans are in effect. The bill essentially substitutes coverage through HAPI plans for most services currently covered by Medicaid and State Children's Health Insurance Program (SCHIP). The Medicaid and SCHIP programs would continue to cover Medicare cost-sharing and supplement to HAPI plans to ensure that Medicaid and SCHIP enrollees (whether children, disabled or elderly) would not experience a decrease in benefits by virtue of the transition to HAPI plans. Certain disproportionate share hospital (DSH) payments would also continue. States would have the option of offering the type of long-term care services currently covered under Medicaid under a new State Choices for Long-Term Care (LTC) Program. Participating states could provide LTC coverage for people eligible for coverage in a long-term care facility as defined by the Medicaid State Plan or under a § 1115 waiver. Each such LTC program would include equal access to both institutional and home-based services. The program also could be operated through a Medicaid managed care plan on a capitated basis.	
Description of affected employers, employees and individuals	All employers, employees and individuals would be affected.	All employers, employees and individuals would be affected.
Eligibility criteria for small employers, employees and individuals	Every citizen or permanent resident residing in the U.S. or any of its territories would be eligible.	Every citizen or permanent resident residing in the U.S. or any of its territories would be eligible.
Premium and cost-sharing requirements for purchasers/ beneficiaries	**<u>Premiums and Premium Subsidies</u>** Enrollees would be required to pay HAPI plan premiums in full, but would be eligible for subsidies and/or a tax deduction depending upon income. Employers with ten or more employees would withhold premiums from paychecks. The withheld premiums would be counted as wages for income and payroll tax purposes. Enrollees with incomes at or below 100 percent of the federal poverty level (FPL) would be eligible for premium subsidies that cover the entire premium amount when the premium is less than or equal to the weighted	Similar to S. 334, except a refundable tax credit for HAPI enrollees would be substituted for the health care tax standard deduction. The credit would be subject to income limitations similar to those of S. 334. The credit would not depend on the premium paid. The maximum amount of the credit would depend upon the taxpayer's marital or domestic partnership status and number of dependent children and would be multiplied by the "applicable fraction" in the same manner as under S. 334. The credit would increase for filers as MAGI rise from 100

Bill Name	Healthy Americans Act	Healthy Americans Act
	average of premiums for HAPI plans in the "same class of coverage" as the enrollee's.[2] When an enrollee selects a more expensive HAPI plan, the subsidy will equal the weighted average of premiums for HAPI plans in the "same class of coverage" as the enrollee's. Enrollees with incomes between 100 percent and 400 percent FPL would be eligible for premium subsidies on a sliding scale. Premium subsidies would be funded by the Healthy Americans Public Health Trust Fund (HAPHTF). Enrollees with incomes of more than 100 percent FPL could claim a health care standard tax deduction for premium contributions. The deduction would be available in increasing amounts as premium subsidies decrease. This deduction would not be subject to the current 7.5 percent of Adjusted Gross Income (AGI) threshold for health care expenditures. The deduction would be the lesser of the annual premium paid or a newly-created health care standard deduction. The standard deduction would be multiplied by an "applicable fraction" that would vary based upon modified adjusted gross income (MAGI) in relation to the FPL and family or household size as it affects FPL for the taxpayer. The applicable fraction varies from 0 for filers with MAGI of 100 percent FPL to 1 for filers with MAGI of 400 percent FPL or more. Thus, the maximum available health care standard deduction amount—assuming such amount exceeded the applicable HAPI premium—would vary depending upon a taxpayer's marital or domestic partnership status, family size and number of dependent children. The deduction would be phased out starting with modified adjusted gross income (MAGI) of $62,500 for an individual ($125,000 for taxpayers filing jointly). The income-related reductions in the deduction are rounded to the next lowest $1,000. Using the 2007 FPL, no deduction would be available to individual filers with MAGI above approximately $135,110 or joint filers with 2 dependent children and MAGI above approximately	percent to 400 percent FPL. The credit would be phased-out for filers with MAGI starting at $62,500 for an individual, and $125,000 for couples filing jointly. The income-related reductions in the credit would be rounded to the next lowest $50. The incomes at which the phase-out disappears would depend on the taxpayer's filing status, marital or domestic partnership status, family size and number of dependent children. Using the 2007 FPL, no credit would be available to individual filers with MAGI above approximately $126,380 or joint filers with two dependent children and MAGI above approximately $250,800. All employers would be required to withhold wages for the purposes of forwarding HAPI premiums to the HHA. Beginning in 2010, both the MAGI thresholds and the maximum credit amounts would be inflation-adjusted annually to the nearest $50 with a base year of 2008. However, the $50 rounding factor used in computing the credit reduction or MAGI threshold would not be inflation adjusted.

[2] Classes of coverage are: individuals; couples without dependent children; individuals with dependent children; and couples with dependent children.

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	$255,700. The income levels at which the phase-out is complete would vary slightly, based on the taxpayer's filing status, marital or domestic partnership status, family or household size and number of dependent children. Beginning in 2010, the standard deduction and MAGI dollar phase-out thresholds would be inflation-adjusted using the consumer price index with the base year set at 2008 and rounded to the nearest $50 and $1,000, respectively. However, the rounding adjustments to the deduction and threshold amounts would not be inflation-adjusted. MAGI would be calculated as AGI plus any tax-exempt interest earned during a taxable year and any social security or railroad retirement benefits, but would not include U.S. savings bond income used to pay educational expenses, adoption expenses paid by an employer, "income attributable to domestic production activities," interest on education loans, tuition and related expenses or income earned abroad or in territories of the U.S. **Cost-Sharing and Cost-Sharing Subsidies** Coinsurance, copayments and deductibles could be similar to those of the FEHBP Blue Cross Blue Shield Standard Plan as of Jan. 1, 2007, except that no such contributions would be required for preventive benefits, early disease detection or chronic care. Enrollees below 100 percent FPL would be eligible for full cost-sharing subsidies. Enrollees at or above 100 percent FPL would be eligible for cost-sharing subsidies at the discretion of the HHA. The bill does not explicitly state what criteria would be used to determine eligibility for such subsidies.	
Requirements for private insurers, health plans or other entities offering coverage	**Benefits** Plans would have to be actuarially equivalent or greater in value than the FEHBP Blue Cross Blue Shield Standard Plan as of January 1, 2007 and must also: • Include wellness program benefits and incentives to promote the use of such programs; • Include coverage for catastrophic medical events that result in out-of-pocket costs	Similar to S. 334, but the bill would expand existing mental health benefit parity provisions by preventing plans from imposing more restrictive limits on substance abuse and mental health benefits as compared to other health benefits. This bill would not eliminate "fictitious group" prohibitions.

Bill Name	Healthy Americans Act	Healthy Americans Act
	for an individual or family if lifetime expenditure limits are exhausted; • Allow enrollees to select a primary care provider (a health home) who is not necessarily a physician, and publish data on how many enrollees have done so; • Make available for each enrollee an initial physical and care plan and require enrollees to develop a care plan upon the first visit with a primary care provider; • Provide for mental health financial benefit parity as provided under existing law applicable to group health plans; and • Provide early disease detection and prevention benefits and chronic care without coinsurance or deductibles. All requirements would be subject to the Department of Health and Human Services' (HHS') guidelines, which would be issued within one year of enactment of the bill. **<u>Premiums</u>** Premiums would be established for at least four classes of purchasers: unmarried individuals without dependents; married/domestic partner couples without dependents; unmarried individuals with dependents; and married/domestic partner couples with dependents. Premiums would be set by HAPI plan insurers, and the state could, at its discretion, allow insurers to adjust premiums only to account for geography, tobacco use or family size. A HAPI plan would be permitted to adjust premiums downward for enrollees who participate in preventive health or wellness programs. Insurers other than self-insured employers offering a HAPI plan would not be permitted to adjust premiums based upon age, gender, industry, health status or claims experience. Self-insured employers would be "subject to a risk adjustment mechanism used to spread risk across all health plans." Premium discounts could be provided for enrollee and dependent participation in prevention/wellness activities. Compliance with loss ratios established by HHS would be required.	HAPI plans would have to pay non-defective claims within 45 days of receipt, and increased detail would be required on the claim form as compared to the Senate version of the bill.

Bill Name	Healthy Americans Act	Healthy Americans Act
	An additional amount to reimburse HHAs for administrative costs would be incorporated into the administrative component of premiums. **State Preemption** The legislation would: • Preempt state benefit mandate laws that would otherwise affect HAPI plans; and • Eliminate "fictitious group prohibitions." **Other** Insurers would be required to: • Demonstrate quality and cost efficiency incentives in their reimbursement methodologies; • Implement electronic personal health records for each enrollee unless the enrollee opts-out; • Utilize common claims forms; • Require hospitals to inform enrollees of bills exceeding $5,000 regardless of the enrollee's liability; • Make publicly accessible provider cost and quality reports; • Report plan features to the HHA in a standardized language and format; and • Pay the administrative fee assessed by the HHA of each state in which the insurer offers a HAPI plan.	
Incentives and federal subsidies	Income-related subsidies for premiums and cost-sharing would be fully federally-funded. HHAs would be required to make risk-adjusted payments to all insurers and employers offering a HAPI plan in the state to account for the specific population covered by the plan. Federal bonus payments would be paid to states that implement medical malpractice tort reform, which would require a plaintiff to submit a complaint to a panel of legal and medical experts prior to filing suit, increase the plaintiff's burden of proof in court, and may subject to sanctions attorneys who repeatedly file frivolous suits, among other requirements. The states would be required to use the bonus payments to carry out activities related to disease and illness prevention and to provide enhanced health care services for children.	Similar to S. 334, but the bill does not include medical malpractice reform bonus payments and would extend the employer tax credit look back period to four years prior to enactment of the bill. HHAs would not make risk-adjusted payments to insurers or employers.

Bill Name	Healthy Americans Act	Healthy Americans Act
	The Secretary of the Treasury would be authorized, but not required, to provide a tax credit to employers who offered health insurance benefits "greater than the 80th percentile of the national average" in the two years preceding the enactment of the bill. The bill would effectively terminate Medicaid and SCHIP coverage except for certain services, would terminate the Medicare DSH program and would reduce by 90 percent the funding available for the Medicaid DSH program. An amount equal to current levels of Medicare DSH payments (inflation-adjusted going forward) would be directed to "strengthen the financial solvency of" the Hospital Insurance Trust Fund on an annual basis. Ninety percent of the former federal share of Medicaid DSH funds (to be frozen at current levels and inflation adjusted going forward) would be directed to the HAPHTF to be used for premium and deductible/coinsurance subsidies and bonus payments to states for medical malpractice litigation reform. Any excess funds during a federal fiscal year would be used to reduce any federal budget deficit, and any additional excess would be transferred to the general fund of the U.S. Treasury. Potential shortfalls in the HAPHTF are not addressed explicitly. However, the general appropriations clause of the bill would allow appropriations to cover any such shortfalls.	
Administration and oversight of the coverage expansion	The HAPI plans would be administered by a HHA in each state, Washington, D.C., Puerto Rico and all U.S. territories. The HHAs would work in conjunction with HHS to determine a variety of policies. At least two HAPI plans would be required to be available in each coverage area (which can be smaller than a state). If there are not two plans available, an enrollee would be able to choose a fallback plan in that area administered by HHS. HHAs also may offer at least one additional HAPI plan that includes coverage for additional benefits, items or services besides the standardized benefits, items or services offered by the other two mandatory HAPI plans.	In addition to the requirements of S. 334, this bill would require HHAs to offer at least one additional HAPI plan that includes coverage for additional benefits, items or services besides the standardized benefits, items or services offered by the other two mandatory HAPI plans. The bill would establish an Advisory Committee that would issue annual reports to recommend modifications to HAPI plans. The first annual report would be issued at the end of the fourth calendar year after enactment of the bill. Additionally, the Advisory Committee, by the end of the second calendar year after enactment of the bill, would issue a report on standardization of HAPI plan enrollment forms.

Bill Name	Healthy Americans Act	Healthy Americans Act
	The legislation would establish an Advisory Committee that would issue annual reports to recommend modifications to HAPI plans. The first annual report would be issued at the end of the second calendar year after enactment of the bill.	
Financing	The program would be financed through premiums paid by individuals, employer payments and federal subsidies. In addition to reallocating money from the current Medicaid DSH program, there would be an open-ended federal appropriation to help fund the premium subsidies. Employers would be required to make shared responsibility payments. These payments would equal between 2 percent and 25 percent of the national average HAPI plan premium for each employed enrollee on a sliding-scale based on the number of employees employed by the employer, the employer's revenue per employee relative to other employers, and whether the employer is a not-for profit organization, state or local government, or "any other type of entity for which the Secretary of HHS determines that calculating revenue per employee is not appropriate." The employer contributions would not be included in the computation of an employee's gross income, and would not be considered "wages" for the purposes of the payroll tax. For each of the first two years during which HAPI plans would be in effect, employers may be required to make transitional payments to the U.S. Treasury. For employers contributing to employees' health care coverage premiums before enactment of the bill, transitional payments would be zero if the employer increased employee salaries by at least the designated employee health insurance premium amount, which is the amount of the employer's yearly premium contributions in either the year prior to enactment of the bill or the year prior to the effective date of the provision, whichever is greater. Otherwise, these employers would pay to the U.S. Treasury the difference between those premium contributions in the year prior to the bill and the increase in employee salaries in each subsequent year. Employers who before the enactment of the bill did not contribute to health insurance	Similar to S. 334, but transitional payment provisions for employers previously contributing to health care coverage would be effective for the first four years of the program. Those employers would make payments to the extent that the designated employee health insurance premium amount exceeds the employer's salary increases over the year prior to the year in which HAPI plans went into effect. During this four-year transition period, any employer salary increases made pursuant to this provision would not be treated as income or taken into account for the purposes of determining a receiving individual's eligibility for benefits or assistance under any government program. The definition of designated employee health insurance premium amount is identical to that in S. 334. Large employers with revenue per employee in the 60th percentile or above that did not provide coverage on the day before the enactment of the bill would be required to make additional contributions for the first four years that HAPI plans would be in effect. For employers not offering coverage on the day before the date of enactment of the bill, transitional payments would be made in the same manner as under S. 334.

Bill Name	Healthy Americans Act	Healthy Americans Act
	costs would phase-in their shared responsibility payments over two years, making one-third the required payment in the first year and two-thirds the required payment in the second year, and then begin to make the full shared responsibility payments in the third year.	
Key implementation dates	Most provisions of the bill would be effective within two years after enactment.	Most provisions of the bill would be effective within four years of enactment.
Other key elements of the bill	With respect to Medicare, the bill would: • Permit Medicare hospice beneficiaries to receive curative care and would introduce additional educational and support resources for beneficiaries regarding end-of-life care; • Allow Medicare Part B premiums to be adjusted to reward Medicare beneficiary healthy behavior; • Enable Medicare, outside of the Medicare Advantage program, to pay for certain primary care services to monitor and coordinate a beneficiary's care; • Implement a chronic care program designed to address the five chronic conditions most prevalent among Medicare beneficiaries; • Require HHS to negotiate drug prices for fallback plans, and upon request of an MA-PD plan, to participate in that plan's negotiation of drug prices; and • Allow beneficiaries to change Part D plans upon reaching the gap in coverage, regardless of whether the gap is reached during an open enrollment period, if the plan to which the beneficiary is switching provides coverage in the gap. Tax deductions for pharmaceutical advertising under certain circumstances would be prohibited. The bill would introduce optional New Drug Application (NDA) and Investigational New Drug (IND) data submissions for drugs and devices that could extend market exclusivity by six months for certain drugs[3] and patent protection by two years for medical devices. To qualify for the extended market exclusivity or patent protection, the data would need to	Similar to S. 334, but the bill would not amend the Medicare hospice benefit or expand end-of-life care education or support. In addition, the bill would not change the Medicare Part D outpatient prescription drug benefit. The bill would allow HAPI plan reimbursement for school-based health centers, but would not include a grant program for those centers. The bill would expand the scope and budget authorization for HHS to study the comparative effectiveness of federal health care programs, including HAPI plans. The bill would not deem medical records to be the property of the individual to whom they pertain.

