APPROACHES TO COVERING THE UNINSURED: A GUIDE

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THE HENRY J. KAISER FAMILY FOUNDATION

THE KAISER COMMISSION ON Medicaid and the Uninsured

Approaches to Covering the Uninsured: A Guide

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INTRODUCTION

In 2007, 45 million individuals in the United States were uninsured. Not having health insurance limits people's ability to access care, which often results in worse health outcomes. The majority of people under age 65 obtain health coverage through their or a family member's employer. Public health care programs provide a safety net for low-income children and some adults, and a small percentage of the population buys coverage in the private individual market. Each type of coverage has strengths and weaknesses, but the gaps in the health care system leave many people vulnerable to health care access problems and high costs.

INTRODUCTION

More than one in six Americans under the age of 65, or 45 million individuals, lacked health insurance in 2007. Not having insurance affects decisions about whether and when to seek medical care. Increasingly, as health care costs have risen, being uninsured can also have significant financial consequences for families, leading to medical debt and even bankruptcy. For these reasons, developing solutions to address the problem of the uninsured has become a pressing public policy concern.

In the absence of federal action, a number of states have adopted different strategies to expand coverage to the uninsured. Massachusetts, Vermont, and Maine have implemented comprehensive health reform, while other states are undertaking more limited reforms designed to improve the accessibility and affordability of health care. Although state efforts vary in approach and scope, many of these plans and proposals include shared responsibility between individuals, employers, and government, an expansion of public coverage, and mechanisms to subsidize premiums.

Massachusetts' health reform plan has been at the forefront of state efforts, and as of March 2008, the state had enrolled 440,000 previously uninsured individuals. Other states, such as Illinois, have been successful in covering children. While these states have improved the accessibility and affordability of health care for some people, all states face enormous financial challenges that limit their ability to provide adequate coverage to more people. These experiences illustrate that all states will not be able to achieve health reform on their own, but we can learn from these pacesetting states to inform future federal action.

This need for a federal solution has sparked a debate over how best to organize the health care system to provide coverage to the 45 million uninsured Americans. National public opinion polling indicates that health care is an important issue for many Americans. Especially in uncertain economic times, the security of having affordable health insurance is a priority for people. In response to this interest, health care was a key issue in the 2008 presidential campaign, with both major party candidates announcing comprehensive reform plans (For more information about the presidential candidates' health care plans, please see: www.health08.org).

With the renewed interest in reducing the number of uninsured, many strategies to address the problem have emerged. The purpose of this Guide is to describe these myriad strategies. While not exhaustive, the options presented here represent the major approaches to increasing the number of Americans with health insurance coverage.

Current Sources of Health Coverage

The current structure for providing health care coverage represents a mixture of private and public insurance. The majority of non-elderly[1] Americans receive health insurance through their or a family member's employer (Table 1). For those with low incomes, public programs, such as Medicaid and the State Children's Health Insurance Program (SCHIP), serve as their primary source of coverage. There is a small individual health insurance market, which is typically used by those without access to employer-provided coverage and who are not eligible for public coverage. The gaps in the current system leave 17 percent of the population uninsured.

The following section describes the different ways in which people currently obtain health coverage, highlighting the strengths and weaknesses of each source. It is in this context that proposals to expand coverage have been developed. Some would build on the strengths of the current system while others offer new approaches for organizing and providing health coverage. These strategies are described in subsequent sections of this Guide.

TABLE 1

Health Insurance Coverage of the Non-Elderly Population, 2007
Percent Distribution

	Private		Public*		
	Employer	Individual	Medicaid	Other	Uninsured
Total population under age 65	60.9%	5.5%	13.9%	2.5%	17.2%
By age					
Children < age 19	55.3%	4.4%	27.6%	1.4%	11.3%
Adults age 19+	63.2%	6.0%	8.0%	3.0%	19.7%
By income					
< 100% FPL	14.1%	5.7%	41.4%	3.4%	35.4%
100–199% FPL	38.3%	6.1%	22.7%	3.9%	29.0%
200–399% FPL	70.6%	5.6%	6.8%	2.4%	14.5%
> 400% FPL	86.5%	5.0%	2.0%	1.5%	4.9%

* SCHIP is included in Medicaid; most of "other" is Medicare and military-related coverage.

Source: Kaiser Family Foundation. The Uninsured: A Primer, Supplemental Data Tables, October 2008.

Employment-based Coverage

The majority of the non-elderly population receive their health benefits through their or a family member's employer. However, the percentage of the non-elderly with employer-based coverage has declined since 2000. Under this type of coverage, the risk of having health care costs is typically pooled across a large number of people, allowing premium costs to be paid based on the average medical cost for the group. While pooling costs works for large employers, it does not work as well for small employers who struggle to afford coverage for their employees. In 2008, the average premium cost for employment-based coverage was $4,700 for single coverage and over $12,600 for family coverage.[2]

Although employers pay a large share of the premium costs, health insurance may still be unaffordable for employees. From 2000 to 2007, the employee share of the premium costs more than doubled and out-of-pocket costs increased. In 2004, nearly 17 percent of those with private employment-based coverage faced out-of-pocket costs that exceeded 10 percent of their family income.[3] Rising health care costs have led employers to offer more limited benefit packages that do not provide broad coverage, thereby increasing out-of-pocket costs. These changes leave many insured individuals at risk of not being able to afford needed medical care.

The availability of employment-based coverage varies by the size of the employer and by the type of industry—smaller employers and those in the service, construction, and agriculture industries are less likely to offer coverage. The percentage of people with employment-based coverage also varies by income—in 2007, just over 14 percent of those in poverty had employment-based health benefits, while over 86 percent of people with incomes greater than four times the poverty level had such coverage.[4]

Employment-based Coverage

Strengths:

- Provides coverage through an insurance pooling mechanism that typically does not contain medical underwriting and reduces administrative costs.
- Coupled with employer contributions, products are more accessible and affordable for employees.
- Employers (especially large ones), as insurance purchasers, play a significant role in efforts to improve the quality and value of health care.

Weaknesses:

- Coverage has declined, especially among smaller employers, in certain industries, and in firms with low-wage workers.
- Even if employers offer coverage, all employees may not be eligible.
- Employers decide which plan(s) to make available, limiting employees' choices.
- Coverage offered to employees may be unaffordable and may include limited benefits, which increase out-of pocket costs for services.
- When individuals change jobs, they are often forced to change their insurance coverage and health care providers, or go without coverage.

Public Program Coverage

Approximately 14 percent of the non-elderly population has public health insurance coverage, predominantly through Medicaid and SCHIP. Medicaid is a federal program that provides health coverage to 60 million people, primarily low-income children, parents, and the disabled. The program is funded jointly by the federal government and the states. Federal law outlines broad requirements for Medicaid, but states have discretion regarding program dimensions, such as eligibility, benefits, and provider payments. SCHIP builds on Medicaid, by providing health coverage to children who are in families with incomes that are too high to qualify for Medicaid but are too low to afford private health insurance. In 2005, over 6 million children were enrolled in SCHIP. Medicaid and SCHIP programs and eligibility vary across states.

