
# THE HEALTH INSURANCE PROVISIONS OF THE 2009 CONGRESSIONAL HEALTH REFORM BILLS: IMPLICATIONS FOR COVERAGE, AFFORDABILITY, AND COSTS

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**ABSTRACT:** This report analyzes the provisions of the health reform bills passed by the U.S. House of Representatives and Senate that seek to expand and improve health insurance coverage. It focuses on: the number of people who would likely gain coverage; under which program or plan they would be covered, and the consequences for federal financing; the estimated insurance premium and out-of-pocket costs for families; the consequences for employers; and the degree to which the reorganization and regulation of insurance markets has the potential to stimulate price competition and lower costs. (A companion Commonwealth Fund report analyzes the bills' implications for health system reform.) Although there are some key differences between the bills' approaches, both would significantly reform health insurance, providing coverage to more than 30 million uninsured Americans and substantially improving the affordability of coverage for small businesses and for people who now buy insurance on their own.

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# EXECUTIVE SUMMARY

The U.S. House of Representatives and Senate have passed major health reform bills. On November 7, the full House voted to pass H.R. 3962, The Affordable Health Care for America Act. On December 24, the full Senate voted to pass H.R. 3590, The Patient Protection and Affordable Care Act.

This report analyzes the provisions of the bills that seek to expand and improve health insurance coverage in the United States. It builds on an earlier report published by The Commonwealth Fund that explains the provisions of the congressional health reform bills in detail.

In this report, we focus on: the number of people who would likely gain coverage under the two bills; under which program or plan they would be covered and the consequences for federal financing; the estimated insurance premium and out-of-pocket costs for families; the consequences of the bills for employers; and the degree to which the reorganization and regulation of insurance markets in the bills has the potential to stimulate price competition and lower costs. A companion Commonwealth Fund report analyzes the bills' implications for health system reform.

## Overall Approach of the Health Reform Bills

The House bill and the Senate bill both aim to provide near-universal health insurance coverage. They would do so by building on the strongest aspects of the insurance system—large-employer insurance, Medicaid, and the Children's Health Insurance Program (CHIP)—and by regulating and reorganizing the individual and small group insurance markets, generally considered the weakest part of the system (Exhibit ES-1).

- The bills would establish new federal rules requiring insurance carriers in all markets to accept every individual and employer who applied for coverage (guaranteed issue) and prohibit rating based on health status.
- The bills would create a new health insurance exchange operated either at the national or state level in which eligible individuals and businesses could purchase health insurance, choosing between private and public health plans.
- Premium and cost-sharing subsidies would be available on a sliding scale to offset the costs of plans purchased through the exchange. An essential standard benefit package, with different levels of cost-sharing, would set a floor for plans offered through the exchange.

## Exhibit ES-1. Congressional Health Reform Bills as of December 2009

| | House of Representatives 11/7/09 | Senate 12/24/09 |
|---|---|---|
| **Insurance market regulations** | GI, adjusted CR 2:1; in 2010: meet 85% medical loss ratio; uninsured eligible for high-risk pools, no annual or lifetime limits or rescissions, dependent coverage to 27 | GI, adjusted CR 3:1; in 2011: health plans required to refund enrollees for non-claims costs >15% in large group market and >20% in small group & individual markets; uninsured eligible for high risk pools; no annual or lifetime limits or rescissions, dependent coverage to 26 |
| **Individual mandate** | Penalty: 2.5% of the difference between MAGI and the tax filing threshold up to the average national premium of the "basic" benefit package | Penalty: Greater of $750/year per adult in household or 2% of income in 2016 phased in at $95 in 2014, $495 in 2015, $750 in 2016, up to a cap of national average bronze plan premium; family penalty capped at $2,250; exempts premiums >8% of income |
| **Exchange** | National or state | Regional, state, or substate |
| **Plans offered** | Private, public, and co-op | Private and co-op; multistate plans with at least one nonprofit plan, supervised by OPM |
| **Eligibility for exchange** | Individuals and small businesses <25 in 2013; <50 by 2014; <100 by 2015: 100+ after 2015 | Individuals and small businesses 50–100, 100 by 2015, 100+ at state option |
| **Essential benefit standard** | Essential health benefits 70%–95% actuarial value, four tiers | Essential health benefits 60%–90% actuarial value, Four tiers; catastrophic policy for young adults <30 and those exempt from individual mandate |
| **Premium/cost-sharing assistance** | Sliding scale 1.5%–12% of income up to 400% FPL; cost-sharing credits 133%–350% FPL | Sliding scale 2%–9.8% of income up to 300% FPL/ flat cap at 9.8% 300%–400% FPL; cost-sharing subsidies for 100%–200% FPL |
| **Medicaid/CHIP expansion** | Up to 150% FPL | Up to 133% FPL |
| **Shared responsibility/ Employer pay-or-play** | Play or pay; firms >$500,000 payroll 72.5% + prem. contribution for indiv./65% + for families; sliding scale phased-in from 2% to 8% of payroll at $750,000; small employer tax credit; young adults can stay on parent's health plan to age 27 | Firms >50 FTEs pay uncovered worker fee of $750; small employer tax credit; young adults can stay on parent's health plan to age 26 |