[3] By its terms, § 505A(b) applies only to NDAs filed on or before October 1, 2007. *See* 21 U.S.C. § 355a(n).

Bill Name	Healthy Americans Act	Healthy Americans Act
	include information about the age of the patient population for whom the product is intended as well as data on the effectiveness of the drug or device as compared to other similar drugs and devices on the market. The bill also would impose substantial advertising restrictions on NDA and IND applicants that do not report the data. The bill also would: • Terminate 26 U.S.C. § 35 (the tax credit for health insurance costs of people receiving trade readjustment allowances, benefits from the Pension Benefit Guaranty Corporation or certain unemployment benefits); • Terminate 26 U.S.C. § 125 (cafeteria plan deduction) with respect to health benefits as defined in the bill; • Terminate Archer Medical Savings Accounts; • Allow health savings accounts (HSAs) to be used in conjunction with HAPI plans; • Impose new requirements upon qualified long-term care insurance plans; • Authorize school-based health centers to receive reimbursement from HAPI plans, and would establish a grant program to encourage local school districts to establish school-based health centers; and • Deem medical records to be the property of the individual to whom the records pertain.	

TABLE A-2. ANALYSIS OF THE "TEN STEPS TO TRANSFORM HEALTH CARE IN AMERICA ACT"

Bill Name	Ten Steps to Transform Health Care in America Act
Bill number(s)	S. 1783
Bill sponsor(s)	S. 1783 is sponsored by Senator Enzi and has 0 cosponsors.
Latest Congressional action	S. 1783 was referred to the Senate Committee on Finance on July 12, 2007.
Overall summary of the bill	The Bill includes provisions related to five major areas: • **Coverage Expansion Provisions**—Expansion of insurance coverage by: o Changing the tax treatment of health insurance; o Altering the regulation of insurance by creating national rules to be adopted by the states for all health plans (other than self-funded plans or federal or state governmental health coverage programs) offered in each state. Insurers in non-adopting states would be allowed to offer certain policies in accord with selected standards with oversight by the Secretary of the Department of Health and Human Services (Secretary of HHS); o Establishing an autoenrollment process; o Authorizing small business health plans and alternative market pooling organizations that would be allowed to operate in multiple states; and o Providing the option of converting the value of Medicaid and the State Children's Health Insurance Program (SCHIP) benefits into private health insurance. • **Health Information Technology**—Promotion of health information technology (HIT) by: o Authorizing the Office of the National Coordinator of Health Information Technology and other public and public-private bodies to encourage and facilitate the adoption of HIT; o Requiring promulgation of standards for electronic exchange of health information; o Extending the provisions of the Health Insurance Portability and Accountability Act (HIPAA) to apply to aspects of HIT; and o Creating grant programs to assist in the adoption and use of HIT. • **Quality Improvement**—Promote quality improvement by: o Creating quality reporting organizations (QROs) to conduct analyses of health data and report quality measures publicly; o Requiring the Secretary of HHS to develop risk-adjusted quality measures of patient care; and o Amending the role of quality improvement organizations (QIOs) in assisting Medicare providers, Medicare Advantage and Medicare Prescription Drug Plans. • **Education and Workforce**—Support health professions education and the health care workforce by: o Reauthorizing several programs under the Public Health Service Act; o Creating a demonstration program to create incentives for nurses to re-enter the workforce; and o Requiring studies by the Secretary of HHS on the effectiveness of health professions education and nursing workforce development programs and by the Medicare Payment Advisory Commission (MedPAC) on Medicare's financing of graduate medical education. • **Tort Reform—**Establish tort reform demonstrations by: o Creating up to ten demonstration grants to states to develop, implement and evaluate alternatives to current medical tort litigation; and Other provisions relate advanced directives, community based long-term care and Medicaid coverage of clinics.

Bill Name	Ten Steps to Transform Health Care in America Act
Coverage Expansion Provisions	
Basic structure of coverage expansion	**Changing the Tax Treatment of Health Insurance** • Grants everyone purchasing health insurance the same treatment under the tax system by: o Eliminating the employer-paid premium exclusion and the medical expense itemized deduction; o Introducing a standard "above the line" tax deduction for qualified health insurance premiums; and o Creating a refundable, advanceable, assignable tax credit for qualified health insurance premiums for lower income households. **Altering the Regulation of Insurance** • Would establish federal standards to be adopted by states. Insurers in non-adopting states would be allowed to offer certain policies in accord with selected standards with oversight by the Secretary of HHS. • The federal standards would: o Require merger of group and individual market rules, establishing a single set of rules for all health plans (other than self-funded plans or federal or state governmental health coverage programs) offered in each state; o Establish criteria for premiums and cost-sharing; and o Establish standards for form filing and rate filing, market conduct review, prompt payment of claims and internal review based on a harmonization of existing state standards. • With respect to the federal standards for health plans, health insurers would be: o Required to offer at least one certified qualified core plan to residents with community-rated premiums in any state they offered coverage; o Allowed to offer one or more certified qualified core compatible plans with modified community rated premiums; and o Permitted to offer other types of plans as well, as long as they offer at least one certified qualified core plan. **Imposing a Partial Individual Mandate** • Uninsured individuals would automatically be enrolled in a qualified core plan or in the applicable government program, if eligible. **Authorizing Small Business Health Plans** • Would allow small business health plans and alternative market pooling organizations to offer health insurance to their members subject to requirements established by the Secretary of HHS. Such insurance would be subject to regulation by a state, but authorized to operate in all states. • Plans offered by these organizations would be required to offer benefits specified by the Secretary of HHS. **Converting the Value of Medicaid and SCHIP** • Beneficiaries would have the option of using the value of Medicaid and SCHIP program benefits to purchase private health insurance.
Changing the Tax Treatment of Health Insurance	
Modification of existing tax treatment of health insurance and medical expenses	Employer contributions to premiums would not be excluded from employee taxable income for income tax or payroll tax purposes. A new tax deduction or a new tax credit would be available. The itemized deduction for medical expense is repealed. These provisions do not apply to persons eligible for Medicare, Medicaid, SCHIP or having certain coverage from a former employer commencing prior to January 1, 2010.

Bill Name	Ten Steps to Transform Health Care in America Act
Description of tax deduction and eligibility criteria	The Act would introduce an "above the line" standard tax deduction for qualified health care insurance premiums. The standard deduction for health insurance would replace the employer paid premium exclusion and medical expense itemized deduction for individuals eligible for the new deduction. The standard deduction would be excluded from payroll taxes. An individual would be eligible for a standard deduction for health insurance on a monthly basis if the person is covered under a qualified health plan as of the first day of the month. For the purposes of the deduction, a qualified health plan must: (1) have a reasonable annual or lifetime maximum benefit; (2) provide coverage for inpatient and outpatient care, emergency benefits, and physician care; (3) not have pre-existing condition limitations imposed with respect to any eligible individual; and (4) have coverage that limits individual economic exposure to extraordinary medical expenses. Certain plans, such as Medicare supplemental policies, would not be included. The standard deduction would equal $7,500 for an individual and $15,000 for a family per year. For subsequent calendar years, the amounts would be increased by a cost-of-living adjustment (based on the Consumer Price Index), and would be rounded to the nearest multiple of $50. The deduction would be applied on a monthly basis. The deduction would be coordinated with other tax incentives. For example, it would not be permitted if the health insurance tax credit is allowed and would be reduced by premiums paid with an Archer medical savings account or a health savings account. Individuals covered under Medicare, Medicaid, SCHIP or grandfathered employer coverage would not be eligible for the tax deduction unless they also were covered by a qualified health plan as of the first day of the month.
Description of tax credit and eligibility criteria	The Act would create for low income persons an advanceable, refundable and assignable income-based tax credit for qualified health insurance coverage equal to the premium paid or the specified amount of credit. For the purposes of the tax credit, qualified health insurance would include a certified qualified core plan or a certified qualified core compatible plan (defined by the Act as described below). Payments to an Archer MSA or an HSA in connection with qualified health insurance also would be treated as payment for qualified health insurance. The amount of the tax credit would depend on the modified adjusted gross income (MAGI). The full credit would be available to filers with MAGI at or below 100 percent of the Federal Poverty Level (FPL) ($20,650 for a family of four), and would be phased-out as income approaches 300 percent FPL. Filers with MAGI above 300 percent FPL would not receive the tax credit. The maximum annual credit would be $2,500 for an individual and $5,000 for a family in the initial calendar year. For subsequent calendar years, the maximum annual credit would be increased by a cost-of-living adjustment (based on the Consumer Price Index), and would be rounded to the nearest multiple of $50. The credit would be applied on a monthly basis. Individuals entitled to benefits under Medicare or entitled to benefits under certain other government programs would not be eligible for the tax credit. Individuals enrolled in Medicaid or SCHIP would not be eligible for the tax credit unless they elected to be enrolled under qualified health insurance in lieu of coverage under those programs. Individuals eligible to participate in any employer-subsidized health plan would not be eligible for the tax credit.
Key implementation dates for changes in tax treatment	The standard deduction for health insurance and the income-based tax credit would apply to taxable years beginning on or after the first day of the first calendar year in which the requirements related to encouraging individuals to enroll in qualified health plans (see below) first apply or are fulfilled.

Bill Name	Ten Steps to Transform Health Care in America Act
Other provisions related to tax treatment	Employers would be required to report the value of employer-provided coverage for each month under an accident or health plan and the category of the coverage on the Form W-2. The Secretary of the Treasury would ensure that any instruction booklet accompanying an individual federal income tax return form and any other publication, announcement or website considered appropriate would include information regarding the standard tax deduction and tax credit available under this Act. The Secretary of HHS would develop a website, linked to state insurance commissioner websites, that would include information on the standard tax deduction for health insurance, the tax credit, the enrollment processes, qualified core plans and qualified core compatible plans (see discussion below).
Altering the Regulation of Insurance	
Basic structure of insurance regulation changes	The Secretary of HHS would through regulations promulgate standards regarding health insurance offerings to be adopted by the states. Insurers operating in non-adopting states would have the option of offering policies in compliance with the Secretary of HHS' regulations regarding the List of Required Benefits (below) and the harmonization of insurance processes. They would then be subject to the Secretary of HHS' oversight in these areas. The standards would require: • Uniform rules for the individual and group insurance markets; • Insurers to offer qualified core policies subject to certain benefit and premium requirements; • Insurers to offer other policies subject to specified requirements; and • The adoption of harmonized standards regarding form filing, rate, market conduct, internal reviews and prompt payment of claims.
Merging of market rules	The Secretary of HHS, in consultation with the National Association of Insurance Commissioners (NAIC), would promulgate standards to merge the regulation of individual and group policies. A single set of rules would apply to all health plans (other than employer-sponsored self-funded plans or federal or state governmental health coverage programs) offered in each state. The standards would require that: • State health insurance laws applicable to the small group market in the state be modified, except as provided for otherwise in the Act, to apply to all health plans regardless of whether the plans are being purchased for the coverage of individuals or groups; and • Existing individual market rules and other provisions that apply independent standards to the individual insurance market or that relate to the relationship between that market and group markets would no longer have any force.
Requirements for health insurance offerings	**General** Each health plan offered in the state must: • Accept every individual who applies for enrollment during the period in which the individual first becomes eligible to enroll; • Not impose restrictions based on health status on eligible individuals enrolling in the plan more stringent than those allowed under HIPAA (which includes federal requirements that prevent discrimination against individual participants and beneficiaries based on health status); • Not raise individuals' health insurance premiums if they become ill or file claims; • Comply with HIPAA portability requirements related to the limitation of exclusions based on pre-existing exclusions; and • Renew or continue an enrollee's coverage at the enrollee's option. **Qualified Core and Qualified Core Compatible Plans** If a health insurer offers health insurance coverage in a state, it would be required to offer at least one certified qualified core plan to individuals residing in the state. Health insurers offering health insurance coverage in a state may also offer one or more certified qualified core compatible plans to individuals residing in the state.

Bill Name	Ten Steps to Transform Health Care in America Act
	Health insurance issuers that do not offer at least one certified qualified core plan and/or do not comply with the requirements pertaining to qualified core plans and qualified core compatible plans (if applicable) would be subject to a civil monetary penalty. A state would certify a plan as a qualified core plan if the plan: • Provides coverage for benefits, items, or services as required by the state; • Provides coverage for basic preventive items or services, pursuant to state law or based on standards or guidelines issued by the Secretary of HHS if no state law exists; • Provides coverage for medical self-management and for items or services needed for self-management as defined by the state; • Requires the payment of the applicable standard premium for coverage under the plan; • Adheres to cost-sharing limitations; • Provides for the submission of data indicating the aggregate actuarial value of the plan to the state insurance commissioner and the Secretary of HHS; and • Complies with any other requirements applicable under state law. A state would certify a plan as a qualified core compatible plan if the plan has an actuarial value that is not less than the national standard actuarial value based on data submitted by insurers and calculated by the Secretary of HHS and meets all of the requirements for the certification of a qualified core plan, except that it does not have to: • Require the payment of the applicable standard premium for coverage under the plan; • Adhere to cost-sharing limitations; or • Provide for the submission of data indicating the aggregate actuarial value of the plan to the state insurance commissioner and the Secretary of HHS. All individuals would be eligible to enroll in qualified core plans or qualified core compatible plans. For qualified core plans offered in a state, premium variation would not be permitted. The standard premium amount would be the same for all enrollees ($2,500 for individual coverage and $5,000 for family coverage during the initial plan year). A qualified core plan would be subject to three cost-sharing limitations: (1) the amount of any deductible could not exceed $2,500 for a plan year; (2) the amount of any copayments could not exceed 20 percent; and (3) the annual limit on cost-sharing payments could not exceed $5,000. Qualified core plans would not be permitted to impose cost-sharing requirements on basic preventive items or services or medical self-management items or services. The standard premium and the cost-sharing limitations would be increased annually by the percentage increase in the Consumer Price Index for the previous plan year. Premium and cost-sharing requirements applicable to qualified core compatible plans would be determined in accordance with state law, except: • Premium variation based on health status would not be permitted, and the only permissible rating factor for rating variation would be enrollee age; and • The total variation in premium rates charged by an insurer for coverage under a plan could not be greater than a factor of 2 to 1. **<u>Restrictions on Premiums for Other Plans (Other Than Qualified Core Plans or Qualified Core Compatible Plans)</u>** For all other health insurance products offered in a state (i.e., not qualified core plans or qualified core compatible plans), premium variation based on health status would be prohibited. Premium variation based on other factors would be permitted in accordance with state law and subject to the application of small group market rules to all insured health plans in a state.