This Guide focuses on the non-elderly population since most Americans 65 and older have health care coverage through another federal program, Medicare. Some of the strategies discussed later in this guide would expand Medicare to cover some or all of those under age 65.

Public programs provide an important safety net of coverage for low-income families and disabled adults, but there are significant gaps in this coverage. Medicaid and SCHIP offer broad coverage for children. However, federal funding for SCHIP is capped, which hinders state efforts to expand this program to cover more children. Most states have much lower income eligibility thresholds for parents. Additionally, federal rules limit states' ability to provide Medicaid to non-disabled adults who do not have dependent children. Consequently, over one-third of the uninsured are low-income adults without children.

Public Program Coverage

Strengths:

- Provides health care coverage for low-income families and those with disabilities who lack access to private health coverage.
- Provides an important source of coverage for those with high health care costs who are unable to find affordable private individual health care coverage.
- Benefits and cost-sharing are tailored to a low-income population with higher health care needs.

Weaknesses:

- Programs do not provide benefits for all individuals and families who need assistance accessing health care coverage.
- As low-wage families change jobs and their incomes fluctuate, they move in and out of public programs, resulting in changes in coverage and providers, and periods of uninsurance.
- Eligibility for public programs varies substantially across states, creating inequities in coverage.
- Cost-sharing may be unaffordable for some families.

Individual Coverage

Individuals who do not have access to employment-based health coverage and are not eligible for public coverage may purchase insurance on their own through the individual insurance market. The individual market is regulated independently by each state, and therefore benefits and costs vary across the country. Approximately 6 percent of the non-elderly population (14 million) has individual coverage, a percentage that has remained stable over time.

In the individual market, consumers have the option to choose between different plans and benefit packages, enabling them to purchase the level of health coverage they need depending on their current health status and foreseeable future needs. Individual coverage allows people to keep their same insurance and providers regardless of whether they change or lose their job.

Because employers do not contribute to the cost of individual coverage, consumers have to pay for the entire premium cost, in addition to other out-of-pocket costs. This can be very expensive, especially for people with medical problems. In many states, insurance companies can charge higher premiums for people based on their age, gender, and health status, and they can deny coverage to people who have pre-existing medical conditions. The combination of having to pay the entire premium cost and insurance companies' ability to charge higher premiums based on an individual's or family's characteristics, often makes individual coverage unaffordable.

Individual Coverage

Strengths:

- Individuals and families can choose from various health care plans, picking the one that best meets their needs.
- Individuals can keep the same insurance coverage and health care providers when they change or lose their job.

Weaknesses:

- Policies can be expensive and often have high cost-sharing requirements.
- In many states, insurance companies may deny coverage to individuals with pre-existing medical conditions.
- In many states, insurance companies may charge higher premiums based on an individual's age, gender, and health status.

APPROACHES TO COVERING THE UNINSURED

While there is general agreement that the problem of the uninsured needs to be addressed, there is little agreement over how best to expand coverage. A wide range of policies targeting every segment of the health care system have been suggested as potential strategies for broadening coverage. These strategies differ in terms of their scope—some seek incremental changes while others would attempt major restructuring of the system—and who they target—some would focus only on the uninsured while others would promote coverage for all Americans. They also offer different mechanisms for achieving coverage expansions.

This Guide describes the many policy options and strategies that are currently being discussed by key stakeholders, including lawmakers, researchers, employers, health care industry representatives, providers, and advocates. These strategies are organized into the following four sections:

- Strengthen current coverage arrangements;
- Improve the affordability of coverage;
- Improve the availability of coverage;
- Change the tax treatment and financing of health insurance.

These approaches are discrete strategies and can be combined in different ways to achieve broader coverage. The various combinations reflect different views on how the health care system should be organized and financed. This report concludes with a discussion of current health care reform proposals.

STRENGTHEN CURRENT COVERAGE ARRANGEMENTS

One approach to increasing the number of Americans with health insurance is to build on the existing health care system. Multiple strategies could be used to enhance one or more of the current sources of coverage. These strategies would seek to improve employment-based coverage, expand public coverage, and strengthen the individual market.

STRENGTHEN CURRENT COVERAGE ARRANGEMENTS

One approach to expanding coverage is to build on the current health care coverage structure. This strategy seeks to reduce the number of uninsured by enhancing one or both of the major sources of coverage: employment-based coverage and public program coverage (largely Medicaid and SCHIP) for families with low incomes. This approach also attempts to improve the individual market.

BUILD ON EMPLOYMENT-BASED COVERAGE

The federal tax code provides incentives for employers to offer health benefits to their employees and for employees to purchase those health benefits. Under the current tax system, employers can deduct from their corporate taxes the cost of employee health benefits. For employees, health benefits provided by an employer are not treated as taxable income for purposes of calculating both income and payroll taxes. In contrast, individuals who are not covered under an employment arrangement and purchase coverage in the individual market do not receive such preferential tax treatment.

Employers, especially large employers, provide a convenient pooling mechanism through which insurance can be offered with lower administrative and marketing costs than in the individual market. Additionally, employers offer benefits, such as health insurance, in a competitive labor market to attract and retain workers. However, while employers remain the dominant source of coverage, this coverage is declining, in part because small employers face higher costs than larger employers and many struggle to afford coverage for their workers.

The rationale for enhancing the employment-based coverage system is that it remains the dominant system for three-fifths of the population. Building on that base would cause the least structural disruption, and would allow people who are happy with their coverage to continue that coverage. Additionally, employer contributions, and the tax benefits of those contributions, are a critically important part of current health care financing, making coverage more affordable for employees and their families.

There are two basic ways to build on the employment-based system: mandates and incentives.

Mandates

Employer mandates require employers to maintain or increase their participation in the health insurance market. There are two ways to do this:

- An employer mandate would require all employers (or at least all employers above a specified number of employees) to offer health benefits that meet a defined standard, and pay a set portion of the cost of those benefits on behalf of the employee.

- An employer play or pay approach would require employers either to offer and pay for the defined set of health benefits on behalf of their employees, or to pay a specified dollar amount or percentage of payroll into a designated public fund. This fund would provide a source of financing for coverage for those who do not have employment-based coverage.

In a play or pay approach, the amount that employers would be required to pay if they do not provide coverage is important. If the amount is too low, employers may determine that it is more cost-effective to drop coverage and pay the assessment than to continue paying for health benefits for their employees. On the other hand, if the amount is too high, it can pose financial challenges for small employers that could result in employment or wage reductions.