Note: GI = guaranteed issue; CR = community rating. Actuarial value is the average percent of medical costs covered by a health plan.
Source: Commonwealth Fund analysis of proposals.

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- Income eligibility for Medicaid and CHIP would be expanded up to 133 percent or 150 percent of the federal poverty level.
- Large employers would be required to either offer coverage or contribute to the cost of their employees' insurance. Small employers would be eligible for tax credits to offset the costs of insurance.
- Individuals would be required to have health insurance.

## HOW MUCH WOULD THE PROPOSALS COST THE FEDERAL GOVERNMENT?

The Congressional Budget Office (CBO) has estimated that the bills would reduce the federal deficit over the next 10 years by $138 billion (House) and $132 billion (Senate) (Exhibit ES-2). The estimated cost over 10 years of expanding and improving health insurance is $891 billion under the House bill and $763 billion under the Senate bill. Costs would be offset by contributions from employers, savings from health system reforms, and new revenues.

## Exhibit ES-2. Major Sources of Savings and Revenues Compared with Projected Spending, Net Cumulative Effect on Federal Deficit, 2010–2019

**Dollars in billions**

| | CBO estimate of House bill (H.R. 3962) | CBO estimate of Senate bill (H.R. 3590) |
|---|---|---|
| **Total Net Impact on Federal Deficit, 2010–2019** | **–$138** | **–$132** |
| **Total Federal Cost of Coverage Expansion and Improvement** | **$891** | **$763** |
| ***Gross Cost of Coverage Provisions*** | ***$1,052*** | ***$871*** |
| • Medicaid/CHIP outlays | 425 | 395 |
| • Exchange subsidies | 602 | 436 |
| • Small employer subsidies | 25 | 40 |
| ***Offsetting Revenues and Wage Effects*** | ***–$162*** | ***–$108*** |
| • Payments by uninsured individuals | –33 | –15 |
| • Play-or-pay payments by employers | –135 | –28 |
| • Associated effects on taxes and outlays | 6 | –65 |
| **Total Savings from Payment and System Reforms** | **–$456** | **–$483** |
| • Productivity updates/provider payment changes | –177 | –151 |
| • Medicare Advantage reform | –170 | –136 |
| • Other improvements and savings | –109 | –196 |
| **Total Revenues** | **–$574** | **–$413** |
| • Excise tax on high premium insurance plans | — | –149 |
| • Surtax on wealthy individuals and families | –461 | — |
| • Other revenues | –113 | –264 |

Note: Totals do not reflect net impact on deficit because of rounding.
Source: The Congressional Budget Office Cost Estimate of the Patient Protection and Affordable Care Act, Dec. 19, 2009, http://www.cbo.gov/doc.cfm?index=10868. The Congressional Budget Office Analysis of H.R. 3962, The Affordable Health Care for America Act, Nov. 20, 2009, http://www.cbo.gov/doc.cfm?index=10741.