Bill Name	Ten Steps to Transform Health Care in America Act
Establishing an Autoenrollment Process	
Autoenrollment	An uninsured individual would be automatically enrolled in a qualified core plan in his or her state or in the government program for which the individual is eligible if: (1) the individual presents for treatment at a licensed health care facility or provider without health coverage under a qualified health plan or a federal or state government health program; or (2) the individual designates the lack of such health coverage on his or her federal tax return. An individual who is covered under a self-insured health plan, as defined for the purposes of the Employee Retirement Income Security Act of 1974 (ERISA), would be deemed to be in compliance with the requirement to be enrolled in a qualified health plan. Within three years of the date of enactment of the Act, states must encourage individuals to enroll in qualified health plans and to enroll their dependent children in qualified health plans, or in federal or state governmental coverage programs if the children are eligible.
Risk adjustment	States would apply state risk adjustment requirements certified by the Secretary of HHS to lessen material risk selection that may occur among qualified core plans, qualified core compatible plans and other licensed insurance products (not including self-insured plans). Prior to the development of such requirements, the Secretary of HHS, in consultation with NAIC, would assess the degree of the actual or anticipated material adverse selection among qualified core plans, qualified core compatible plans, and other insured health plans and the comparative efficiency of state risk adjustment requirement options. The Secretary of HHS would submit a report on the results of the analysis to Congress.
National rules regarding benefits	Within three months after the enactment of the Act, the Secretary of HHS, in consultation with the NAIC, would issue an interim final rule that contains the List of Required Benefits. The List of Required Benefits would include a list of covered benefits, services or categories of providers that at least a majority of the states mandate health insurance issuers provide in each of the small group, individual and large group markets. The coverage list applicable to the small group market would apply to small business health plans. The List of Required Benefits would be updated by the Secretary of HHS, in consultation with NAIC, two years after the date the list is issued, and every two years thereafter, based on changes in the laws and regulations of the states. States with mandates regarding covered benefits, services or categories of providers that are on the List of Required Benefits would have to apply the laws uniformly. These states would be required to allow plans offered in the small group, individual or large group markets or through small business health plans to apply the mandated benefit, service or category of provider coverage consistently with how coverage is applied under one of the three most heavily subscribed national health plans offered under the Federal Employee Health Benefits Program (FEHBP). If the benefit, service or category of provider is not offered by one of these three FEHBP national health plans, the requirement would be applied consistently with how the coverage is offered in the most heavily subscribed plan of the remaining FEHBP plans. States that do not enact laws allowing small group, individual or large group health insurers in the state to offer and sell products conforming to the List of Required Benefits and the terms of application as set forth in the Act could not prohibit eligible insurers from offering, marketing or implementing health insurance coverage consistent with these standards. Insurers could become eligible by providing notification to the Secretary of HHS and the insurance department of the state that it intends to offer coverage consistent with the List of Required Benefits and the terms of application 30 days prior to offering such coverage and including a description of the List of Required Benefits and the Terms of Application in the insurer's contract. States could not retaliate against an eligible insurer for offering, marketing or implementing such coverage.

Bill Name	Ten Steps to Transform Health Care in America Act
Harmonization of other state insurance regulations	A Health Insurance Consensus Standards Board (HICS Board) would be established to develop recommendations that harmonize inconsistent state health insurance laws, including standards for form and rate filing, market conduct review, prompt payment of claims and internal review. The HICS Board would consist of insurance commissioners and representatives of state governments, health insurers, insurance agents and brokers, and the American Academy of Actuaries. An advisory panel also would be established to assist the HICS Board. • Once the recommended standards are developed, and within 18 months of all initial HICS Board members being selected, the HICS Board would advise that the Secretary of HHS certify the standards. • Within 120 days of receiving the HICS Board's recommendations, the Secretary of HHS would certify the recommended harmonization standards and issue the standards in an interim final regulation. • The Secretary of HHS would establish a certification process for the harmonization standards that would ensure that: o The standards for a particular process achieve regulatory harmonization with respect to health plans on a national basis; o The approved standards are the minimum necessary, with respect to substance and quantity of requirements; and o The approved standards will not limit the range of group health plan designs and insurance products. The standards would become effective 18 months after the date that the standards are certified by the Secretary of HHS. States that fail to enact the harmonized standards within 18 months, in their entirety and as the exclusive laws of the state relating to the covered processes could not prohibit insurers from offering, marketing or implementing health insurance coverage consistent with these standards. Also, these states could not retaliate against an eligible insurer for offering, marketing or implementing such coverage. To become eligible, insurers in such states that offer coverage consistent with the harmonized standards would have to notify the Secretary of HHS and the state's insurance department of their intent to offer such coverage at least 30 days before offering the coverage and include the harmonized standards as a term of the insurance contract. Non-specified sums would be appropriated to carryout the provisions of the Act regarding the harmonization standards.
Administration and oversight of the coverage expansion	**<u>Qualified Core Plans and Qualified Core Compatible Plans</u>** • States would determine appropriate mechanisms to encourage individuals to demonstrate coverage under qualified health plans for themselves and their dependent children. These methods would not include revocation or ineligibility for coverage under a qualified core plan or qualified core compatible plan. • The Secretary of HHS, in consultation with the NAIC, would promulgate regulations setting forth the standards and procedures for the certification, and the suspension or revocation of the certification of qualified core plans and qualified core compatible plans. • Prior to implementing the regulations regarding the certification of qualified core plans, the Secretary of HHS, in consultation with the NAIC, would conduct an assessment of the effect of the application of the national standard qualified core plan actuarial value as a requirement for the certification of qualified core compatible plans. The Secretary of HHS would submit the results of this assessment to Congress. • States would certify qualified core plans and qualified core compatible plans. The plans would be subject to state oversight and state laws, including, but not limited to consumer protection laws, benefit mandates and solvency requirements. States could suspend or revoke the certification of a qualified core plan if it appears that a policy or procedure could materially alter the level of cost-sharing obligations of enrollees. States also could suspend or revoke the certification of a qualified core plan or a qualified core compatible plan if the insurance issuer does not submit its annual determination as to the aggregate actuarial value of each qualified core plan and qualified core compatible plan. • States would require the health insurance issuers that issue, sell or renew health insurance

Bill Name	Ten Steps to Transform Health Care in America Act
	coverage in the state meet the Act's requirements regarding qualified core plans and qualified core compatible plans. The Secretary of HHS would oversee the states with respect to the implementation and enforcement of requirements related to qualified core plans and qualified core compatible plans. If a state does not fulfill its duties, the Secretary of HHS would be responsible for enforcing the requirements in the state. **Self-Insured Health Plans** The Secretary of Labor, in consultation with the state insurance commissioner, would administer the certification, suspension or revocation of certification of self-insured health plans.
Key implementation dates for insurance regulation modifications	States would be presumed to be implementing and enforcing the requirements with respect to health insurance issuers, qualified core plans and qualified core compatible plans by: (1) notifying the of the enactment or the intention to enact necessary legislation by January 1, 2009 (or July 1, 2009 in the case of states with legislatures that do not meet within the 12-month period beginning on the enactment of the Act; and (2) providing the Secretary of HHS with the information necessary to review the legislation and its implementation. The requirements pertaining to the List of Required Benefits would begin applying to health insurance provided to participating employers of small business health plans 12 months after the date of enactment. These requirements would begin applying to health insurance provided to groups or individuals other than participating employers of small business health plans 15 months after the date of enactment. The harmonized standards certified by the Secretary of HHS would apply and become effective 18 months after the date on which the Secretary of HHS certifies the harmonized standards. The provisions related to enhanced marketplace pooling and related market rating would take effect 12 months after the enactment of the Act.
Reports	The Secretary of HHS, in consultation with NAIC, would conduct ongoing reviews of the effects that modification of state health insurance premium rating rules have on health insurance affordability, access and market competition. No later than one year after the date of enactment of the Act, and every two years thereafter, the Secretary of HHS would submit a report to Congress on the reviews. With respect to the harmonized standards, the Secretary of HHS would be required to prepare a report, in consultation with the NAIC and the entities and constituencies represented on the HICS Board and the advisory panel, every three years assessing the effect of the harmonized standards on access, cost and health insurance market functioning. Within one year after the enactment of the Act and every three years thereafter, the Secretary of HHS, Secretary of Labor and Secretary of the Treasury, in consultation with NAIC, would review the effect of merging the rules for the individual and group insurance markets on health insurance access, affordability and market competition, and submit a report to Congress.
Courts	Federal courts would have exclusive jurisdiction over civil actions involving the interpretation of the parts of the Act setting forth the rating requirements, the provisions pertaining to the List of Required Benefits (see above) and the terms of application and the interpretation of the part on harmonized standards.
Authorizing Small Business Health Plans	
Description of affected small employers, employees and organizations	**Small Employers** Small employers that are members of qualified associations, cooperatives or employer groups could sponsor and provide coverage to their employees through a small business health plan (SBHP). In addition, self-employed individuals and large employers that are members of the sponsor could access coverage through the SBHP.

Bill Name	Ten Steps to Transform Health Care in America Act
	Organizations Alternative market pooling organizations would be permitted, which would enable organizations comprised of individuals and groups with little or no association through employment to access coverage.
Eligibility criteria for participating in small business health plans and alternative market pooling organizations	Employers would have to be a member or an affiliated member of the sponsoring entity, or the sponsoring entity itself, to offer coverage through a SBHP. Alternative market pooling organizations would be permitted that are not principally comprised of employers and their employees, professional organizations or SBHP entities. Organizations such as unions, churches and other faith-based organizations, or other organizations comprised of individuals and groups that may have little or no association through employment could participate in an alternative market pooling organization. Individuals participating in SBHPs would have to be active or retired owners (including self-employed individuals), directors, employees or partners in participating employers (or such individuals' dependents). Employers offering coverage through a SBHP could not pay for an employee to purchase coverage in the individual market if the decision to purchase individual coverage is based on the employee's health status and the employee otherwise is eligible to obtain coverage through the SBHP.
Requirements for small business health plans	A SBHP would be a fully insured group health plan sponsored by a permanent and active entity, such as a bona fide trade or industry association, professional association or employer group (e.g., a chamber of commerce). A franchiser could also establish a small group health plan for the franchisor or for its franchisees. The sponsor of a SBHP would have to meet the following criteria for at least three years before seeking certification for a SBHP: • The sponsor must have been organized for substantial purposes other than obtaining or providing medical care; • The sponsor could not condition membership, dues or coverage under the plan on factors related to the health of employees or dependents or group health plan participation; and • Membership in the sponsoring entity could not be based on a minimum group size. Certain entities would not have to meet all of the above criteria related to the SBHP or its sponsoring organization to be certified as a SBHP. These entities would be arrangements that provided coverage to 200 or more employers, had been in existence for at least 10 years and were licensed in at least one state. These exemptions would not apply if, after the bill was enacted, the plan began providing coverage in a new state. A SBHP would be required to have a board of trustees responsible for fiscal control and have rules in effect for the operation and control of the plan based on a three-year plan of operation. The board of trustees generally would have to be comprised of individuals selected from owners, officers, directors or employees of the participating employers and actively participate in the business. In general, board members could not include service providers (e.g., health plan contract administration or health care providers). SBHPs would be required to permit all eligible employers to obtain coverage through the plan in all geographic areas in which coverage was available. An employer eligible to participate in a small group health plan would have to be the sponsor, a member of the sponsor, or an affiliated member of the sponsor. The Secretary of HHS would be required to promulgate regulations within one year of the date of enactment applying the rules and standards that apply to SBHPs and alternative market pooling organizations.

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	SBHPs ceasing operations would be required to provide notice to enrollees at least 60 days in advance of a voluntary termination. Nothing in the Act related to marketplace pooling and no provision of state law would prohibit SBHPs from exercising sole discretion with respect to selecting specific benefits and medical care services to be included as benefits under the plan or coverage. However, the benefits and services would have to meet the terms and specifications of the provisions of the Act related to the List of Required Benefits, as discussed above.
Premium and cost-sharing requirements for small business health plans	Premium rates for small employers participating in a SBHP could not vary on the basis of health status-related factors of employees or their beneficiaries or the type of business or industry in which the employer is engaged. However, health insurance issuers offering health insurance coverage in connection with a SBHP and at the request of the SBHP could: • Set premium rates for a plan based on the experience of the plan; or • Vary premium rates for participating small employers in a SBHP in a state to the extent that such rates could vary using the same methodology used in the state for regulating small group premium rates. Within six months after enactment of the Act, the Secretary of HHS would be required to promulgate regulations in accordance with the Act establishing minimum standards for premium variations and model small group rating rules. The minimum standards for premium variations would include restrictions on the variation of premium rates and on the adjustment of rates. • The composite variation limit would be no less than 3 to 1. The composite variation limit would be defined as the total variation in premium rates charged by a health insurance issuer in the small group market as permitted under applicable state law based on the following factors or case characteristics: age; duration of coverage; claims experience; and health status. The use of age, health status or both would be required, and the use of duration of coverage and/or claims experience would be allowed. • The total variation limit would be no less than 5 to 1. The total variation limit would be defined as the total variation in premium rates charged by a health insurance issuer in the small group market as permitted under applicable state law based on all factors and case characteristics. • For the purposes of calculating the total variation limit, states would be prohibited from using factors other than those used to calculate the composite variation limit and industry, geographic area, group size, participation rate, class of business and participation in wellness programs. The model small group rating rules would apply to eligible insurers in states that did not enact small group rating rules meeting the minimum standards and would include provisions related to: • Premium rates; • The establishment of a separate class of business by a small employer carrier; • Limitations on the number of classes of business established by a small employer carrier; and • Limits on the transfer of a small employer into and out of a class of business. Within six months after enactment, and if necessary to provide for a graduated transition to the minimum standards for premium variation described above, the Secretary of HHS would also be required to promulgate state-specific transitional small group rating rules, which would be applicable in any state that has not enacted small group rating rules meeting the minimum standards (non-adopting states) and eligible insurers in a non-adopting state for a period no longer than three years.

Bill Name	Ten Steps to Transform Health Care in America Act
	• A state that complies with the transitional group rating rules and has in effect a small group rating rules methodology that allows for variation that is less than the variation allowed under the minimum standards would be deemed an adopting state. • Special transition standards would be developed related to independent rating classes for old and new business to protect health insurance consumers and to ensure a stable and fair transition for old and new market participants. • A carrier operating in a non-adopting state could maintain independent rating classes for old and new business for up to five years, beginning when the carrier offers a book of business meeting the minimum standards for premium variation or the transitional small group rating rules, but in any case, no later than three years after the date of enactment of the title pertaining to marketplace modernization. Eligible insurers in non-adopting states would be able to provide coverage conforming with the model small group rating rules (or, as applicable, transitional small group rating rules). Insurers could become eligible by notifying the Secretary of HHS and the insurance department of the state that it intends to offer coverage consistent with the model small group rating rules (or transitional small group rating rules, if applicable) 30 days prior to offering such coverage and including a description of the model small group rating rules in the insurer's contract. The rating requirements for the small group market would supersede the state laws of non-adopting states related to rating in the small group insurance market as applied to an eligible insurer, or small group health insurance coverage issued by an eligible insurer. Non-adopting states could not prohibit these insurers from offering, marketing or implementing health insurance coverage consistent with the standards for premium variations and model small group rating rules. Also, non-adopting states could not retaliate against an eligible insurer for offering, marketing or implementing such coverage.
Administration and oversight of the coverage expansion of small business health plans	The Department of Labor (DOL) would certify SBHPs. The DOL would have 90 days to accept or reject an application for certification, after which time the SBHP would be deemed certified. The DOL could subsequently deny the application. The application for certification would include information regarding: the sponsor and its board of trustees; the states in which the plan intends to offer coverage (and the number of employers and employees in each state); evidence that the plan is bonded; copies of health plan documents that would be provided to enrollees; and copies of agreements between the SBHP and plan administrators or other plan providers. The SBHP also would be required to notify each state in which it plans to operate that an application for certification was filed with DOL. The state in which the sponsor's principal place of business is located would be considered the state in which coverage was issued (i.e. the state of domicile). In addition to the state of domicile, SBHPs would have to be licensed in every state (or contract with an insurer that is licensed in each state) in which covered members are located (i.e., non-domiciled state). If participating employers of a SBHP are located in a state other than the state of domicile, and the insurer is not yet licensed in that state, a temporary period may occur where the state's health insurance licensure laws would temporarily be preempted. Non-domiciled states would have 90 days to approve or deny a SBHP's application for licensure, after which the SBHP would be considered licensed in the state unless and until determined otherwise by the state. The SBHP would be subject to the state insurance rules for each state in which it provides coverage, except for the new federal rules that the SBHP could elect to follow, as applicable. SBHPs would pay the DOL a $5,000 fee to cover administrative costs and certification.