Healthy San Francisco: Employer Requirement

In July 2006, the San Francisco Board of Supervisors adopted the Health Care Security Ordinance, which created the Healthy San Francisco program. Healthy San Francisco is not health insurance, but rather it provides access to affordable, basic and ongoing health care services for uninsured residents. As part of the financing for this program, employers are required to spend a minimum amount per hour on health care for their employees. The requirement applies to all medium and large employers; small employers and non-profit organizations are exempt. The required contributions are based on the following schedule:

<table>
<tr><th colspan="2">Business Size</th><th>January 1, 2008</th><th>April 1, 2008</th><th>January 1, 2009</th></tr>
<tr><td>Large</td><td>100+ Employees</td><td colspan="2">$1.76/hour</td><td>$1.85/hour</td></tr>
<tr><td rowspan="2">Medium</td><td>50–99 Employees</td><td colspan="2">$1.17/hour</td><td rowspan="2">$1.23/hour</td></tr>
<tr><td>20–49 Employees</td><td>Not Applicable</td><td>$1.17/hour</td></tr>
<tr><td>Small</td><td>1–19 Employees</td><td colspan="3">Not Applicable</td></tr>
</table>

Legal Challenge to Employer Requirement

In November 2006, the Golden Gate Restaurant Association filed a lawsuit challenging the city's employer spending requirement on the grounds that it violated the Employee Retirement and Income Security Act of 1974 (ERISA). ERISA prohibits state or local governments from regulating employee benefit plans, including health insurance.

In December 2007, a District Court ruled in favor of the Restaurant Association and barred the implementation of the employer requirement. However, in September 2008, the U.S. Ninth Circuit Court of Appeals reversed the lower court's decision. It ruled that the employer requirement does not violate ERISA because the ordinance does not specify what benefits employers must provide in their ERISA plans, and by giving employers the option of contributing to the cost of coverage, it does not require them to provide coverage through an ERISA plan.[5]

The ERISA Issue

To the extent that states seek to pursue health reform by imposing requirements on employers, the Employee Retirement Income Security Act of 1974 (ERISA) is a barrier. Under ERISA, states cannot regulate employer pension or benefit plans, leaving that regulatory prerogative to the federal government. It was passed in an effort to set standards for benefit plans and encourage larger employers to maintain pension and other employee benefits by limiting them to one overall federal standard, rather than subjecting them to different benefit plan standards in each state in which they operate.

When ERISA is applied to health care, it means that states can regulate the health insurance market and products that are offered by insurers and purchased by employers and individuals, but they cannot require employers to provide health care benefits or specify what those benefits include. It is somewhat less clear whether states can adopt play or pay models under which the employer is not technically required to offer benefits because they have the option of paying into a fund instead. To date, the employer requirements in Massachusetts and Vermont have not been challenged in court. However, an employer requirement recently implemented as part of the "Healthy San Francisco" program was challenged on the grounds that it is preempted by ERISA. On September 30, 2008, the U.S. Ninth Circuit Court of Appeals ruled that the San Francisco ordinance requiring employers to offer coverage to their workers or help to finance the city's health care program did not violate ERISA. In its ruling, the court suggests that to avoid ERISA preemptions programs should apply to multiple classes of employers and should give employers options for meeting the requirements. Additionally, there should be a direct benefit to the employees of the employers that choose to pay the assessment.

Incentives

Financial incentives usually target small employers and are designed to encourage them to provide health benefits to their employees. Incentives can be an alternative to mandates but can also be used to provide financial assistance to employers that are subject to a mandate. Employer incentives typically take the form of tax credits to provide greater fiscal subsidies for employers that offer and pay for a share of their employees' health benefits.

Depending on the policy intent, subsidies could be calculated and targeted in different ways.

- By employer size: since smaller employers are less likely to offer health benefits to workers, tax credits could be provided to employers with a specified number of employees.

- By employer participation: subsidies could be targeted for a period of time to those employers that newly offer health benefits.

- By average or individual payroll cost: since the issue of affordability arises when health benefit costs add substantially to total compensation for a company, incentives could be provided to employers whose health benefit costs exceed, on average, a certain percentage of payroll. In this situation, the tax credit would most likely benefit employers with larger proportions of lower wage employees. Or the tax credit could be further targeted for employer expenses that exceed some percentage of wages for particular individuals, more specifically targeting firms with lower wage workers.

One issue in any incentive arrangement is the degree to which the new dollars help subsidize employers that are already providing health benefits versus employers that newly offer health benefits. On the one hand, providing a tax credit to employers already offering benefits assists employers in continuing to provide health benefits and rewards them for having "done the right thing" all along. On the other hand, such an approach spreads the subsidy broadly and is more costly. In contrast, incentives targeted at firms that newly offer benefits directs the new money toward the goal of increasing health insurance coverage, but at the expense of treating employers differently.

Health Reform in Massachusetts

In 2006, Massachusetts passed landmark legislation to provide health care coverage to nearly all state residents. As of March 2008, 440,000 previously uninsured individuals had gained health coverage. The Massachusetts plan imposes requirements on individuals to obtain coverage and on employers to offer or pay toward coverage for their employees. It also expands public coverage, provides subsidies to low-income individuals to make health care more affordable, and creates the Commonwealth Connector to provide a choice of unsubsidized private plans.

COMPONENTS OF THE PLAN

Individual Mandate: Requires all residents to purchase health insurance, with certain exceptions.

Employer Assessment: Requires employers with 11 or more employees to offer coverage to their employees or pay $295 per employee per year.

Commonwealth Care: Provides subsidized health coverage for individuals with incomes below 300% FPL.

Commonwealth Choice Connector: Provides individuals and small businesses access to easily comparable insurance products. Insurers offering products in this market are subject to guarantee issue and modified community rating requirements.

Medicaid Expansion: Expands eligibility for MassHealth (Medicaid) to children in families with incomes up to 300% FPL.

BUILD ON PUBLIC COVERAGE

A second way to build on the current sources of coverage is to enhance public coverage, through programs such as Medicaid and SCHIP or Medicare. These programs provide an important source of coverage for vulnerable populations, including low-income children and families, people with disabilities, and the elderly. Combined, these programs cover over 100 million people and are a key component of the U.S. health care system.

Expand Medicaid and SCHIP

The rationale for building on Medicaid and SCHIP is that these programs have largely been successful at providing coverage for low-income and vulnerable populations. The practical reality is that the federal-state infrastructure already exists, making expansions administratively feasible. In addition, the benefits and cost-sharing are designed to meet the needs of low-income individuals, so coverage and care are affordable for them.

The Medicaid program faces a number of limitations that could be addressed through policy changes. In particular, the variation in eligibility levels across states as well as the exclusion of adults without dependent children from coverage, limits the reach of the program. Additionally, it is estimated that as many as three-quarters of uninsured children are eligible for public programs but not enrolled. Therefore, policy strategies could seek to expand eligibility, improve outreach and enrollment, or both.

Expand eligibility

Expanding eligibility for public programs is one policy option. There are a number of ways to accomplish this goal. Below are two possible approaches.

- Increase income eligibility for groups that are currently eligible for Medicaid, such as children, pregnant women, parents of covered children, and/or those with disabilities. States would be required to expand eligibility to the new, higher income levels for one or more of the currently eligible populations. To assist states in financing this expansion, enhanced federal matching payments (FMAP) could be made available.