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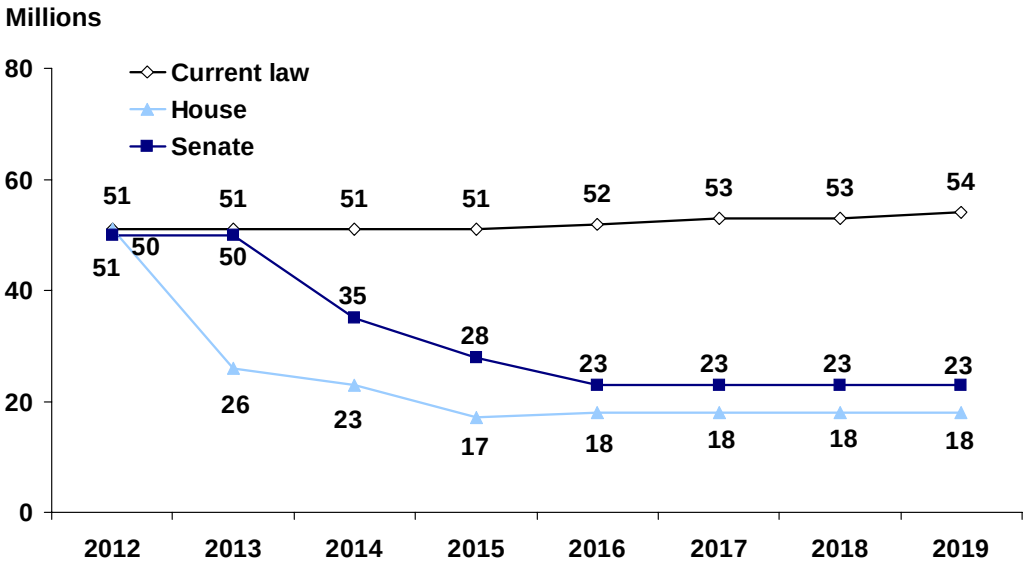
### How Many People Would Gain Coverage?

In the absence of health reform, the CBO estimates that the number of uninsured Americans will rise to 54 million by 2019, from 46 million in 2008. The House and Senate proposals would lower that estimate substantially.

- The CBO estimates that the House bill would reduce the number of people without coverage by 36 million, leaving 18 million people without health insurance in 2019 (Exhibit ES-3).
- The Senate bill would reduce the number of people without insurance by about 31 million, leaving 23 million people uninsured in 2019.

**Exhibit ES-3. Trend in the Number of Uninsured Nonelderly, 2012–2019 Under Current Law and House and Senate Bills**




Note: The uninsured includes unauthorized immigrants. With unauthorized immigrants excluded from the calculation, nearly 94% and 96% of legal nonelderly residents are projected to have insurance under the Senate and House proposals, respectively.
Data: Estimates by The Congressional Budget Office.

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- The CBO estimates that, under the House and Senate bills, employer-sponsored insurance would remain the primary source of insurance for most families, covering about 56 percent to 60 percent of the under-65 population in 2019.
- Small to mid-size companies purchasing coverage through the exchange would bring about 5 million to 9 million people into the exchanges under the Senate and House bills.
- Under both bills, the exchanges would provide a new source of coverage to an estimated 30 million people by 2019, by allowing either individuals or companies to purchase coverage in the exchanges.
- Under both bills, the number of people covered through the Medicaid program would increase by 15 million, from 35 million today to about 50 million by 2019.

## WOULD HEALTH INSURANCE BE MORE AFFORDABLE AND PROTECTIVE?

Overall, the House and Senate bills would make health insurance coverage more affordable and provide protection against heavy financial burdens, especially for uninsured people, people who purchased coverage on the individual market, and small businesses. Specific improvements in affordability and protection would stem from:

- an expansion of Medicaid eligibility;
- new insurance market regulations against rating on the basis of health, limits on rating on the basis of age, and prohibitions against annual or lifetime limits on benefits or cancellations of medical coverage after policyholders have become sick or injured;
- new essential benefit standards;
- premium subsidies for lower- and middle-income people who purchase insurance on their own;
- cost-sharing subsidies and out-of-pocket limits that reduce out-of-pocket expenses and improve the financial protection of the plans for people who become sick; and
- insurance reform provisions aimed at slowing the overall rate of growth in health care costs and premiums, including a reduction in administrative costs, the insurance exchange's authority to review and reject premiums, and a public health insurance option.