Bill Name	Ten Steps to Transform Health Care in America Act
Reports	Within five years after the date on which the model small group rating rules are issued under the Act, and every five years thereafter, the Secretary of HHS, in consultation with NAIC, would prepare and submit to Congress a report assessing the effect of the model small group rating rules on access, cost and market functioning in the small group market.
Key implementation dates for small business health plans and alternative market pooling organizations	Small business health plans and alternative market pooling organizations could begin offering coverage 12 months after the bill's enactment. The DOL would issue interim rules for establishing small business health plans within six months of the bill's enactment.
Converting the Value of Medicaid and SCHIP	
Medicaid/SCHIP opt-out	Individuals eligible for Medicaid or SCHIP would be able to choose to enroll in a qualified core plan in their state of residence rather than enrolling in a public plan.

TABLE A-3. ANALYSIS OF THE "EVERY AMERICAN INSURED HEALTH ACT" MODIFICATIONS TO HEALTH INSURANCE TAX POLICIES PROPOSED IN THE 110TH CONGRESS

Bill Name	Every American Insured Health Act
Bill number	S. 1886
Bill sponsor(s)	S. 1886 is sponsored by Senator Burr and has 6 cosponsors.
Latest Congressional action	S. 1886 was referred to the Senate Committee on Finance on July 26, 2007.
Overview	Creates eligibility for residents of states meeting "refundability" requirements established by the Department of Health and Human Services (HHS) to receive a refundable, advanceable[4] federal income tax credit for individuals and families to purchase qualified health insurance. Residents of states not meeting HHS' refundability requirements would be permitted to take a deduction for health insurance premiums under current rules. Requires HHS to deem whether a state has met the refundability requirements through efforts to provide its citizens with greater access to affordable private health insurance through initiatives including, but not limited to, the establishment of a state health insurance exchange or a high risk pool with affordable coverage. Establishes a program for the certification of state health insurance exchanges. Repeals the current exclusion for employer paid premiums from employee income for tax purposes. Expands the ability to establish Medicaid health opportunity accounts to all states.
Description of eligible participants	An individual in a state meeting the refundability requirements would be eligible for the refundable federal income tax credit if the individual is: covered under qualified health insurance as of the first day of the month and is not entitled to Medicare; enrolled in Medicaid or the State Children's Health Insurance Program (SCHIP); or entitled to military health care coverage (including TRICARE). Additionally, prisoners and alien individuals who are not lawful permanent residents of the United States would not be eligible. An individual is eligible to use a state's certified health insurance exchange if the individual is, as of the first day of the month: • A resident of the state; • A citizen or national of the United States, an alien lawfully admitted to the United States for permanent residence, or an alien otherwise lawfully residing in the United States for a certain period of time; and • Not covered under group-based qualifying health insurance coverage, which includes employer-sponsored group health plans, Medicare, military health programs (including TRICARE), the Federal Employees Health Benefits Plan (FEHBP) or certain health care coverage through the Department of Veterans Affairs.

[4] The term "advanceable" means that the credit will be paid before the individual files a tax return.

Bill Name	Every American Insured Health Act
Description of tax credit and eligibility criteria	The bill would establish a refundable, advanceable tax credit for eligible individuals to purchase qualified health insurance. For calendar year 2009, the credit for an adult would be $2,160, for a child $1,620 and for a household or filing unit a maximum of $5,400. The bill specifies increases in the applicable amounts of the credit through calendar year 2017. If the amount of the tax credit exceeds the cost of a health plan, the excess funds would be deposited into a designated account, which could be a health savings account (HSA), an Archer MSA or a health insurance reserve account. (A health insurance reserve account is an account that would be established by the bill for the purpose of paying for qualified medical expenses.) Excess tax credit money placed in a health insurance reserve account would be considered income when calculating an individual's gross income and would be taxable. However, any payment of excess funds deposited into an HSA or an Archer MSA would receive the same tax treatment currently provided to HSAs and MSAs. Qualified health insurance would be defined as any health insurance covering medical care that has a reasonable annual and lifetime benefit maximum and provides coverage for inpatient and outpatient care, emergency benefits and physician care. Other provisions governing the health insurance tax credit include:. • Any amount paid by a taxpayer for health insurance to which the tax credit applies would not be allowable as a medical expense deduction; • The tax credit would be reduced by the aggregate amount distributed from HSAs or Archer MSAs that is excluded from gross income for the taxable year; • The tax credit would not be available to persons claimed as dependents on another tax return; and • For married couples, the tax credit would only be allowed if the couple files a joint return for the taxable year.
Criteria for states meeting refundability requirements, certified health insurance exchanges and participating health plans	The bill would require HHS to deem whether a state has met refundability requirements, meaning that the state has taken efforts to provide its citizens with greater access to affordable private health insurance through efforts including, but not limited to: • Establishing a certified state health insurance exchange; or • Establishing a high risk solution, such as a high risk pool, reinsurance mechanism or other state-designed high risk solutions, and making affordable coverage available. The requirement would be met if at least one plan available in the state has average premiums that are less than 6 percent of the state's median income. States would be required to demonstrate that state initiatives taken to provide greater access to affordable private health insurance, in combination with the qualified health insurance federal income tax credit, would result in a reduction in the number of eligible individuals who do not have health insurance coverage. A certified health insurance exchange would serve as a mechanism for pooling individual consumers purchasing private health insurance. • All insurance plans licensed in the state and in compliance with the requirements pertaining to state health insurance exchanges could participate in and offer health insurance products through an exchange. • A certified exchange would be required to offer at least one plan that meets the criteria of being affordable qualified exchange-based health insurance coverage. • State health insurance exchanges could organize into a multi-state pooling arrangement.

Bill Name	Every American Insured Health Act
	In establishing a certified health insurance exchange, the following requirements would be imposed on states. • States could not impose new benefit requirements on plans participating in the exchange beyond the requirements that the state imposes on all licensed health insurance providers operating in the state. • States would be prohibited from setting prices for any products offered through the exchange. • States would make certain that an effective and efficient method for collecting premiums owed for qualified exchange-based health insurance coverage exists. • A state could meet the affordability requirement by drawing on its funds to supplement the premiums of the lowest cost plan participating in the exchange, so that the average premium for individuals enrolling in the plan does not exceed 6 percent of the state's median income. The average premium would not include any increase in premiums resulting from late enrollment penalties imposed by the state as a method to promote the collection of premiums. • A state could vary the amount of supplemental payments made in different areas within the state. • A state would not be required to provide supplemental payments if at least one plan is available in all areas of the state with average premiums below 6 percent of the state's median income. Health insurance plans participating in the exchange would be required to abide by certain requirements. • The plans would be required to have uniform mechanisms for encouraging and facilitating the enrollment of all eligible individuals in qualified exchange-based health insurance coverage. • The plans participating in a certified exchange in a state may have available a uniform mechanism, such as reinsurance, a high risk pool, or other mechanism approved by HHS to protect plans offering qualified exchange-based health insurance coverage • Participating health insurance plans would ensure the wide dissemination of information regarding health insurance coverage options, including the plans offered, and premiums and benefits for such plans, to eligible individuals and to employers that provide financial assistance in purchasing such coverage. • Health insurance plans participating in the exchange would permit the enrollment and changes of enrollment of individuals when they become eligible in the state. Such eligibility may arise through the loss of group-based qualifying health insurance coverage, changes in residency or family composition, or other circumstances specified by HHS. • The plans would have an annual open enrollment period during which plans would be required to permit eligible individuals to change enrollment among such plans. • Participating health insurance plans would be subject to the HIPAA requirements regarding limitations on pre-existing condition exclusions that apply to group health plans. • The plans would be required to have a method to reduce adverse selection in the enrollment of eligible individuals. The mechanism would be uniform for all plans, and could include waiting periods, premium surcharges or other devices reasonably designed to decrease adverse selection in the enrollment of eligible individuals. • Health insurance plans participating in the exchange would report to the Secretary of the Treasury the information needed to administer the qualified health insurance tax credit.

Bill Name	Every American Insured Health Act
Administration	HHS would deem whether a state has met the refundability requirements. HHS would create a process for the review and certification of state applications for state-based programs to be certified health insurance exchanges for the state. HHS, in consultation with the Secretary of the Treasury would determine whether a program meets the requirements for an exchange. The tax credit for health insurance would only be permitted if an individual's coverage is verified in such manner as arranged by the Secretary of the Treasury. The Secretary of the Treasury would establish a program for making payments to providers of qualified refund eligible health insurance on behalf of eligible individuals. States could contract with the health insurance plans participating in the exchange or with a third party administrator to operate the exchange.
Financing provisions	Employer paid health insurance premiums would become part of employees' taxable income.
Key implementation dates	The amendments pertaining to the health insurance tax credit would apply to taxable years beginning after December 31, 2008. The expansion of the ability to establish Medicaid health opportunity accounts to all states would begin on January 1, 2008.
Other key elements of the bill	Medicaid and SCHIP eligible individuals could enroll in qualified exchange-based health insurance coverage. The bill would allow all states to establish Medicaid health opportunity accounts, which are currently limited to implementation as demonstration projects in a maximum of ten states. Medicaid health opportunity accounts are comparable to health savings accounts; they provide Medicaid beneficiaries with an account to pay for certain health care expenditures. If a state allows or requires Medicaid beneficiaries to enroll in Medicaid managed care organizations, these individuals would be able to participate in a state health opportunity account program if the state assures to the Secretary that the following conditions are met: • The number of individuals enrolled in any Medicaid managed care organization that participate in the Medicaid health opportunity accounts is limited to 5 percent of the total number of individuals enrolled in the organization. • The proportion of enrollees in the Medicaid managed care organization that participate in the health opportunity accounts is not significantly disproportionate to the proportion of enrollees in other Medicaid managed care organizations that participate. • The state has provided for an appropriate adjustment in the per capita payments to the managed care organization to account for the participation of individuals in the health opportunity accounts, taking into consideration differences in the likely use of health services between enrollees who participate and enrollees who do not participate. States would provide contributions into Medicaid health opportunity accounts on a sliding-scale based on income. If an individual were to become ineligible for public benefits, balances from a health opportunity account could be transferred into a health savings account.

Bill Name	Every American Insured Health Act
	The Comptroller General of the United States would submit a report to Congress by March 31, 2013 that evaluates the Medicaid health opportunity accounts. The Act would extend the time of an existing appropriation of $550,000 to the Comptroller General for the creation of the report through 2013 and would require the report to evaluate the program rather than the demonstration projects.
Administration	The Secretary of HHS would deem whether a state has met the refundability requirements. The Secretary of HHS would create a process for the review and certification of state applications for state-based programs to be a certified health insurance exchange for the state. HHS, in consultation with the Secretary of the Treasury would determine whether a program meets the requirements for an exchange. The tax credit for health insurance would only be permitted if an individual's coverage is verified in such manner as arranged by the Secretary of the Treasury. The Secretary of the Treasury would establish a program for making payments to providers of qualified refund eligible health insurance on behalf of eligible individuals. States could contract with the health insurance plans participating in the exchange or with a third party administrator to operate the exchange.
Financing provisions	Employer paid health insurance premiums would become part of employees' taxable income.
Key implementation dates	The amendments pertaining to the health insurance tax credit would apply to taxable years beginning after December 31, 2008. The expansion of the ability to establish Medicaid health opportunity accounts to all states would begin on January 1, 2008.
Other key elements of the bill	The bill would expand the ability to establish Medicaid health opportunity accounts (which are currently limited to being implemented as demonstration projects in a maximum of ten states) to all states. Medicaid health opportunity accounts are comparable to health savings accounts, providing Medicaid beneficiaries with an account to pay for certain health care expenditures. If a state allows or requires Medicaid beneficiaries to enroll in Medicaid managed care organizations, these individuals would be permitted to participate in a state health opportunity account program if the state meets the following conditions: • The number of individuals enrolled in any Medicaid managed care organization that participate in the Medicaid health opportunity accounts is limited to 5 percent of the total number of individuals enrolled in the organization; • The proportion of enrollees in the Medicaid managed care organization that participates in the health opportunity accounts is not significantly disproportionate to the proportion of enrollees in other Medicaid managed care organizations that participate; and • The state has provided for an appropriate adjustment in the per capita payments to the managed care organization to account for the participation of individuals in the health opportunity accounts, taking into consideration differences in the likely use of health services between enrollees who participate and enrollees who do not participate.

Bill Name	Every American Insured Health Act
	States would provide contributions into Medicaid health opportunity accounts on a sliding-scale based on income. If an individual becomes ineligible for public benefits, balances from a health opportunity account could be transferred into a health savings account. The Comptroller General of the United States would submit a report to Congress by March 31, 2013 that evaluates the Medicaid health opportunity accounts. The Act would extend the time of an existing appropriation of $550,000 to the Comptroller General for the creation of the report through 2013 and would require the report to evaluate the program rather than the demonstration projects.