- Restructure eligibility by eliminating the current categorical requirements and provide health coverage for all individuals with incomes below a certain income threshold, such as 200 percent of the federal poverty level. This approach would restructure the Medicaid program to base eligibility solely on income and would provide coverage to many adults who are not eligible under the current rules. Providing federal matching payments for these newly eligible populations could help states finance the expansion.

Enactment of the State Children's Health Insurance Program (SCHIP) in 1997 is one recent federal example of a public program expansion. Numerous states have broadened eligibility under their Medicaid and SCHIP programs, and states such as Massachusetts and Vermont have established new income-related programs as part of their health reform plans.

Increase enrollment for those who are already eligible

In addition to expanding the base of eligibility under the programs, policy efforts could focus on identifying and enrolling those who are already eligible for, but not yet enrolled in Medicaid and SCHIP. These efforts include improving outreach so that more people know about the programs and how to apply. Eligibility and enrollment processes could be simplified and mechanisms could be implemented to automatically enroll and re-enroll those who are eligible.

Children's Coverage Expansions

From 2006 to 2008, 28 states and the District of Columbia expanded coverage for children, most by expanding their state's SCHIP program. Currently, 44 states and the District of Columbia cover children with family incomes at or above 200% of the federal poverty level.[6]

Expand Medicare

The Medicare program also offers a mechanism for expanding coverage, though it is looked to less often as an expansion vehicle than the Medicaid and SCHIP programs. Because eligibility for the program is not based on income, Medicare expansions would more likely target people within a certain age range rather than those at a particular income level. One option that has been discussed is to provide access to Medicare at age 55, rather than the current eligibility age of 65. Under this scenario, the newly eligible would be required to pay a premium set at the full actuarial cost of the program. This strategy would target a group with higher health care needs and costs due to their age, who may have difficulty accessing affordable private insurance. It would be especially helpful for those who work for an employer that does not offer benefits and for those who have left the employment setting.

Provide Temporary Benefits for Newly Unemployed

Another option is to target coverage on individuals who have lost or changed jobs and, as a result, lost coverage. In 1986, Congress passed the Consolidated Omnibus Budget Reconciliation Act, which includes a provision providing employees who lose coverage under certain circumstances temporary continuation of the employer-provided benefit. This provision was intended to provide a coverage option for people who would have otherwise become uninsured. One critical drawback to this coverage is that the former employee is responsible for the full cost of the coverage (which averaged $12,680 for family coverage in 2008). To make this coverage more affordable, the federal government could provide income-based premium subsidies. Other changes could strengthen this coverage by expanding the circumstances under which people would qualify and extending the length of time that people are eligible for the coverage.

BUILD ON INDIVIDUAL INSURANCE

The third approach to building on the current sources of coverage is to bolster the individual insurance market. The rationale for this approach is that individual coverage is the only insurance option for those who do not have access to employer-sponsored coverage and are not eligible for public programs. Strategies aimed at expanding coverage through the individual market must address the failings of this market. Efforts to strengthen the individual market focus on changing how it is regulated.

Market Regulation

States are responsible for regulating the individual insurance market, and as a result, these markets function differently across states. Some argue that the problems with this market must be addressed by increasing regulation of insurance companies that participate in it. Others claim that the current regulations in the market, particularly rating and mandatory benefit requirements, are responsible for driving up premium costs and further exacerbate the affordability problem.

Proponents of increased market regulation point to the need to ensure that coverage is available to everyone, including those with pre-existing medical conditions. Proposals to increase the regulation of individual insurance typically include some key features:

- **Guarantee issue and renewal** requires insurers to offer and renew coverage, without regard to health status, use of services, or pre-existing conditions. This requirement ensures that no one will be denied coverage for any reason, including their age and health status.

- **Rating requirements** allow premiums to vary but limit the amount of that variation based on age, gender, and health status, and in some cases prohibit price variation based on health status. This approach is designed to limit pricing differences that prevent the highest risk individuals from obtaining affordable coverage.

- **Standard benefit levels** or some minimum benefit standard can be required. This standard is designed to assure that covered benefits meet the reasonable health care needs of enrollees. It prevents people from having limited plans that fail to cover basic services.

- **Standards for insurance company medical loss ratios** set the minimum amount that insurers have to pay out for medical services, as opposed to administrative costs and profits. This requirement is designed to help assure that the appropriate share of premium dollars is paid out as health care benefits.

Proposals to reduce current regulation of the individual insurance market include some features that shift policy in the opposite direction. These policies focus on enhancing competition in the market by allowing insurers to compete on a "level playing field". By reducing current regulations, proponents believe a greater variety of products will become available at lower cost.

- **Lessen or eliminate current state requirements,** which can include guarantee issue requirements, rating rules and benefit mandates. This approach would allow the market to determine what products will be available and at what price, to meet the diverse needs of consumers. It would maintain or increase the opportunity for differential pricing and underwriting so that younger and lower risk individuals have access to coverage with lower premiums to reflect their lower costs, with higher risk individuals pooled and priced to reflect their higher costs. It would also continue to allow insurers to deny coverage to those with pre-existing health conditions.

- **Permit the purchase of insurance across state lines.** This provision would allow individuals and smaller businesses to shop for lower cost products offered in states that have minimal requirements and potentially lower costs. People would be able to bypass insurance market requirements in their own state which may be more restrictive than in other states.

IMPROVE THE AFFORDABILITY OF COVERAGE

For coverage expansions to be successful, health insurance needs to be affordable. Rising health care costs increasingly make it difficult for low and moderate income families to afford coverage. The affordability of coverage could be improved by subsidizing the purchase of coverage, offering less expensive insurance products, and/or by creating a reinsurance program for high-cost individuals.

IMPROVE THE AFFORDABILITY OF COVERAGE

No coverage expansion is feasible or sustainable if the affordability of insurance is not addressed. Rising health care costs are driving up the cost of health insurance premiums. Between 1999 and 2008, health insurance premiums for employer-sponsored family coverage increased 119 percent, while wages increased just 34 percent. The cost of health insurance is becoming increasingly unaffordable, especially for low income and even moderate income families.

Changing the underlying trend in health care costs is not the subject of this paper, but there are two basic strategies within the health insurance market to make health coverage more affordable for individuals: subsidize coverage or design and offer lower cost insurance products.

SUBSIDIES

The most direct mechanism to make coverage more affordable is to provide direct financial assistance to individuals and families to help them purchase insurance. Some of the previously noted policies, such as requiring employers to offer and subsidize a portion of premiums, would help address this issue for some individuals.

The most common mechanisms for subsidizing health coverage include tax deductions, refundable tax credits, and/or direct financial support to help finance the premium expenses. Such subsidies could pay a fixed amount or a designated percentage of the premium of either coverage purchased in the individual market or the employee share of employer policies. The subsidies could be extended to all individuals regardless of income. Or, they would more likely be designed as a sliding scale subsidy, with people with higher incomes paying a higher share of the premium cost. In Massachusetts and Vermont, for example, the premium costs people are required to pay for the state-subsidized health insurance programs vary based on income level.