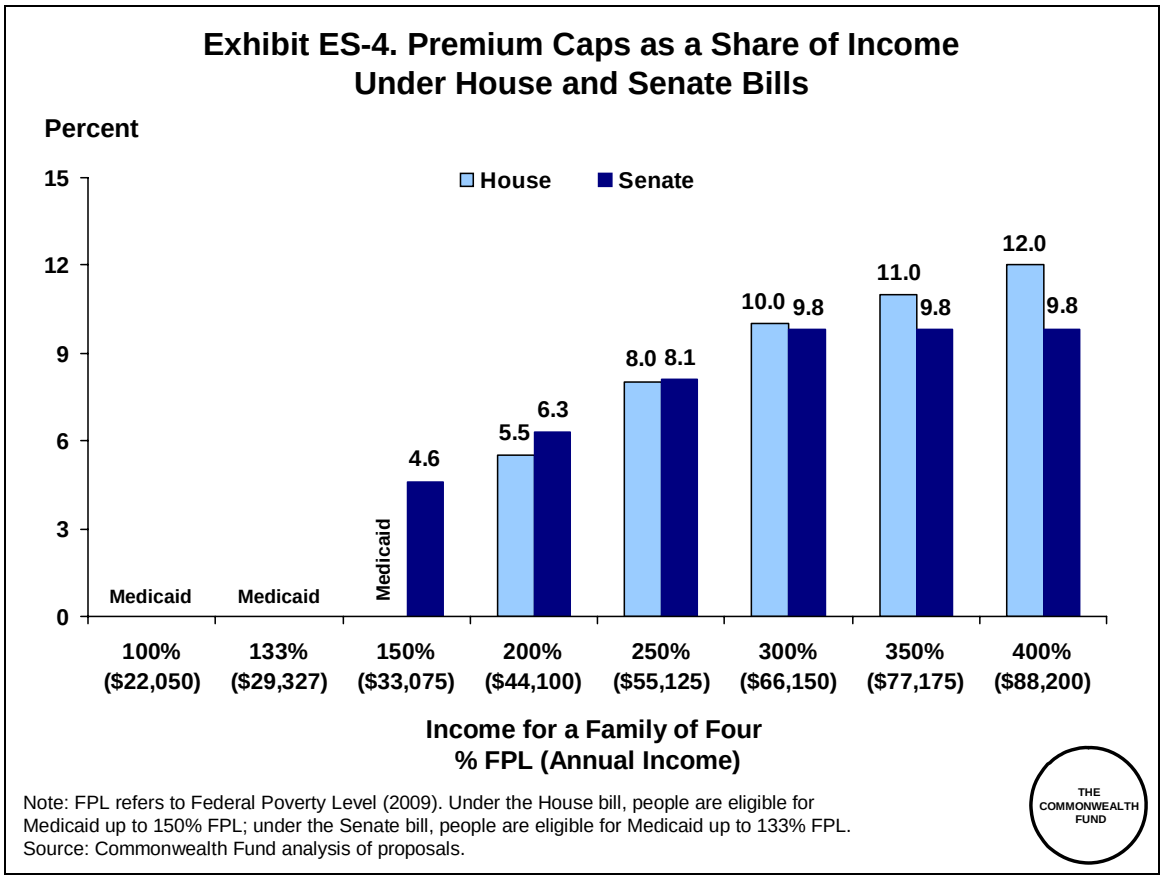
**Affordability of Premiums**

Provisions in the bills that would affect premiums paid by families include: the share of medical costs covered by the plan (known as "actuarial value"), the size of the premium subsidies, the degree to which premiums are allowed to vary by age, and how the premium subsidies are allowed to grow over time.