TABLE A-4. SIDE-BY-SIDE ANALYSIS OF THE "HEALTH PARTNERSHIP ACT," "HEALTH PARTNERSHIP THROUGH CREATIVE FEDERALISM ACT," AND "STATE-BASED HEALTH CARE REFORM ACT"

Bill Name	Health Partnership Act	Health Partnership Through Creative Federalism Act	State-Based Health Care Reform Act
Bill number	**S. 325**	**H.R. 506**	**S. 1169**
Bill sponsor(s)	S. 325 is sponsored by Senator Bingaman and has 2 cosponsors.	H.R. 506 is sponsored by Representative Baldwin and has 80 cosponsors.	S. 1169 is sponsored by Senators Feingold and Graham and has 2 additional cosponsors.
Latest Congressional action	S. 325 was referred to the Senate Committee on Health, Education, Labor, and Pensions on January 17, 2007.	H.R. 506 was referred to the House Committee on Energy and Commerce on January 17, 2007, including the Subcommittee on Health on February 2, 2007.	S. 1169 was referred to the Senate Committee on Health, Education, Labor, and Pensions on April 19, 2007.
Basic structure of coverage expansion	Establishes a 21-member State Health Innovation Commission (Commission) that would oversee demonstration grants to regional groups, states or local governments for expanding health coverage and improving health care quality and efficiency. The Commission would make recommendations to Congress regarding grant applications to be funded. States seeking to receive federal grants would submit plans to expand access to health care coverage and reduce the number of uninsured individuals.	Establishes a 19-member State Health Coverage Innovation Commission (Commission) that would oversee demonstration grants to regional groups, states or local governments for expanding health coverage. The Commission would make recommendations to Congress regarding grant applications to be funded. States seeking to receive federal grants would submit plans to expand access to health care coverage and reduce the number of uninsured individuals.	Establishes a 16 or more member Health Care Coverage Task Force (Task Force) that would oversee demonstration grants to states or local governments for expanding access to care and improving health care quality and efficiency with an ultimate goal of universal coverage within the states. The Task Force would make recommendations to Congress regarding grant applications to be funded. States seeking to receive federal grants would submit plans to expand access to health care coverage and reduce the number of uninsured individuals.
Description of target population	No single population would be targeted.	No single population would be targeted.	No single population would be targeted.
Eligibility criteria	States and regional groups (i.e., more than one state) could apply to establish a health care expansion and improvement program. If a state declines to submit an application, or if unique demographic needs can be demonstrated, a unit of local government or Indian tribe could submit an application.	States and regional groups (i.e., more than one state or one or more local governments within a State) could apply to establish a health care expansion and improvement program. If a state declines to submit an application, a unit of local government could submit an application.	States could apply to establish a health care expansion and improvement program in the entire state or regions of two or more states. If a state declines to submit an application, a unit of local government could submit an application in collaboration with the state. A unit of local government or Indian tribe could submit an application without state collaboration if unique demographic needs can be demonstrated.

Bill Name	Health Partnership Act	Health Partnership Through Creative Federalism Act	State-Based Health Care Reform Act
	The application would comply with the following requirements: • Describes the manner in which the state will ensure that an increased number of individuals will have expanded access to coverage with a 5-year target for reducing the number of uninsured; • Describes the number and percentage of uninsured who would be covered under the program; • Describes the minimum benefit package; • Identifies other programs that could be coordinated with the demonstration program; • Provides for increased access for medically underserved populations; • Provides a plan to improve health care quality; • Contains results-based quality indicators established by the Commission as well as state-specific measures; • Provides for the development of systems to improve the efficiency of health care; • Describes private and public sector financing; • Estimates the amount of federal, state and local expenditures, as well as the costs to businesses and individuals; • Describes how the applicant would ensure the financial solvency of the program; • Provides that the applicant would submit required reports; and • Provides a methodology for the appropriate use of health information technology to improve infrastructure.	The application would comply with the following requirements: • Describes the manner in which the state will ensure that an increased number of residents will have expanded access to coverage with a 5-year target for reducing the number of uninsured; • Describes the number and percentage of uninsured who would be covered under the program; • Describes the coverage that will be provided under the program; • Identifies other programs which could be coordinated with the demonstration program; • Provides for increased access for medically underserved populations; • Describes steps that the state may undertake to improve the efficiency of health care; • Describes private and public sector financing; • Estimates the amount of federal, state and local expenditures, as well as costs to business and individuals; • Describes how the applicant would ensure the financial solvency of the program; and • Describes exceptions to otherwise applicable federal statutes, regulations and policies that would apply. The application may: • Describe efforts to improve health care quality in the state; and • Describe efforts to improve the use of health information technology, including an explanation of how such efforts would change under the program.	The application would comply with the following requirements: • Designates the lead state entity responsible for administering the state program; • Describes the benefits to be provided to all covered individuals (which, at a minimum, must provide for the same scope of coverage as State Children's Health Insurance Program (SCHIP) coverage); • Provides a methodology for demonstrating that the benefits available under the program are based upon available medical evidence; • Describes health care reforms that will be implemented under the program; • Describes the manner in which the state will ensure that an increased number of residents have expanded access to coverage with a 5-year target for reducing the number of uninsured; • Describes the number and percentage of uninsured who would be covered under the program; • Identifies programs that currently provide health care services within the state and describes total expenditures on such programs (if public funding is utilized) and how such programs would be coordinated with the demonstration program; • Provides for increased access for medically underserved populations; • Includes provisions to improve the effectiveness and efficiency of health care within the state; • Describes private and public sector financing; • Estimates the amount of federal, state and local expenditures, as well as costs to business and individuals; • Describes how the applicant would ensure the financial solvency of the program; and

Bill Name	Health Partnership Act	Health Partnership Through Creative Federalism Act	State-Based Health Care Reform Act
			• Provides assurances that the state would comply with premium and cost-sharing limitations (described below). **Note:** S. 1169 does not include a requirement regarding health information technology.
Benefits	None specified.	Coverage under the state plan could be: • Actuarially equivalent to a State Children's Health Insurance Program (SCHIP) benchmark benefit package (including the Federal Employees Health Benefits Plan (FEHBP), state employee coverage or coverage offered through the largest non-Medicaid HMO in the state); or • Provide access that is, on average, not less than that provided by the benchmark benefit packages; or • A combination of coverage and a consumer-directed health care spending account, provided the actuarial value of the coverage plus deposits for the spending account is not lower than a benchmark benefit package.	The benefit package under a program must, at a minimum, provide for the same scope of coverage as SCHIP coverage.
Premium and cost-sharing requirements	None specified.	None specified.	Imposes specific premium and cost-sharing limitations based on individual/family income level. • Families with income at or below 100 percent of the federal poverty level (FPL): there would be no premiums and cost-sharing would not exceed 0.5 percent of the family's income; • Families with income greater than 100 percent FPL but equal or less than 200 percent FPL: premiums would not exceed 20 percent of the average costs of providing benefits or 3 percent of the family's income, and the aggregate annual amount of premiums and cost-sharing (combined) would not exceed 5 percent of the family's income;

Bill Name	Health Partnership Act	Health Partnership Through Creative Federalism Act	State-Based Health Care Reform Act
			• Families with income greater than 200 FPL but equal or less than 300 percent FPL: premiums would not exceed 20 percent of the average cost of providing benefits or 5 percent of the family's income, and the aggregate annual amount of premiums and cost-sharing (combined) would not exceed 7 percent of the family's income.
Incentives and Federal subsidies	Approved applicants would receive a federal grant to carry out the health care program. The amount of each grant would be determined based on recommendations of the Commission. A state would be required to maintain its expenditures for health care coverage at a level equal to that of the year preceding receipt of a Commission grant.	Approved applicants would receive a federal grant to carry out the health care program. The amount of each grant would be determined based on recommendations of the Commission.	Approved applicants would receive a federal grant to carry out the health care program. The amount of each grant would be determined based on recommendations of the Task Force. If awarded a grant, the state or region would be required to maintain expenditures for the support of direct health care delivery at or above the level of expenditures of the fiscal year preceding the grant year.
Changes to public program(s)	No direct changes would be made to public programs. Prohibits any entity from affecting any Medicaid provisions in the course of implementing this bill. States may not shift Medicaid enrollees into this new program.	No direct changes would be made to public programs. Prohibits any entity from affecting any Medicaid provisions in the course of implementing this bill. States may not shift Medicaid enrollees into this new program.	No direct changes would be made to public programs. The Task Force would not be permitted to approve a state plan that shifts individuals from existing health care programs into the new program or restricts eligibility criteria of existing federal programs.
Requirements for private insurers or health plans	Not applicable.	Not applicable.	Not applicable.
Administration and oversight of the coverage expansion	The Commission would be charged with responsibility for monitoring the status and progress achieved under approved projects and would be required to hold an annual meeting with participating states to have the states report on progress toward the goals of the program. The Commission's responsibilities would include:	The Commission would be charged with responsibility for monitoring the status and progress achieved under approved projects and would be required to hold an annual meeting with participating states to have the states report on progress toward the goals of the program. The Commission's responsibilities would include:	The Task Force would be charged with responsibility for monitoring the status and progress achieved under approved projects and would be required to hold an annual meeting with participating states to have the states report on progress toward the goals of the program. The Task Force's responsibilities would include:

Bill Name	Health Partnership Act	Health Partnership Through Creative Federalism Act	State-Based Health Care Reform Act
	• Providing states with reform options for state health care expansion and improvement programs; • Establishing minimum performance measures and goals regarding coverage, quality and cost of state programs; • Reviewing applications from states; • Submitting recommendations to Congress with respect to state applications that the Commission recommends for approval; • Monitoring the status and progress of approved programs; • Promoting information exchange between states and the federal government; and • Making recommendations to the Secretary of Health and Human Services (HHS) and Congress for minimizing any adverse impacts of approved programs on national employer groups, provider organizations and insurers. The Commission would submit annual reports to Congress that would include, among other items, the effects of the reforms undertaken, the effectiveness of such reforms and recommendations regarding increasing federal financial assistance. Each state would be required to submit an annual report detailing compliance with Commission and HHS requirements.	• Requesting state proposals, which may include reform options for state health care expansion and improvement programs developed by the Commission or other options suggested by the states or the public; • Reviewing applications from states; • Submitting recommendations to Congress with respect to state applications that the Commission recommends for approval; • Receiving information to determine the status and progress of approved programs; • Public reporting of state progress with respect to performance measures and goals; • Promoting information exchange between states and the federal government; • Making recommendations to the Secretary of Health and Human Services (HHS) and Congress for minimizing any adverse impacts of approved programs on national employer groups, provider organizations and insurers; and • Potentially requiring states to submit additional information or reports regarding the status and progress of their demonstration projects. The Commission would submit annual reports to Congress that would include, among other items, the effects of the reforms undertaken, the effectiveness of such reforms, and recommendations regarding increasing federal financial assistance. Each state would be required to submit an annual report detailing compliance with Commission and HHS requirements.	• Establishing minimum performance measures regarding coverage, quality and cost of state programs; • Reviewing applications from states; • Approving applications from states for grants and submitting legislative proposals on such approvals to Congress with recommendations on the level of funding; • Monitoring the status and progress of the program; and • Publicly reporting state progress with respect to performance measures and goals. Each state would submit an annual report with a description of program results. At the end of the 5-year period (beginning on the date on which the first grant is awarded), the Task Force would prepare and submit to Congress a report on the progress made by states receiving grants in meeting programmatic goals.

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	At the end of the 5-year period (beginning on the date on which the first grant is awarded), the Commission would prepare and submit to Congress a report on the progress made by states receiving grants in meeting programmatic goals.	At the end of the 4th year (beginning on the date on which the first grant is awarded), the Commission would prepare and submit to Congress a report on the progress made by states receiving grants in meeting programmatic goals.	
Financing	For FY 2007 (and each year thereafter), $3 million to carry out the provisions regarding the creation and responsibilities of the Commission. Funds for state programs would be appropriated each fiscal year. Each state's grant would be based on the recommendation of the Commission.	For FY 2008 (and each year thereafter), $3 million to carry out the provisions regarding the creation and responsibilities of the Commission. Funds for state programs would be appropriated each fiscal year. Each state's grant would be based on the recommendation of the Commission.	For FY 2008 (and each year thereafter), $4 million to carry out the provisions regarding the creation and responsibilities of the Task Force. For FY 2007 through FY 2016 there would be a cap of $40 billion on the total amount of funds expended on grants and administration. Funds would be obtained, in part, by increasing the rebates for Medicaid covered outpatient drugs (from 15.1 percent to 20 percent, effective December 31, 2007).
Key implementation dates	HHS would be required to establish the Commission, with specified membership, within 90 days of the enactment. The Commission would hold its first meeting within 30 days after all members had been appointed. HHS and the Commission would complete an initial review of grant applications within 60 days of receipt to analyze each proposal's scope and determine whether additional information is required. Within 90 days of the initial review, the Commission would determine whether to submit the proposal to Congress for approval; a determination to submit a proposal would require the approval of 2/3 of the Commission's members. Annually, no later than 90 days prior to October 1, the Commission would submit a list (in the form of a joint resolution) of state applications that the Commission recommends for	HHS would be required to establish the Commission, with specified membership, within 90 days of the enactment. The Commission would hold its first meeting within 30 days after all members had been appointed. HHS and the Commission would complete an initial review of grant applications within 60 days of receipt to analyze each proposal's scope and determine whether additional information is required. In a timely manner, the Commission would determine whether to submit the proposal to Congress for approval; a determination to submit a proposal would require the approval of 2/3 of the Commission's members. Annually, no later than 90 days prior to October 1, the Commission would submit a list (in the form of a joint resolution) of state applications that the Commission recommends for approval to Congress. The joint resolutions would be considered on an expedited basis.	The Secretary of Health and Human Services (HHS) would be required to establish the Task Force, with specified membership from the legislative branch, within 180 days of enactment. The Task Force would hold its first meeting within 30 days after all members are appointed. HHS and the Task Force would complete an initial review of a grant application within 90 days of receipt to analyze each proposal's scope and determine whether additional information is required. No later than 90 days after completion of the initial review, the Task Force would determine whether to submit the proposal to Congress for approval. A determination to submit a proposal would require the approval of 2/3 of the Task Force members. The Task Force would seek Congressional approval in the form of a joint resolution submitted to both Houses of Congress. The joint resolutions would be considered on an expedited basis.

Bill Name	Health Partnership Act	Health Partnership Through Creative Federalism Act	State-Based Health Care Reform Act
	approval to Congress. The joint resolutions would be considered on an expedited basis. A proposal that had been recommended and submitted to Congress for approval and which does not require waiver of federal law would be deemed approved and federal funds would be provided to such program unless a joint resolution by Congress is enacted disapproving the proposal. A program may be approved for up to 5 years, and may be extended for subsequent 5-year periods upon approval of the Commission and HHS, based on achievement of targets.	H.R. 506 would require a joint resolution for approval of grants. A program may be approved for a 5-year period and may be extended by the Commission based on the achievement of targets.	S. 1169 would require a joint resolution for approval of grants. A program could be approved for a period of 5 years and extended for subsequent 5-year periods by HHS and the Task Force, based on the achievement of targets specified by the Task Force.
Other key elements of the bill	The potential reform options described in S. 325 include: • Tax credit approaches; • Expansions of public programs such as Medicaid and State Children's Health Insurance Program (SCHIP); • Creation of purchasing pooling arrangements similar to the Federal Employees Health Benefits Plan (FEHBP); • Individual market purchasing options; • Single risk pool or single payer systems; • Health savings accounts; and • Other options determined appropriate by the Commission, including options suggested by states, Indian tribes and the public. In awarding grants, HHS would be required to: • Fund a diversity of approaches identified by the Commission;	Potential reform options described in H.R. 506 include: • Tax credit approaches; • Expansions of public programs, such as Medicaid and SCHIP; • Creation of purchasing pooling arrangements similar to the FEHBP; • Individual market purchasing options; • Single risk pool or single payer systems; • Health savings accounts; and • Other options determined appropriate by the Commission, including options suggested by the states or public. In awarding grants, the Commission would direct HHS to: • Fund a diversity of approaches identified by the Commission; • Link allocations to the meeting of	Potential reform options described in S. 1169 include: • Expansion of Medicaid, SCHIP or other public programs; • Single-payer systems; • Implementation of state-based health savings accounts; • Establishment of health care purchasing or pooling arrangements; • New individual insurance purchasing options; • State tax credits; and • Other approaches submitted by the state and approved by the Task Force. **Note:** S. 1169 would not require performance-based funding, but contains a matching requirement unlike S. 325 or H.R. 506. A state must provide assurances to HHS that the state will contribute an amount equal to the product of: (A) the amount of the grant; and (B) one minus the sum of the enhanced Federal Matching Assistance Percentage (FMAP) for the state (as defined in SCHIP) and 5 percent for the purpose of this bill. FMAP is the percentage of a state's SCHIP

Bill Name	Health Partnership Act	Health Partnership Through Creative Federalism Act	State-Based Health Care Reform Act
	• Give priority to programs determined by the Commission to have the greatest opportunity to succeed in expanding coverage and improving access for vulnerable populations; and • Link allocations to the meeting of goals and performance measures. HHS could, for good cause and in consultation with the Commission, revoke any program granted under the Act.	goals and performance measures established during the application process. The Commission, on recommendation of HHS, could revoke any program granted under the Act.	expenditures that is paid for by the federal government. HHS could withhold payments under the Act if any state fails to comply with its plan.
	Grantees generally could not impose preexisting condition exclusions for covered benefits under a program approved by the Act.	Grantees generally could not impose preexisting condition exclusions for covered benefits under a program approved by the Act.	Grantees generally could not impose preexisting condition exclusions for covered benefits under a program approved by the Act.
	States would not receive payments for services provided to an individual where a private insurer is otherwise obligated to pay for those services. Similarly, no payment would be provided if payment would be made under any other federally operated or financed health care insurance program.	States would not receive payments for services provided to an individual where a private insurer is otherwise obligated to pay for those services. Similarly, no payment would be provided if payment would be made under any other federally operated or financed health care insurance program.	States would not receive payments for services provided to an individual where a private insurer is otherwise obligated to pay for the services. Similarly, no payment would be provided if payment would be made under any other federally operated or financed health care insurance program.