Premium Subsidies in Vermont

Vermont provides subsidies to individuals and families with incomes below 300% FPL through a newly-created state health care plan, Catamount Health. As of September 2008, 5,704 individuals were enrolled in Catamount Health. The state also provides premium assistance to individuals with income below 300% FPL to help them purchase insurance through their employer. The employee share of the premium is set such that it does not exceed what they would pay if they purchased Catamount Health.[7] The premiums for Catamount Health are:

Income*	Monthly Premium Cost
Below 200% FPL	$60.00
200–225% FPL	$90.00
225–250% FPL	$110.00
250–275% FPL	$125.00
275–300% FPL	$135.00
Over 300% FPL	Full cost: $393/Individual $1,100/Family**

* The federal poverty level is $10,210 for an individual and $13,690 for a couple in 2007.

** Full cost of Blue Cross Blue Shield Plan.

OFFER LESS EXPENSIVE PRODUCTS

Another strategy to improve the affordability of coverage is to facilitate the design and offering of less expensive insurance products. Products with lower premiums typically cover fewer benefits and require higher cost sharing.

High Deductible Health Plans

As part of the consumer-driven movement in health care, high deductible health plans have been marketed as lower cost alternatives to more traditional insurance plans. These plans exchange higher premiums for higher deductibles, which is the amount that people have to pay out-of-pocket for health care services before insurance begins to pay. In general, deductibles for these plans are $1,000 or more for individual coverage. These plans can be combined with a health savings account (HSA), which allows people to pay premiums and other medical expenses with pre-tax dollars.

Young Adult Plans

In another similar effort, private insurance companies and states have begun to offer specially-designed, less expensive health care products to young adults. Blue Cross Blue Shield and American Community Mutual Insurance Company are among the first health insurance companies to target this population. Many of the plans they offer exchange low premiums for high deductibles and limited benefit packages.

Young Adult Health Care Plans: Massachusetts

As part of its comprehensive health care reform plan, which included a requirement that all adults purchase health coverage, Massachusetts developed a lower-cost health insurance product for 18–26 year olds. Though the benefit packages must be "reasonably comprehensive," they do not need to meet all of the benefit standards required of other plans in the state. As of August 2008, over 4,000 individuals in Massachusetts were enrolled in these young adult plans.[8]

REINSURANCE

A final strategy for improving the affordability of coverage is to provide some form of reinsurance for high cost claims. These high cost claims are incurred by a small share of individuals but represent a large share of total health costs. By limiting insurance companies' exposure to very high health costs, reinsurance programs enable insurers to lower the premiums they charge to employers and individuals. This type of program is a form of subsidy to the insurer that lowers the premium cost for all purchasers. Currently, a handful of states, including New York and Arizona, operate reinsurance programs.

Reinsurance Program: Healthy New York

In 2001, New York began Healthy New York, a state-subsidized reinsurance program that provides health care coverage to nearly 150,000 uninsured individuals, small businesses, and sole proprietors who meet income and eligibility criteria. Seventeen insurers participate in Healthy New York, offering 285 plans. For two-thirds of enrollees, monthly premium costs range between $200 and $250. The program keeps premiums low by reimbursing insurers for 90% of claims paid between $5,000 and $75,000 on one policy.[9]

IMPROVE THE AVAILABILITY OF COVERAGE

Another way to expand coverage is to increase the options available to people for obtaining health insurance. Currently, those who are not offered insurance through their employer and who are not eligible for public coverage often face significant challenges finding affordable coverage. The availability of coverage could be improved by creating new group purchasing arrangements or by expanding high-risk pools for those with pre-existing medical conditions.

IMPROVE THE AVAILABILITY OF COVERAGE

Health insurance must be readily available and affordable for consumers in order to achieve coverage expansions. While large employers face few problems obtaining coverage for their employees, some small businesses and individuals may have difficulty finding affordable insurance. Small businesses may not benefit from the pooling arrangements that make coverage more affordable for larger groups, and individuals with high health risks are more likely to be charged higher premiums or be denied coverage.

CREATE OR PROVIDE ACCESS TO LARGE GROUP PURCHASING POOLS

One way to increase the availability of insurance is to make the group purchasing advantages of large employers available to small businesses and individuals. This approach generally involves reorganizing the insurance market to create larger purchasing pools. It can be done by creating new pools or by providing access to existing pools.

- **Create large purchasing arrangements through which insurers offer and smaller employers and individuals purchase health insurance.** These arrangements have many names—purchasing cooperatives, "exchanges," or "connectors". Individuals and small employers would no longer select from among each individual insurer and all of its products. Instead, the state, regional, or even national purchasing cooperatives would set standards for what benefits would be covered, how much insurers could charge, and the rules insurers must follow in order to participate in the market. Individuals and small employers would select their coverage within that more organized arrangement. By virtue of its size, these purchasing entities could offer a choice of multiple insurance plans, a feature that is currently not available for individuals and some small employers. Massachusetts created the Commonwealth Connector as a component of its health reform plan through which 18,000 people have obtained coverage.

- **Provide access to existing purchasing pools such as the Federal Employees Health Benefits Program (FEHBP) or state employee pools.** This approach would typically provide employers and individuals with the opportunity to buy the same health benefits that are made available to government employees, including members of Congress. Insurers would be required to offer products to all individuals in order to maintain their position in the large government employee market. Individuals could be included in the same insurance risk pool as government employees, or a similar but separate pool could be created. The same products and benefit plans would be available to everyone.

Federal Employees Health Benefits Program (FEHBP)

A program that provides health insurance to employees of the U.S. federal government. Federal employees choose from a menu of plans that include fee-for-service plans, plans with a point of service option, and health maintenance organizations. There are more than 170 plans offered; a combination of national plans, agency-specific plans, and more than 150 HMOs serving only specific geographic regions. The various plans compete for enrollment as employees can compare the costs, benefits, and features of different plans.

INCREASE THE AVAILABILITY OF ASSOCIATION HEALTH PLANS

One way to increase the purchasing authority of small businesses is to allow them to form purchasing arrangements, called Association Health Plans (AHPs). Through AHPs, members of the association could develop and offer their own insurance product, much like a large self-insured employer. Such arrangements would not be subject to the insurance regulations in the state, such as guarantee issue, mandatory benefits and/or rating rules, and therefore might be able to offer lower premiums to lower risk groups.

EXPAND HIGH-RISK POOLS

Another way to reorganize the individual market is to establish or build upon high-risk pools. High-risk pools operate in 34 states and provide health insurance to nearly 200,000 U.S. residents who are considered medically uninsurable (or meet other eligibility requirements) and are unable to buy coverage in the individual market. These pools often cap the premiums insurers can charge and provide some form of subsidy to help make coverage more affordable to individuals. Allowing insurers to exclude such individuals from coverage in the individual market keeps average premiums in that market lower, while still providing a source of coverage for those with the highest health care risk.

CREATE A NEW PUBLIC PROGRAM

A different approach is to create a new public program, modeled on Medicare, and provide employers and individuals with the option of enrolling. This new plan could be offered through a newly created insurance exchange and would compete directly with the private plans available in this market. People would have the option of enrolling in a private plan or in the new public program.

INDIVIDUAL MANDATE

The new pooling arrangements described above are sometimes discussed in concert with an individual mandate or requirements placed on individuals to enroll in some form of health insurance. The rationale is that the only way to achieve near-universal coverage is by requiring people to purchase coverage. With a mandate in place, insurers would likely be less concerned about the occurrence of adverse selection, in which only those who are sick purchase health coverage, enabling the purchasing pools to work as designed. It is also more feasible to enforce requirements that insurers guarantee issue and limit rating variation in the individual market.

The challenges associated with implementing and enforcing an individual mandate are substantial. Even with public support for reform, an individual mandate would be a major new approach. It would need to be coupled with some of the regulatory reforms previously noted, as well as cost controls and subsidies in order to assure individuals that coverage would be available and affordable. To address the affordability issue, Massachusetts provides subsidized coverage for people with incomes below 300% of the federal poverty level ($21,203 for a family of four in 2007) and exempts from the mandate those individuals who cannot purchase insurance that meets an established affordability standard.

Individual Mandate: Massachusetts

Massachusetts is the first state to experiment with an individual mandate, which went into effect on July 1, 2007. A key component of the state's comprehensive health reform plan, the mandate requires all adults in the state to have health insurance, which is enforced through tax filings. In the first year, failure to comply with the mandate resulted in the loss of the personal tax exemption. In the second year, that penalty increased to the lesser of half the cost of an average priced health plan in the individuals' region or $912. Initial reports from the state Department of Revenue suggest that there has been strong compliance with the mandate.[11]

CHANGE THE TAX TREATMENT OF HEALTH INSURANCE AND THE WAY IT IS FINANCED

The tax code currently provides incentives for employees to obtain health insurance through their employer. Incremental and comprehensive proposals to change the tax treatment of health insurance would alter the incentives for health insurance in and out of the employment setting. Adopting a single payer plan would even more fundamentally restructure the organization and financing of the health care system.

CHANGE THE TAX TREATMENT OF HEALTH INSURANCE AND THE WAY IT IS FINANCED

The tax code currently provides an incentive for employers and employees to arrange for health benefits within the employment setting. Employer payments for health benefits are tax-deductible for employers and not treated as taxable income for employees. These tax benefits have encouraged and subsidized the employment-based insurance market, which is currently the dominant source of coverage.

Excluding employer payments for health benefits from the taxable income for employees is a substantial cost to the federal treasury—in excess of $200 billion in 2008. This tax preference tends to primarily benefit those with more comprehensive coverage. It also provides greater benefits to higher income individuals who have higher marginal tax rates. In contrast, individuals who are not covered under an employment arrangement and purchase coverage as individuals do not receive such a tax preference, and pay full premiums with after-tax dollars. Thus, the current tax subsidy for health care is inequitable.

It is sometimes argued that the subsidy for employer-based coverage makes individuals and employers less sensitive to the premium cost, resulting in the purchase of richer health benefits than they would otherwise choose, in turn contributing to health cost growth. Additionally, this subsidy supports a system with some drawbacks—individuals typically have a limited choice of plans and they cannot keep their coverage when they change or lose their job. Finally, employers competing in the global economy see themselves at a competitive disadvantage because they have to pay directly for the health benefits of their employees while competing with companies in other countries where financing is more indirect through the tax system (and health costs overall are much lower).

There are a number of strategies for restructuring the tax treatment of health insurance and the financing of care. These range from incremental approaches to a complete restructuring of the federal tax and spending policy for health care.

INCREMENTAL APPROACHES

One set of strategies would keep in place the current tax preference for employer-based coverage, but would attempt to address some of the perceived policy problems with this system. While these proposals would not fundamentally alter the current system, they would make the system more equitable.

- **Provide the same tax preference currently available for those receiving employment-based coverage to individuals who purchase insurance directly.** This goal can be achieved by making the premium payments in the individual market tax-deductible, or by providing refundable tax credits for the purchase of insurance in the individual market. Offering tax credits would particularly benefit those with low-incomes who pay relatively lower taxes or no taxes at all.

- **Cap the amount of the employer health benefit that is not subject to taxes.** In this case, the employer health benefit remains largely tax-free; however, if the value of the health plan exceeds the cap, the amount by which the health plan exceeds the cap would be added to employees' salaries or wages and would be taxed. Limiting the amount of money that can be excluded from income taxes is viewed by proponents as a way to eliminate the incentives for higher cost insurance coverage. In addition, capping the current tax preferences would provide a source of financing that could be used to provide subsidies to individuals who purchase insurance in the individual market.

MAJOR RESTRUCTURING OF HEALTH CARE FINANCING

Another set of strategies would seek to move away from the current employment-based system. These strategies would lead to a major restructuring of the current health care system, in some cases shifting people into coverage through the individual market and in others by creating a tax-financed single payer system.

Replace Tax Preference for Employer Coverage with a Tax Credit or Tax Deduction

An alternative policy approach envisions a complete restructuring of both tax policy and the private health insurance market with the goal of shifting away from an employment-based system to individual coverage. The rationale for this policy direction is based on the view that the employment-based system is an inefficient way to provide health coverage and that encouraging the purchase of insurance in the individual market promotes greater consumer choice and responsibility.

Such a policy approach would eliminate the employment-based tax preference completely, and replace it with a standard health care tax deduction or a tax credit for all individuals to apply toward the purchase of health insurance. The advantage of a tax credit over a tax deduction is that a refundable tax credit is a credit against any taxes that are owed. Because it is refundable, and thus available even to those who do not pay taxes, it would provide greater benefit to those with lower incomes. In contrast, a standard deduction for health care, which reduces the amount of income subject to taxes, only benefits those who pay taxes and provides greater benefits to those who have higher incomes and face higher tax rates.

One challenge with this approach is that it would rely on an individual insurance market that has never been robust, and in which administrative and marketing costs are substantially higher. To avoid the problems of large-scale movement into the individual market, these tax credits or deductions could be applied to the purchase of employer-based coverage or could be combined with new purchasing arrangements, such as an insurance exchange.

Single Payer System

A final strategy that would substantially alter both the private market and federal financing of health coverage is to adopt a single payer plan. The single payer approach would essentially replace the current sources of financing for health coverage for those under age 65 with a government organized and financed plan. Instead of financing health care through employer and employee premiums, the financing would be more directly through income and other taxes.

The rationale is that such a plan would guarantee coverage for all and would provide the coverage more efficiently than the current system. Proponents argue that by eliminating many of the participants in the current market, the plan would generate substantial administrative savings over the current system.