TABLE A-5. SIDE-BY-SIDE ANALYSIS OF THE "AMERICARE HEALTH CARE ACT OF 2007" AND THE "MEDICARE FOR ALL ACT"

Bill Name	AmeriCare Health Care Act of 2007	Medicare for All Act
Bill number(s)	H.R. 1841	S. 1218/H.R. 2034
Bill sponsor(s)	H.R. 1841 is sponsored by Representative Stark and has 31 cosponsors.	S. 1218 is sponsored by Senator Kennedy and has no cosponsors. H.R. 2034 is sponsored by Representative Dingell and has 19 cosponsors.
Latest Congressional action	H.R. 1841 was referred to the House Committee on Education and Labor, Subcommittee on Health, Employment, Labor, and Pensions on July 9, 2007.	S. 1218 was referred to the Senate Committee on Finance on April 25, 2007. H.R. 2034 was referred to the House Committee on Ways and Means, and to the Committees on Energy and Commerce, and Oversight and Government Reform on April 25, 2007, for consideration of the provisions that fall within the jurisdiction of each committee. The House Energy and Commerce committee referred the bill to its Subcommittee on Health on April 26, 2007.
Basic structure of coverage expansion	Creates a new public health insurance program, AmeriCare, that would be administered by the federal government and financed using a combination of general tax revenues, enrollee premiums, mandatory employer contributions and "maintenance of effort" payments by states (to cover payments that would have been made under Medicaid and the State Children's Health Insurance Program (SCHIP)). Benefits correspond to those available through Medicare Part A and Medicare Part B, plus preventive services, mental health parity, substance abuse coverage and prescription drug coverage. Children, pregnant women and low-income individuals receive full benefits without cost-sharing. The bill also allows for enrollment in private plans under Medicare Part C rules.	Creates a new public health program, Medicare for All, administered by the federal government's contracting process and financed through new payroll taxes on employees and employers. Establishes a new Medicare for All Trust Fund. Enrollees would have two choices for coverage. The first option would include the benefits available under Medicare Part A and Part B, plus an additional package of benefits. The second option would be Federal Employees Health Benefits Plan (FEHBP)-style coverage under a private plan that would contract with the federal government.
Target Population	Establishes coverage for every resident of the United States, plus automatic enrollment of individuals at birth. Establishes coverage for non-residents on a reciprocity basis (receive benefits equal to those a U.S. resident would receive in the non-resident's state of origin).	All U.S. citizens not otherwise eligible for health care coverage under the Medicare program would be covered, as well as those who are lawfully present in the United States.
Eligibility criteria	Individuals would be required to be U.S. residents. Persons under age 24, pregnant women, and low-income individuals under 200 percent of the federal poverty level (FPL) would be designated "special eligibility categories."	Individuals would be required to be: • U.S. citizens or immigrants lawfully present in the U.S.; and • Not eligible for Medicare Part A or Part B.

Bill Name	AmeriCare Health Care Act of 2007	Medicare for All Act
		Eligibility would be phased-in by age group according to the following schedule: • During the first 2 years of the program, eligibility would be limited to individuals under 25 or over 55 years old; • During the second 2 years of the program, eligibility would be expanded further to include individuals under 35 or over 45 years old; and • Beginning in the fifth year, eligibility would be expanded to include all age groups.
Benefits	Eligible individuals could enroll in one of two types of coverage. Under Choice 1, AmeriCare enrollees would receive the following benefits: • Medicare Part A and Part B benefits; • Preventive services recommended by the U.S. Preventive Services Task Force; • Coverage for treatment of substance abuse; • Newborn and well-baby care, including normal newborn care and pediatrician services for high-risk deliveries; • Well-child care, including routine office visits, routine immunizations, routine laboratory tests and preventive dental care; • Pregnancy-related services including prenatal care (including care for all complications of pregnancy), inpatient labor and delivery services, postnatal care and family planning services; • Mental health treatment parity (i.e., mental health benefits must be comparable to other medical benefits); • The early and periodic screening, diagnostic, and treatment services (EPSDT) provided to individuals under age 21 in the Medicaid program; and • Prescription drug coverage equivalent to the Blue Cross/Blue Shield Standard Plan provided under the Federal Employees Health Benefits Plan (FEHBP). Benefit exclusions under Medicare Part A and Part B also would apply to AmeriCare, unless benefits are expressly guaranteed (see list above). In addition, payment could not be denied for services for pregnant women, or for eyeglasses and hearing aids/examinations for children and low-income individuals.	Eligible individuals could enroll in one of two types of coverage. Under Choice 1, enrollees would be entitled to the following benefits: • The full range and scope of benefits provided to Medicare beneficiaries under Part A and Part B; • Prescription drug coverage at least as comprehensive as that offered under the Blue Cross/Blue Shield Standard Plan provided under FEHBP; • The early and periodic screening, diagnostic, and treatment services (EPSDT) provided to individuals under age 21 in the Medicaid program; • Parity in coverage of mental health benefits (i.e., mental health benefits must be comparable to other medical benefits); • Preventive services; • Home and community-based services; and • Any additional benefits deemed appropriate by the Secretary of Health and Human Services (HHS). Enrollees in Choice 1 would be guaranteed the same free choice of providers that is available to current Medicare beneficiaries. Under Choice 2, eligible individuals could enroll in an FEHBP-style private health plan. To qualify for participation, private plans would be required to guarantee a level of benefits at least as generous as those offered to members of Congress and federal employees under FEHBP.

Bill Name	AmeriCare Health Care Act of 2007	Medicare for All Act
	Under Choice 2, private health plans would be required to comply with minimum benefit levels required of private plans participating in Medicare Part C, with payment rates based on the adjusted average per capita cost (AAPCC) methodology.	
Premium and cost-sharing requirements	Premiums would be established by HHS based on the cost of coverage (determined on a state-by-state basis and taking into account administrative expenses) and enrollment class (e.g., individual, couple or family). Premiums would be reduced for employed enrollees because employers would be required to make a contribution on behalf of their enrolled employees. Individuals receiving equivalent coverage through their employers would not be required to enroll in AmeriCare and would not be required to pay any premiums. Premiums would be collected using a mechanism similar to payroll tax withholding and would be reconciled through annual income tax filing. Enrollees in Choice 1 would be subject to the following cost-sharing requirements: • Deductibles of $350 for individuals and $500 for families; • 20 percent coinsurance; • Out-of-pocket cap of $2,500 for individuals and $4,000 for families; Special cost-sharing provisions would be as follows: • Special eligibility categories (children, pregnant women and low-income individuals below 200 percent FPL) would pay no cost-sharing; • Total out-of-pocket spending (premiums, deductibles and coinsurance) would be capped at 5 percent of annual income for individuals and families between 200-300 percent FPL; • Total spending would be capped at 7.5 percent for individuals and families with income between 300-500 percent FPL; • Premium subsidies would be provided to families with annual income less than 300	Enrollees in Choice 1 would be subject to the following cost-sharing requirements: • Enrollees would pay cost-sharing – including deductibles, coinsurance and copayments – for all Medicare Part A and Part B services; • For prescription drug benefits, enrollees would pay cost-sharing – including deductibles, coinsurance and copayments – applicable under the Blue Cross/Blue Shield Standard FEHBP plan as in effect on January 1, 2007; • For preventive services, enrollees would pay cost-sharing – including deductibles, coinsurance and copayments – consistent with the cost-sharing levels under Medicare Part A or Part B; • For EPSDT and home and community-based services, enrollees would pay nominal cost-sharing – including deductibles, coinsurance and copayments – that is consistent with cost-sharing levels for these services under the Medicaid program as in effect on January 1, 2007; and • Low-income individuals would pay reduced cost-sharing amounts at least as protective as the cost-sharing levels for Qualified Medicare Beneficiaries (QMBs) under Medicaid as in effect on January 1, 2007.[5] • A premium would be established for members of the same family. Enrollees in private plans under Choice 2 would be subject to cost-sharing requirements established by the individual plans. Beneficiary protections applicable under FEHBP and Medicare Advantage (Medicare Part C) would apply to enrollees in private plans.

[5] See SSA § 1902(a)(10)(E). States must cover Medicare Part A and Part B premiums, deductibles and coinsurance for elderly and disabled individuals who are eligible for Medicare Part A, have incomes less than 100 percent FPL, and have resources that do not exceed twice the SSI resource standards. SSA § 1905(p); 42 C.F.R. § 406.1 *et seq.*

Bill Name	AmeriCare Health Care Act of 2007	Medicare for All Act
	percent FPL and for individuals who receive Temporary Assistance for Needy Families (TANF) or Supplemental Security Income (SSI) (i.e., individuals receiving welfare or disability payments); and • Pregnant women presenting for prenatal care during their first trimester would receive a 5 percent additional reduction in the fees for such services. Cost-sharing and out-of-pocket spending limits would be indexed to the consumer price index (CPI) after 2007.	
Incentives and federal subsidies	Premium subsidies would be provided to families with annual income less than 300 percent FPL and for individuals who receive Temporary Assistance for Needy Families (TANF) or Supplemental Security Income (SSI) (i.e., individuals receiving welfare or disability payments). • For individuals with a family income that is less than 200 percent of the applicable poverty level, the premium subsidy would be the amount that would reduce the premium obligation of the individual to zero. • For other individuals eligible for a premium subsidy, the subsidy would equal the product of the premium obligation of the individual (and family members) multiplied by the number of percentage points by which the individual's family income is less than 300 percent. Employers' contributions would be subsidies for their employees.	Health care providers participating under Choice 1 would be eligible for additional payments for meeting certain quality standards established by HHS.
Changes to public program(s)	AmeriCare would be secondary payer to Medicare. AmeriCare could be primary payer to group health plans. Medicaid and FEHBP would be prohibited from providing benefits that are duplicative to AmeriCare (that is, if enrollees have already received medical care under AmeriCare, Medicaid and FEHBP would not be permitted to pay for those services as well).	Enrollees would not be required to receive and would not be prohibited from obtaining benefits from other public health care programs, such as Medicaid, the State Children's Health Insurance Program (SCHIP) and programs sponsored by the Departments of Defense and Veterans Affairs. The new program would be the primary payer over other public health care programs.
Administration and oversight of the coverage expansion	Choice 1: The administrative structure of AmeriCare would be based on the current Medicare program, including the use of Medicare's certification, provider qualifications	Under Choice 1, HHS would consult with the Medicare Payment Advisory Commission (MedPAC) to set a payment schedule for providers and suppliers. Additional payments

Bill Name	AmeriCare Health Care Act of 2007	Medicare for All Act
	and Medicare Administrative Contractors (MACs). Medicare fraud and abuse provisions also would apply. Choice 2, HHS would enter into contracts with private health plans. These private plans would be subject to the same or similar requirements that govern insurance plans under Medicare Advantage (Medicare Part C). Private health insurance plans would be permitted to offer supplemental coverage to AmeriCare enrollees, but would be required to comply with standards established by HHS. These standards would include consumer protections and the prohibition of duplication of benefits.	would be made to those providers and suppliers that achieve certain levels of quality established by HHS. These quality standards would include the use of health information technology. Under Choice 1, HHS also would enter into contracts with health care providers, taking into account the types of contracts currently used with participating providers under Medicare. Under Choice 2, HHS would enter into contracts with private health plans so long as the plans meet the following requirements: • The plans would be required to offer a package of benefits equivalent to those provided by any of the four largest health benefits plans offered under FEHBP. • The plans would be prohibited from offering financial payments or rebates to enrollees; • The plans would be required to provide enrollees with a level of beneficiary safeguards no less protective than required under both FEHBP and Medicare Advantage (Part C); and • The plans would have to comply with requirements established by HHS relating to licensure and solvency, protection against fraud and abuse, inspection, disclosure, periodic auditing, and administrative operations and efficiencies. HHS would take into account similar requirements under FEHBP and Medicare Part C in arriving at this set of requirements.
Financing	A new AmeriCare trust fund would be based on the Medicare trust fund model and would be used to support program operations. All premiums would be deposited into the AmeriCare trust fund, as would new "maintenance of effort" payments that states could be required to pay. These payments would be equal to the amount that the state would have paid under Medicaid and SCHIP in the absence of AmeriCare. Employers would be required to contribute 80 percent of the premium for AmeriCare coverage or to provide coverage equivalent to AmeriCare. HHS would be authorized to impose additional liability for employers to the extent it is necessary to prevent adverse selection into AmeriCare. Employer contributions for part-time employees would be reduced based on the ratio of hours	In addition to existing taxes, the new program would be financed through a new tax imposed on employees (1.7 percent of wages in excess of $25,000) and a new tax on employers (7.0 percent of wages). Self-employed individuals would be subject to a new tax (the sum of 1.7 percent of self-employment income in excess of $25,000 plus 7.0 percent of self-employment income).[6] The taxes would only apply to income or wages paid to an individual who is enrolled in the program or whose family member(s) is enrolled in the program during the period. A new Medicare for All Trust Fund would be established. Funds accrued under the new payroll taxes would be placed directly into the Trust Fund.

[6] The taxable wage and income amounts applicable to employees and self-employed individuals would be adjusted beginning after 2008 for cost-of-living changes.