The simplest way to consider this approach is as a "Medicare for All" plan, replacing the employment-based and individual insurance markets. Under Medicare for All, the federal government would contract directly with providers and, in some cases, insurance companies, to provide benefits on behalf of the American public, much in the same way as it currently does for Medicare beneficiaries. While the government would finance the coverage, the health care delivery system would remain largely private.

Expanding Medicare in this way would be administratively doable, but such a transformation would require major cultural and administrative shifts for the American public, providers, and insurers. This kind of fundamental restructuring of our health care system is not likely in the current political environment.

PUTTING THE PIECES TOGETHER

The strategies described in this Guide can be combined in different ways to create comprehensive health care reform proposals. Plans put forward by President-Elect Barack Obama, Senator John McCain, Senator Max Baucus, and Senators Ron Wyden and Robert Bennett demonstrate how the different combinations can achieve policy and political goals. All of these proposals contribute to the discussions over how to reform the system and may serve as a starting point for a national health reform debate.

PUTTING THE PIECES TOGETHER

This Guide describes the major strategies for covering the uninsured that are likely to be part of any debate over how to reform the health care system. Offering diverse ways for improving the availability and affordability of health coverage, these strategies can be put together in a variety of ways to form comprehensive health care reform plans. A comparison of several significant proposals illustrates how different combinations can achieve particular ideological, policy, and political objectives.

During the 2008 Presidential campaign, both major party candidates, then-Senator Barack Obama (D) and Senator John McCain (R), announced comprehensive health care reform proposals. Not surprisingly, the plans adopt very different approaches to promoting coverage and reveal contrasting visions for how the health care system should be structured. These fundamental differences are likely to underlie policymakers' choices in future health reform discussions.

The plan President-Elect Obama offered during the campaign seeks to attain near-universal coverage by building on the current employment-based and public program structure, and by providing new coverage options.[12]

- Large employers would be required to offer health benefits to their workers or pay some assessment or portion of payroll into a pool to subsidize coverage. Small employers that offer coverage would receive tax credits of up to 50% of the premium costs for their employees. A reinsurance program would be created to lower premium costs. Tax policy would still maintain a preference for employers to offer and employees to accept coverage.

- Parents would be required to obtain coverage for their children, but adults would not be required to have insurance.

- A new National Health Insurance Exchange would be created, allowing individuals and small businesses to choose from among several private plans and a new public plan, modeled on Medicare. The benefits would be similar to those available through FEHBP. Income-related premium subsidies would be provided to low and moderate income individuals and families.

- Insurance regulations would be tightened, requiring insurers to guarantee issue and renew policies, and prohibit them from adjusting premium rates based on health status.

- Medicaid and SCHIP would be expanded and a new public program would be created as an optional source of coverage in the National Health Exchange.

Senator McCain provides a different health care strategy. His plan would change the tax code to alter the financing for health care and encourage people to purchase insurance on their own through the individual market.[13]

- The current tax preference for employer-sponsored coverage would be replaced with a tax credit of $2,500 per individual and $5,000 per family to be used for the purchase of insurance coverage. Any tax credit funds not used to purchase insurance would be placed in a health savings account.

- The tax changes would not alter current incentives for employers to offer coverage, and individuals and families could obtain coverage through their employer, if available, or they could use the tax credit to purchase insurance in the individual market.

- Insurance market regulations would be reduced—individuals would be allowed to purchase insurance across state lines and small businesses would be allowed to purchase insurance through Association Health Plans.

- New Guaranteed Access Plans would be created for people who are denied coverage. These plans would be structured similarly to existing state high risk pools. Premium subsidies would be available for low-income individuals.

While attention was focused on the presidential candidates' reform plans during the election, legislative initiatives have also been advanced in Congress. Senator Baucus (D-MT), Chairman of the Senate Finance Committee, recently released a White Paper laying out his vision for health care reform. Previously, several health care reform bills had been introduced, including Medicare for All legislation by Representative John Conyers (D-MI), and more can be expected in early 2009. The Healthy Americans Act (S. 334) introduced by Senator Ron Wyden (D-OR) and co-sponsored by Robert Bennett (R-UT) has generated attention and garnered bipartisan support.

In his White Paper, Senator Baucus, offers a vision similar to that of President-Elect Obama's, with a few key differences.[14]

- Large employers would be required to provide coverage or contribute to a fund to cover the uninsured. Contributions would be a percentage of payroll based on the firm's size and revenues. Firms with the fewest workers would be exempt from the requirement and would instead be offered a tax credit if they provide coverage to their workers.

- Once affordable health insurance options are available, individuals would be required to obtain coverage.

- A new Health Insurance Exchange would be created to provide individuals and small businesses with a range of comparable private insurance plans. A new public plan would also be available through this Exchange. Premium subsidies would be available to individuals with incomes up to 400% FPL.

- Public programs would be expanded. Medicaid coverage would be extended to all individuals with incomes below 100% FPL and SCHIP would be made available to children with family incomes below 250% FPL. A new Medicare buy-in for those aged 55-64 would be available and the two-year waiting period for people with disabilities to obtain Medicare coverage would be phased out.

- Insurers would be subject to increased regulation, including guarantee issue and modified community rating.

The Healthy Americans Act (Wyden-Bennett bill) offers yet another approach to expanding coverage. It includes some features from both the Obama and the McCain plans.[15]

- New state-based purchasing pools, called Health Help Agencies, would be created, offering a choice of private plans. The benefits offered by these plans would be similar to those available through FEHBP.

- All individuals would be required to obtain coverage through state-based pools unless they are enrolled in Medicare or have military-related coverage. Those individuals who do not choose a plan would be automatically enrolled in the lowest cost plan. Premiums for everyone would be automatically deducted from paychecks.

- The Medicaid and SCHIP programs would be eliminated as comprehensive coverage programs and instead would be converted to supplemental wrap-around insurance programs for low-income beneficiaries.

- Insurance market regulations would be tightened—insurers would be required to guarantee issue and renew policies; insurance policies would be required to meet minimum benefit standards; and premiums would be subject to community rating standards.

- The tax preference for employer-sponsored coverage would be replaced with a health premium tax deduction. Premium subsidies would be available for individuals and families with incomes between 100 and 400% FPL. Those with incomes below 100% FPL would not pay premiums.

- The availability of employer-sponsored coverage would be reduced or eliminated. Employers would be required to "cash-out" their existing health coverage and increase their workers' wages by the amount saved. While no longer offering coverage, employers would be required to contribute toward the costs of health insurance for their workers; the required contribution would vary by firm size.

The different approaches to covering the uninsured embodied in each of these plans are summarized in Table 2.