Bill Name	AmeriCare Health Care Act of 2007	Medicare for All Act
	worked per week divided by 40 hours. Employers would begin contributions on January 1, 2010, although employers with fewer than 100 employees would have until January 1, 2013 to comply. Covered individuals and families must satisfy the remaining portion of premiums.	
Payments to Providers and Plans	The Secretary is directed to develop a new schedule of Diagnosis Related Groupings (DRGs) for use in reimbursing providers for AmeriCare paid services. Under Choice 1, payments to health care providers for benefits would be made on the same basis as under the Medicare program, using the new DRG schedule. Payment must be made on an assignment-related basis. HHS would establish a global fee for obstetrical services provided throughout the course of pregnancy with a 5 percent increase in the fee schedule amount for women presenting for prenatal care during the first trimester. HHS would establish a fee schedule for outpatient prescription drugs. Under Choice 2, participating private plans would be paid a per enrollee rate by HHS. This amount, referred to as the "annual per capita amount," would be calculated by HHS based on the average cost of benefits per enrollee under the entire new program.	Private plans participating under Choice 2 would be paid a per enrollee rate by HHS. This amount, referred to as the "annual per capita amount," would be calculated by HHS based on the average cost of benefits per enrollee under the entire new program (including both individuals enrolled and not enrolled under private health plans). Payments to private health plans by HHS would be risk-adjusted. Risk adjustment factors would be similar to those used for payments to private plans under Medicare Advantage (Medicare Part C), and HHS also would ensure that payments are adjusted to reflect the health status of enrollees.
Key dates for implementation	January 1, 2010	18 months after date of enactment of statute.
Other key elements of the bill	Current Medicare benefits would be modified to conform with the new AmeriCare benefit package. HHS would develop an enrollment process, including a process for automatic enrollment of individuals at birth. Individuals could opt-out of AmeriCare coverage upon demonstrating coverage under a group health plan that is at least equivalent to AmeriCare coverage. HHS would establish standards for an electronic system to verify an individual's entitlement to benefits, to track out-of-pocket spending and to verify enrollment of qualified providers within 12 months of the bill's enactment. HHS also would establish a website accessible to providers and private health plans to verify enrollees' eligibility and liability for cost-sharing.	Individuals would be deemed to be enrolled automatically upon birth in the U.S. or upon time of legal immigration into the U.S. During the phase-in period, if an individual is eligible for benefits, each member of the individual's immediate family who is a U.S. citizen or a legal immigrant not otherwise eligible for health care coverage under the Medicare program would be eligible for such benefits. Enrollees would not be prohibited from obtaining supplemental coverage through private health insurance. Employers would not be prohibited from providing or funding, pursuant to a collective bargaining agreement, supplemental or improved benefits for individuals who are entitled to benefits under the program.

Bill Name	AmeriCare Health Care Act of 2007	Medicare for All Act
	HHS would establish national standards for claims submission within 6 months of enactment. The standards would be developed in coordination with standards for electronic medical records and would take into account recommendations of current task forces. HHS would promulgate standards for electronic medical records no later than January 1, 2009. Health care providers that fail to comply with uniform and electronic claims requirements would be subject to a civil monetary penalty of either $100 per day or the amount of the claim, whichever is greater, for each violation. Providers would have 36 months after the effective date of the bill to comply with the new standards. Health care providers would be required to maintain electronic medical record data for all patients and transmit electronically upon request by HHS as a condition of participation by January 1, 2010. Civil monetary penalties of $100 would be levied on any AmeriCare supplemental plan that fails to comply with electronic medical record standards. During or after FY 2008, hospitals would be required to use uniform cost reporting.	Under Choice 2, there would be an annual open enrollment process when individuals could enroll, terminate enrollment, or change health plans. This process would be similar to the FEHBP annual open enrollment process. The legislation places a "maintenance of effort" requirement on states' Medicaid plans. States would be prohibited from reducing standards of eligibility or benefit levels provided under their Medicaid plans. Violation of this requirement could lead to ineligibility for federal financial participation. Obligations to provide or fund health care benefits under group health plans that were established or maintained by collective bargaining agreements between employee representatives and employers in effect on the date of enactment would not be affected by the Act. The Act would not apply to eligible individuals covered by such a group health plan until the applicable collective bargaining agreement terminates. The group health plan may, in accordance with an agreement between the parties, limit coverage under the plan to individuals who are ineligible for the Medicare for All program.

TABLE A-6. ANALYSIS OF THE "ENDING THE MEDICARE DISABILITY WAITING PERIOD ACT OF 2007"

Bill Name	Ending the Medicare Disability Waiting Period Act of 2007
Bill number(s)	S. 2102/H.R. 154
Bill sponsor(s)	S. 2102 is sponsored by Senator Bingaman and has 15 cosponsors. H.R. 154 is sponsored by Representative Green and has 79 cosponsors.
Latest Congressional action	S. 2102 was referred to the Senate Finance Committee on September 26, 2007. H.R. 154 was referred to: • The House Committee on Ways and Means, Health Subcommittee and Social Security Subcommittee on January 24, 2007; • The House Energy and Commerce Health Subcommittee on February 2, 2007; and • The House Transportation and Infrastructure Committee Railroads, Pipelines, and Hazardous Materials Subcommittee on March 5, 2007.
Basic structure of coverage expansion	Phases-out the 24-month waiting period for individuals under age 65 to be eligible for Medicare on the basis of disability. In addition, the bill would create new Medicare eligibility for individuals suffering from fatal diseases that are identified by the Secretary of Health and Human Services (HHS).
Description of target population	This expansion would target non-elderly disabled individuals and individuals suffering from fatal diseases.
Eligibility criteria	Individuals under age 65 would become eligible for Medicare on the basis of disability (i.e., individuals receiving Social Security Disability Insurance or a railroad disability annuity based on total disability). In addition, individuals with life-threatening diseases that are identified by HHS as fatal without medical treatment. In compiling the list of diseases, HHS would be required to consult with the Director of the National Institutes of Health, the Director of the Centers for Disease Control and Prevention, the Director of the National Science Foundation and the Institute of Medicine of the National Academy of Sciences (IOM).
Benefits	Eligible individuals would be covered for the full range of benefits under the Medicare program. The waiting period for beneficiaries eligible for Medicare based on disability would be phased-out as follows: • In 2008, the waiting period would be reduced to 18 months; • In 2009, 16 months; • In 2010, 14 months; • In 2011, 12 months; • In 2012, 10 months; • In 2013, 8 months; • In 2014, 6 months; • In 2015, 4 months; • In 2016, 2 months; and • In 2017 and each subsequent year, 0 months. Similar to the current policy for individuals with amyotrophic lateral sclerosis, there would be no waiting period for individuals with life-threatening diseases.

Bill Name	Ending the Medicare Disability Waiting Period Act of 2007
Premium and cost-sharing requirements	New beneficiaries would be subject to the same cost-sharing requirements currently in place under the Medicare program.
Incentives and federal subsidies	None specified.
Changes to public program(s)	The legislation would expand the population of eligible Medicare beneficiaries.
Administration and oversight of the coverage expansion	The expansion would retain the current Medicare administrative structure.
Financing	No funding source is specified for coverage of the new eligible populations. The bill would authorize $750,000 for an IOM report (discussed below).
Key implementation dates	"No sooner than" 90 days after the enactment date of the legislation. **Note:** S. 2102 also specifies that the bill's provisions would become effective no earlier than January 1, 2008.
Other key elements of the bill	The legislation would require HHS to request a study from the IOM on the range of disability conditions that could be delayed or prevented if individuals receive access to health care services and coverage before the condition renders the individual "disabled." Results of the study would be submitted to Congress within 2 years after the date of enactment of the legislation.

TABLE A-7. ANALYSIS OF THE "KIDS COME FIRST ACT OF 2007"

Bill Name	Kids Come First Act of 2007
Bill number(s)	S. 95/H.R. 1111
Bill sponsor(s)	S. 95 is sponsored by Senator Kerry and has seven cosponsors. H.R. 1111 is sponsored by Representative Waxman and has 43 cosponsors.
Latest Congressional action	S. 95 was referred to the Senate Committee on Finance on January 4, 2007. H.R. 1111 was referred to: • The House Committee on Education and Labor, Subcommittee on Health, Employment, Labor, and Pensions on June 5, 2007; • The House Committee on Ways and Means, Subcommittee on Health on March 7, 2007; and • The House Committee on Energy and Commerce, Subcommittee on Health on February 27, 2007.
Basic structure of coverage expansion	Expands coverage for children by increasing access to public and private coverage in several ways. The bill would: • Provide 100 percent federal financing of children in poverty in Medicaid in exchange for states expanding coverage to children under Medicaid and the State Children's Health Insurance Program (SCHIP) and streamlining enrollment procedures; • Create a refundable tax credit for amounts paid to cover children through private health insurance; • Require group market insurers to offer individuals the option to purchase dependent coverage (without a required employer contribution); • Reduce individuals' federal tax exemptions proportionate to the length of time that dependent children are uninsured during the taxable year; and • Require 100 percent forfeiture of the dependent tax exemption for any uninsured child (not applicable to the lowest income tax bracket).
Description of target population	Children in families with incomes that do not exceed 300 percent of the federal poverty level (FPL) could be covered under Medicaid and SCHIP. Children in families with incomes in excess of 300 percent FPL could "buy-in" to SCHIP. Tax credit and tax exemption forfeiture would apply to children regardless of family income.
Eligibility criteria	States would have the option of expanding Medicaid and SCHIP eligibility to: • Children up to age 21 in families with annual incomes not exceeding 300 percent FPL (up from SCHIP's current limit of 200 percent FPL and children through age 18); • Legal immigrant children under age 21 lawfully residing in the United States; and • Low-income children under age 21 of state employees.
Benefits	States could elect to receive an enhanced Federal Matching Assistance Percentage (FMAP) for Medicaid in exchange for making all children (under age 21) in families with annual incomes that do not exceed 300 percent FPL eligible for Medicaid or SCHIP. The Medicaid FMAP is the percentage of a state's Medicaid expenditures that is paid for by the federal government.

Bill Name	Kids Come First Act of 2007
	For a state electing this option, enrolled children would receive: • Benefits under SCHIP if their families' incomes are between 100 and 300 percent FPL; or • Coverage through the state-subsidized purchase of dependent coverage under a group health plan (so long as the Secretary of Health and Human Services (HHS) determines that the coverage is consistent with the benefit standards under SCHIP, and the state provides wraparound coverage either under Medicaid or SCHIP to ensure that all children receive the same level of benefits regardless of the source of coverage). States electing this option also would be required to permit families with incomes exceeding 300 percent FPL to purchase full or wraparound coverage for children under age 21 under SCHIP at the full cost of providing such coverage. States would no longer be prohibited from providing SCHIP coverage to children of low-income state employees, and would have the option of offering supplemental coverage to children in SCHIP, even for children covered by other insurance. States could provide coverage for legal immigrant children under age 21 through Medicaid or SCHIP. Under current law, states are generally prohibited from providing anything other than emergency medical services under the Medicaid or SCHIP programs to legal immigrants until these individuals have been in the country for at least five years. States would be required to pay health care providers for services provided to Medicaid-eligible children at payment rates that are no less than the average rates for similar services established under the benchmark benefit packages for SCHIP. (These benchmark benefit packages include children's health insurance coverage equivalent to the Federal Employees Health Benefits Plan (FEHBP), state employee coverage, or coverage offered through the health maintenance organization with the largest insured commercial, non-Medicaid enrollment). States also would be required to ensure that these payment rates are adequate to guarantee that children enrolled under Medicaid or SCHIP have adequate access to comprehensive care, subject to quality assurance and utilization review processes. The legislation does not specify coverage requirements for individuals claiming the refundable tax credit or for coverage provided through an employer-sponsored Plan, Medicaid or SCHIP. Group market insurers would be required to offer every beneficiary the option to purchase dependent coverage. No employer contribution for dependent coverage would be required.
Premium and cost-sharing requirements	No specified modifications to established Medicaid or SCHIP requirements.
Incentives and federal subsidies	The Federal government would provide 100 percent FMAP for coverage of children in families with incomes that do not exceed 100 percent FPL, and SCHIP funding would no longer be capped, if states agree to: • Cover all children in families up to 300 percent FPL in Medicaid or SCHIP; • Permit higher-income families to purchase SCHIP coverage, either full or wraparound coverage; and • Remove enrollment and access barriers while maintaining current Medicaid eligibility levels for children.

Bill Name	Kids Come First Act of 2007
	The legislation would require federal, state and private payers to provide individuals and families with information that shows the amounts expended for child health coverage each year. The legislation would create a new refundable tax credit for health insurance coverage for children. The credit would be equal to the amount paid for qualified health insurance for a dependent child under the age of 19 during a taxable year that exceeds 5 percent of the taxpayer's adjusted gross income. This exemption would not be available to an individual who is the dependent of another individual. Any deductions taxpayers would have taken for medical expenses or high-deductible health plans would be reduced by the credit allowed under this bill. The personal tax exemption currently available to taxpayers for dependent children would be reduced according to the length of time the dependent children go without qualified health insurance. Failure to provide proof of health coverage for a dependent child would be penalized by a full reduction in a taxpayer's personal tax exemption. These provisions would not apply to taxpayers in the lowest tax bracket.
Changes to public program(s)	States would receive 100 percent FMAP for children under age 21 in poverty covered by Medicaid if states agree to expand coverage in Medicaid and SCHIP to children up to 300 percent FPL, allow children in families with incomes greater than 300 percent FPL to purchase coverage in SCHIP, and simplify enrollment procedures. These states also would be required to offer coverage to low-income legal immigrant children under their SCHIP programs. These states must offer "presumptive eligibility" for children under state Medicaid plans and SCHIP, which provides up to two months of coverage while a child's income eligibility is being verified. They would be prohibited from imposing any waiting lists, waiting periods or other limitations or barriers on the eligibility or enrollment of children for assistance under SCHIP. The increase in FMAP would not apply to disproportionate share hospital payments, payments made under the Temporary Assistance for Needy Families (TANF) program or SCHIP. States that expand coverage under the legislation would be guaranteed funding through the elimination of SCHIP payment caps for the fiscal year(s) at issue. Eligibility determination and re-determination processes would be revised as follows: • States would be required to provide 12-month continuous eligibility for children described under this legislation; • States could not require face-to-face interviews for initial eligibility determinations or re-determinations for children under Medicaid or SCHIP. Applications and renewals by mail, telephone and internet would be sufficient; • States would be required to use all information already possessed and to avoid duplication of information requests from parents; • States would be required to accept eligibility determinations by other federal programs; and. • States would be required to accept a family's certification with regard to income, and would not be permitted to apply an asset test to determine coverage for a child. States would have to maintain eligibility income, resources and methodologies no more restrictive than those already currently applied to children under Medicaid.
Administration and oversight of the coverage expansion	No new administrative or oversight measures or responsibilities would be added.

Bill Name	Kids Come First Act of 2007
Financing	The legislation would appropriate amounts necessary to accomplish the expansion of Medicaid and SCHIP coverage. The legislation includes provisions to prevent substitution of Medicaid or SCHIP payment for other health coverage, to ensure that Medicaid and SCHIP are secondary payers for services and to apply enhanced federal matching for Medicaid funds. *S. 95 only*: A partial repeal of the rate reduction in the highest federal income tax bracket would be used to help finance the coverage expansions. The Secretary of the Treasury would determine what the new rate would be to provide sufficient revenues to offset any federal outlays required to implement the legislation.
Key implementation dates	January 1, 2007 for several tax provisions; October 1, 2007 for all other provisions.
Other key elements of the bill	None other than as discussed above.

TABLE A-8. ANALYSIS OF THE "SMALL BUSINESS HEALTH FAIRNESS ACT OF 2007"

Bill Name	Small Business Health Fairness Act of 2007
Bill number(s)	H.R. 241[7]
Bill sponsor(s)	H.R. 241 is sponsored by Representative Sam Johnson and has 67 cosponsors.
Latest Congressional action	H.R. 241 was referred to the House Committee on Education and Labor, Subcommittee on Health, Employment, Labor, and Pensions on May 9, 2007.
Basic structure of coverage expansion	Permits certain trade or industry associations, cooperatives and employer groups to provide health benefits to their members across the country through association health plans (AHPs). AHPs would be a new type of health plan available to eligible employers. AHPs could offer both self-funded and fully-insured health coverage. Self-funded benefits would be paid for by the AHP and the AHP would bear the financial risk for the medical claims. Fully-insured benefits would be purchased from a health insurer and the insurer (not the AHP) would bear the financial risk for the medical claims. The certification of AHPs would be the responsibility of the federal government. Self-funded AHPs would be subject to federal oversight, new federal rules and relevant state tax requirements. Fully-insured AHPs would be subject to oversight only by the state in which the AHP's licensure and coverage is approved. AHP would be exempt from certain state requirements regarding benefit mandates, but not those regarding coverage of specific diseases.
Description of affected small employers, employees and individuals	Small employers that are members of qualified associations, cooperatives or employer groups could provide coverage to their employees through an AHP. In addition, self-employed individuals and large employers that are members of the sponsoring entity could have access to coverage through the AHP.
Eligibility criteria for small employers, employees and individuals	Employers must be a member or affiliated member of the sponsoring entity,[8] or the sponsoring entity itself, to offer coverage through an AHP. Employers offering coverage through an AHP could not pay for employees to purchase coverage in the individual market if the decision to purchase individual coverage is based on the employees' health status and the employees otherwise are eligible to obtain coverage through the AHP. To obtain coverage from an AHP, individuals must be active or retired owners (including self-employed individuals), officers, directors, employees or partners in a participating employer, or the beneficiaries of such individuals, For AHPs that existed prior to the enactment of this bill, an affiliated member of the plan sponsor could be offered coverage only if:

[7] The Small Business Growth Act of 2007 (H.R. 1012) introduced by Representative Vern Buchanan and the Working Families Wage and Access to Health Care Act (H.R. 324) introduced by Representative Howard McKeon both have identical provisions to H.R. 241 with respect to association health plans. H.R. 1012 and H.R. 324 both include additional provisions that are not related to health care.

Bill Name	Small Business Health Fairness Act of 2007
	• The affiliate's membership had been in effect when the AHP received its certification from the Department of Labor (DOL); and • The affiliate had not offered health coverage during the preceding year.
Benefit requirements for private insurers, health plans or other entities offering coverage	AHPs would be required to adhere to federal laws related to coverage for maternity stays, mental health benefits and reconstructive surgery following a mastectomy, as applicable. AHPs would not have to comply with state benefit requirements and could offer benefit packages that do not cover all of the benefits, services or types of providers required by state rules, subject to one exception for fully-insured AHPs. Fully-insured AHPs would be required to comply with state rules for covering individuals with specific diseases required by the state of domicile (e.g., diabetes or AIDS).[9]
Premium requirements for private insurers, health plans or other entities offering coverage	Rates for any small employer may not vary on the basis of the health status of any employee or their beneficiaries, or on the basis of the type of business or industry in which the employer is engaged. Rates may vary based on the claims experience of the plan or may vary to the extent the rates would otherwise vary under the methodology used by the domicile state for regulating the small group market for bona fide associations. For self-insured plans, rates must be sufficient, in the opinion of a qualified actuary, to fund the plan's reserves for unearned contributions, benefit liabilities including administrative costs, other plan obligations, a margin of error and other fluctuations, and the establishment of aggregate and specific excess and stop loss insurance and solvency indemnification.
Requirements for private insurers, health plans or other entities offering coverage	An AHP must be sponsored by a permanent and active entity, such as a bona fide trade or industry association, professional association or employer group (e.g., a chamber of commerce). Franchisers also could establish an AHP for members of the franchise network. The sponsoring entity must meet the following criteria for at least three years before a plan could be certified as an AHP: • The sponsor must have been organized for substantial purposes other than obtaining or providing medical care; and • The sponsor cannot condition employer membership, dues or coverage under the AHP on the basis of factors related to the health of employees or dependents. Certain sponsoring entities need not meet all of the above criteria to establish a certified AHP, including arrangements that previously have provided coverage to 200 or more employers, have existed for at least ten years and are licensed in at least one state. These exemptions would not apply if, after the bill was enacted, the plan began providing coverage in a new state.

[8] The sponsor of an AHP is an organization with a constitution and bylaws as a bona fide trade association, industry association, professional association or chamber of commerce, including a corporation that operates on a cooperative basis for purposes other than obtaining or providing medical care.

[9] The state of domicile is the initial state in which the AHP licensure and coverage is approved. The AHP would not have to comply with the rules for coverage of specific diseases required by other states (i.e., states outside of the state of domicile).

Bill Name	Small Business Health Fairness Act of 2007
	An AHP would be required to have a board of trustees responsible for fiscal control and have rules in effect for the operation and control of the plan based on a three-year plan of operation. The board of trustees generally must comprise members of the sponsoring entity and could not include health care providers (e.g., health plan contract administrators or medical providers). AHPs would be required to permit all eligible employers to obtain coverage through the AHP in all geographic areas in which coverage is available. The AHP must comply with existing federal nondiscrimination rules related to the treatment of employees' pre-existing conditions and existing federal requirements for guaranteed renewal of coverage for multiple employer welfare arrangements (MEWAs).[10] AHP's offering self-funded coverage would be required to have a minimum of 1,000 enrollees. Such an AHP also must meet one of the following three criteria: • The plan offered self-funded coverage prior to the enactment of this bill; • The plan's sponsor represents a broad cross-section of trades and businesses or industries; or • The plan's participating employers represent one or more types of businesses listed in the bill or typically considered to have average or above average risk (e.g., experienced denials of coverage). Self-funded AHPs must comply with new federal solvency standards. The DOL could adjust these standards, as necessary. These new standards would require that self-funded AHPs: • Maintain a minimum surplus (in addition to reserves for claims) of at least $0.5 million, or as required by the DOL up to $2 million; • Maintain sufficient reserves to cover outstanding obligations of the plan (e.g., claims that have been incurred but not paid) and take into account fluctuations in expected expenses; • Purchase aggregate excess/stop loss insurance to cover unexpectedly high claims costs overall, which would provide, at a minimum, coverage for claims incurred above 125 percent of expected claims for the year; • Purchase specific excess/stop loss insurance to cover unexpectedly high claims for an individual, as recommended by the plan's qualified actuary; and • Purchase solvency indemnification insurance to pay for claims if the plan becomes insolvent. AHPs offering fully-insured coverage must sell coverage through state-licensed agents.
Federal subsidies	None.

[10] When two or more employers join together to offer health benefits to their employees, this coverage generally is considered a multiple employer welfare arrangement (MEWA) that is subject to applicable federal and state rules. The Department of Labor determines whether arrangements offering health coverage meet the definition of a MEWA. Federal rules require MEWAs to renew coverage for existing employers except under certain circumstances, such as when employers fail to pay premiums or the MEWA is ceasing to offer coverage in the geographic area where the employer is located.

Bill Name	Small Business Health Fairness Act of 2007
Administration and oversight of the coverage expansion	The DOL would have oversight responsibility for the certification of AHPs. The application for certification of a fully-insured or self-funded AHP would include information regarding: • The sponsor and its board of trustees; • The states in which the plan intends to offer coverage (and the number of employers and employees in each state); • Evidence that the plan is bonded; • Copies of health plan documents that would be provided to enrollees; and • Copies of agreements between the AHP and plan administrators or other service providers. The AHP would be required to notify each state in which at least 25 percent of participants are located that an application for certification was filed with DOL. Self-funded AHPs would be required to provide information about the plan's financial standing, including: • A statement certified by the board of trustees and signed by a qualified actuary attesting that the plan meets the federal financial requirements for self-funded AHPs; • A statement signed by a qualified actuary describing the adequacy of the contribution rates to pay all obligations and meet the surplus requirements for the upcoming year. If the contribution rates were not adequate, information must be provided about the changes needed to ensure adequacy; • A statement signed by a qualified actuary of the current and projected value of the plan's assets and liabilities for the upcoming year. This statement would identify separately administrative expenses and claims; and • A statement of the costs of coverage that would be charged and an itemization of the cost amounts for administration, reserves and other operating expenses for the plan. The board of trustees of a self-funded AHP would be required quarterly to ensure the plan meets all of the federal solvency rules for the plan. Upon discovery of failure to meet these rules, the board must obtain recommendations from the plan's actuary for correcting the failure and provide the DOL with such recommendations along with a description of the actions that have been or will be taken. The DOL could terminate an AHP plan if there were reason to expect that the plan is failing to meet federal solvency rules and does not have a corrective plan to restore compliance or is expected to continue to fail regardless of the corrective actions. The DOL would become the trustee for an insolvent AHP. The DOL would coordinate with the state of domicile regarding its enforcement and oversight of the certification of fully-insured AHPs or "classes" of AHPs, in accordance with the rules that the DOL establishes for the class certification of these plans. The DOL would identify a single state to consult with regarding the DOL's oversight and enforcement responsibilities for the certification of each AHP. In the case of a plan that provides health insurance coverage, oversight would be the responsibility of the state that initially approved the policy type. In any other case, the state would be the one in which enrollees live and the state in which the trust is maintained.

Bill Name	Small Business Health Fairness Act of 2007
	Self-funded AHPs would not be subject to state oversight and rules with one exception. Self-funded AHPs established after the bill's enactment would be subject to state tax rules related to health coverage. The tax imposed on AHPs would be reduced to reflect taxes paid on fully-insured products offered by the AHP. Fully-insured AHPs offering coverage in multiple states would be subject to the applicable rules of only the state of domicile. These applicable state rules include the rules for setting premiums, solvency and the prompt payment of claims. As noted above, AHPs would not have to comply with state benefit rules except for those state rules requiring coverage for specific diseases. Existing or new state rules precluding a fully-insured AHP from offering coverage would be superseded by this bill.
Financing	AHPs would pay the DOL a $5,000 fee to cover administrative costs for certification. Self-funded AHPs would contribute $5,000 annually to a newly created Association Health Plan Fund. This fund would be used by the DOL to continue the excess/stop loss and indemnification insurance coverage for plans unable to meet their financial obligations. The DOL could require that AHPs contribute additional amounts to the fund during the year, as required to sustain the fund. AHPs could face a late payment charge up to 100 percent of the payment due.
Key implementation dates	AHPs could begin offering coverage a year after the bill's enactment. By January 1, 2012, the DOL would report to Congress any effect that AHPs have had on reducing the number of uninsured individuals.
Other key elements of the bill	Non-member employers that are nonetheless eligible to become members of the entity sponsoring an AHP would be permitted to obtain similar coverage from the AHP in certain circumstances. The AHP must be offering fully-insured coverage and the AHP's insurer must offer similar coverage outside of the AHP to these employers. The bill would require the DOL to establish a solvency standards working group within 90 days of enactment. The recommendations of this working group would be considered by the DOL when setting the initial solvency requirements for AHPs. AHPs ceasing operations would be required to provide notice to enrollees at least 60 days in advance of a voluntary termination. The bill would change existing federal laws relating to state oversight of MEWAs in two ways: • MEWAs that become certified AHPs would no longer be subject to state laws for MEWAs; and • MEWAs that do not become certified AHPs would be subject entirely to state rules for MEWAs. (i.e., this bill would remove the current requirement for state rules on MEWAs to be consistent with certain provisions within the federal Employee Retirement Income Security Act (ERISA)).

TABLE A-9. ANALYSIS OF THE "HSA IMPROVEMENT AND EXPANSION ACT OF 2007"

Bill Name	HSA Improvement and Expansion Act of 2007
Bill number(s)	H.R. 3234
Bill sponsor(s)	H.R. 3234 is sponsored by Representative Cantor and has 46 cosponsors.
Latest Congressional action	H.R. 3234 was referred to the House Committee on Ways and Means on July 31, 2007.
Basic structure of coverage expansion	Amends Internal Revenue Code provisions relating to health savings accounts (HSAs) to: • Increase the annual HSA contribution limit; • Permit the use of HSAs to purchase health insurance; • Allow the use of HSA funds for medical expenses incurred 60 days prior to establishment of an HSA; • Temporarily allow individuals to maintain HSAs in combination with flexible spending accounts or health reimbursement accounts; • Allow some Medicare beneficiaries (Part A-only beneficiaries) and some veterans (those individuals exclusively eligible for service-connected disability benefits) to contribute to an HSA; and • Allow spouses to make increased "catch-up" contributions if only one spouse has an HSA.
Description of target population	The bill would affect any individual maintaining an HSA.
Eligibility criteria	The bill would expand HSA availability to individuals covered by: • Veterans Affairs benefits, but only if the recipient is exclusively eligible for service-connected disability benefits; or • Medicare Part A only. The bill would not otherwise modify existing eligibility criteria. In addition, the bill would not modify the requirement that all HSA holders be covered under a high-deductible health plan (HDHP), as currently defined.
Premium and cost-sharing requirements	No change from current HDHP requirements.
Incentives and federal subsidies	None specified.
Benefits	Allows individuals to maintain an HSA in combination with flexible spending arrangements (FSAs, commonly called flexible spending accounts) or health reimbursement arrangements (HRAs, commonly called health reimbursement accounts). Through 2012, the annual sum of FSA contributions, HRA reimbursements, and HSA contributions may not exceed the sum of the HDHP deductible and the individual's out-of-pocket minimums (exclusive of HDHP premiums and HRA/FSA amounts set aside for specified supplemental coverage). Increases maximum annual HSA contribution limits. The maximum annual contribution would be limited to the lesser of the annual HDHP deductible or either $4,500 (for individuals) or $9,000 (for individuals with family HDHP coverage). These thresholds would be inflation-adjusted from a 2007 base year. Current law limits the maximum annual contribution to the lesser of the annual HDHP deductible or either $2,250 (for individuals) or $4,500 (for individuals with family HDHP coverage) inflation-adjusted from a 1997 base year.

Bill Name	HSA Improvement and Expansion Act of 2007
	The existing "catch-up" contribution limit for married individuals where both spouses are over age 55 and eligible for an HSA, but only one spouse has an HSA is doubled. Allows HSAs to be used to purchase health insurance. Treats as a qualified medical expense (i.e., reimbursable from an HSA) a health expense made within 60 days prior to the person's effective date of coverage under an HDHP, even if the person did not have an HSA at the time of HDHP enrollment. Allows employers greater freedom to convert unused FSA or HRA benefits (that otherwise would be lost to the individual) into a one-time HSA deposit on behalf of the HSA beneficiary.
Changes to public program(s)	Allows Medicare Part A-only enrollees to contribute to an HSA. Allows Medicare beneficiaries participating in a Medicare Advantage Medical Savings Account (MSA) to contribute their own money to the MSA. Allows veterans receiving only Veterans Affairs service-connected disability benefits to contribute to an HSA.
Administration and oversight of the coverage expansion	None specified.
Key implementation dates	For contribution limits: Taxable years beginning after December 31, 2007. For provisions allowing participation in an HSA and an FSA or HRA: Taxable years beginning after December 31, 2007 and before December 31, 2012. For all other provisions: The taxable year beginning after the enactment of the Act.
Financing	None specified.
Other key elements of the bill	An eligible individual would, at the time of creation of the HSA, be permitted to disclaim coverage that would otherwise make the individual ineligible to contribute to an HSA.