TABLE 2

A Comparison of Health Reform Proposals

Approach	Massachusetts Model	Obama Plan	McCain Plan	Baucus Plan	Wyden-Bennett
Build on employer market					
Incentives for employers	No	Yes	No	Yes	No
Requirements for employers	Yes	Yes	No	Yes	Yes
Build on public programs					
Medicaid/SCHIP improvements	Yes	Yes	No	Yes	No
New public program option	Yes	Yes	No	Yes	No
Individual coverage					
Subsidies/tax incentives	Yes	Yes	Yes	Yes	Yes
Mandates	Yes	Yes*	No	Yes	Yes
Insurance market reforms					
Strengthen regulation of private insurance	Yes	Yes	No	Yes	Yes
Lessen regulation, allow marketplace innovation	No	No	Yes	No	No
Revise organization of insurance market					
Purchasing groups/connectors	Yes	Yes	No	Yes	Yes
Association Health Plans	No	No	Yes	No	No
Allow nationwide offerings	No	No	Yes	No	No
Reinsurance	No	Yes	No	No	No
Change tax policy					
Eliminate tax preference for employer contributions	No	No	Yes	Yes**	Yes
Single payer plan	No	No	No	No	No***

* Obama plan would mandate coverage for children but not adults

** Indicates that capping the tax exclusion based on the value of the health benefits or for higher income individuals should be considered.

*** Individuals who don't choose a plan would be automatically enrolled into a qualified plan and for everyone premium payments would be automatically deducted from paychecks.

Although prospects for major health reform at the national level remain uncertain, the debate leading up to the 2008 elections has helped refocus attention on the plight of the uninsured. It has also more clearly delineated the different choices available to policymakers as they consider changes to the existing system. If a health reform plan that significantly expands coverage is to emerge from future discussions, it will likely be framed by decisions around three key issues: how the health system should be organized; the relative roles and responsibilities of different stakeholders, particularly the role of government; and the availability of subsidies for purchasing coverage, whether provided to all or a few based on need. The challenges to enacting health reform are significant. Finding a solution will require compromise and will likely involve incorporating different aspects of the major strategies being discussed.

GLOSSARY OF KEY TERMS

Adverse Selection	People with a higher than average risk of needing health care are more likely than healthier people to seek health insurance. Health insurers strive to maintain risk pools of people whose health, on average, is the same as that of the general population. Adverse selection results when the less healthy people disproportionately enroll in a risk pool.
Consumer-Directed Health Plans	Consumer-directed health plans seek to increase consumer awareness about health care costs and provide incentives for consumers to consider costs when making health care decisions. These health plans usually have a high deductible accompanied by a consumer-controlled savings account for health care services. There are two types of savings accounts: Health Savings Accounts (HSAs) and Health Reimbursement Arrangements (HRAs).
Co-Payment	A fixed dollar amount paid by an individual at the time of receiving a covered service from a participating provider. Individuals with private and public insurance may be required to pay.
Federal Medical Assistance Percentage (FMAP)	The statutory term for the federal Medicaid matching rate—i.e., the share of the costs of Medicaid services or administration that the federal government bears. In the case of covered services, FMAP varies from 50 to 76 percent depending upon a state's per capita income; on average, across all states, the federal government pays at least 60 percent of the costs of Medicaid.
Federal Poverty Level (FPL)	The federal government's working definition of poverty that is used as the reference point for the income standard for Medicaid eligibility for certain categories of beneficiaries. Adjusted annually for inflation and published by the Department of Health and Human Services in the form of Poverty Guidelines, the FPL in calendar year 2007 was $20,650 for a family of four.
Group health insurance	Health insurance that is offered to a group of people, such as employees of a company. The majority of Americans have group health insurance through an employer.
Health Savings Account (HSA)	A savings account that is often available to people with a high deductible health plan. Contributions to the account are not taxable and the funds can be used for qualified health care expenses.
Individual Insurance Market	The market for individuals who choose to purchase private medical insurance on their own.
Mandatory benefits	All states have laws that require state-licensed health insuring organizations selling health coverage to offer or include coverage for certain benefits or services, including items such as mental health services, substance abuse treatment, and breast reconstruction following a mastectomy. The number and type of these mandates varies across states.
Medicaid Waivers	Various statutory authorities under which the Secretary of the U.S. Department of Health and Human Services may, upon the request of a state, allow the state to receive federal Medicaid matching funds for its expenditures for certain categories of individuals for which federal matching funds are not otherwise available.
Medical Underwriting	Underwriting is the process of determining whether or not to accept an applicant for health care coverage and looking at their medical history in order to predict future health risks. This process determines what the terms of coverage will be, including the premium cost.
National Health System	A publicly funded health care system in which all individuals have health insurance. Examples include the health systems in England and Germany.

Pay For Performance	A health care model in which providers are rewarded for providing high quality health care services.
Purchasing Pools	Health insurers pool the health care risks of a group of people in order to make the individual costs predictable and manageable. For health coverage arrangements to perform well, the risk pooling should balance low and high risk individuals such that expected costs for the pool are reasonably predictable for the insurer and relatively stable overtime.
Pre-existing Condition Exclusions	An illness or medical condition for which a person received a diagnosis or treatment within a specified period of time prior to becoming insured under a policy. Health insurers can exclude benefits for a defined period of time for the treatment of medical conditions that they determine to have existed within a specific period prior to the beginning of coverage.
Refundable Tax Credit	A tax credit that can reduce the taxes an individual owes to below zero dollars, which results in a net payment to the individual. An example includes the Earned Income Tax Credit (EITC).
Section 125/ Cafeteria Plan	A section 125 plan allows employees to receive specified benefits on a pre-tax basis. Qualified benefits include health benefits and health savings accounts.
Self-insured Plan	A plan where the employer assumes direct financial responsibility for the costs of enrollees' medical claims. Employers sponsoring self-insured plans typically contract with a third-party administrator or insurer to provide administrative services for the self-insured plan.
Single Payer System	A health care system in which a single entity pays for health care services. This single entity collects health care fees and pays for all health care costs, but is not involved in the delivery of health care.
Small Group Market	Firms with 2-50 employees can purchase health insurance for their employees through this market, which is regulated by the states.
Socialized Medicine	A health care system in which the government operates and administers health care facilities and employs health care professionals. Examples include the Veterans Health Administration.
State Children's Health Insurance Program (SCHIP)	Enacted in 1997, SCHIP is a federal-state matching program of health care coverage for uninsured low-income children. SCHIP is a block grant to the states. States have the option of administering SCHIP through their Medicaid programs or through a separate program (or a combination of both).
Tax Credit	A tax credit is an amount that a person can subtract from the amount of income tax that they owe. If a tax credit is refundable, the taxpayer can receive a payment from the government to the extent that the amount of the credit is greater than the amount of tax that the individual would otherwise owe.
Tax Deduction	A deduction is an amount that a person can subtract from their adjusted gross income when calculating the amount of tax that they owe. Generally, families that itemize their deductions can deduct the portion of their medical expenses, including health insurance premiums that exceed 7.5% of their adjusted gross income.
Uncompensated Care	A measure of the cost of health care services that are provided but not paid for by the patient or by insurance. Health care providers incur some of this cost along with the federal government.
Underinsured	People who have health insurance but face significant health care costs or limits on benefits, which may affect its usefulness in accessing or paying for health care services.

ENDNOTES

[1] This primer reviews the population under age 65, as most older Americans have coverage through the federal Medicare program.

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