*Premium Subsidies*

- For families earning less than 400 percent of the federal poverty level who are eligible to purchase health insurance through the exchange, the bills would provide premium subsidies that would cap premium costs as a share of income.
- For families with incomes between 150 percent and 400 percent of the poverty level, the House bill would limit people's premium contributions to 3 percent of income at just over 150 percent of poverty and rise to 12 percent (those at 150 percent of poverty or less would be eligible for Medicaid). The Senate bill would limit people's premium contributions to about 4 percent of income at just over 133 percent of poverty and gradually increase them to 9.8 percent for families with incomes between 300 and 400 percent of poverty (those at 133 percent of poverty or less would be eligible for Medicaid) (Exhibit ES-4).
- Families earning less than $55,125 per year would pay a larger share of their incomes on premiums under the Senate bill than under the House bill, while those

with higher incomes ($77,000–$88,000) would pay a larger share of their income under the House bill.




Note: FPL refers to Federal Poverty Level (2009). Under the House bill, people are eligible for Medicaid up to 150% FPL; under the Senate bill, people are eligible for Medicaid up to 133% FPL.
Source: Commonwealth Fund analysis of proposals.

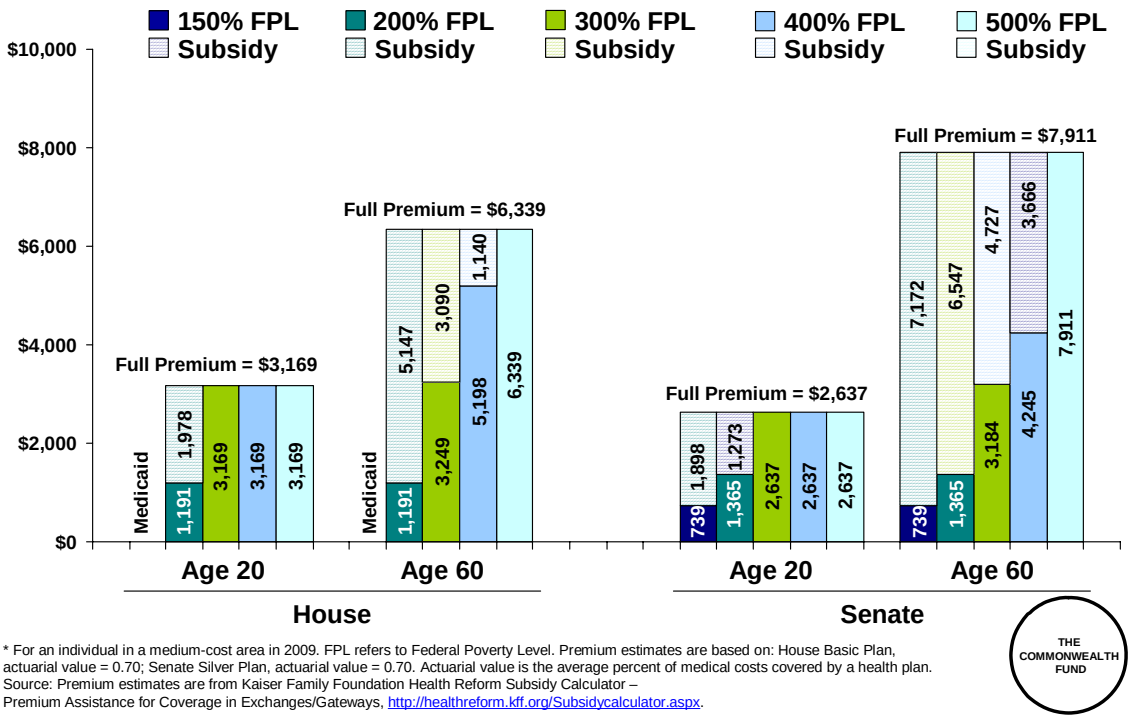
*Premiums for Older Adults*

Currently, older people generally pay higher premiums in the individual market than younger people do, because their expected medical expenses are higher. Similarly, insurance carriers will charge small companies with older workforces higher premiums. Premiums can vary by age by as much as 25 to 1 in the individual and small-group markets. Both the House and the Senate bills place limits on the degree to which premiums can rise with age (these limits are known as "age bands"). The Senate bill specifies slightly wider age bands than the House bill (3:1 vs. 2:1). This means that older adults under the Senate bill could face somewhat higher premiums than they would under the House bill, and young adults would face lower premiums in the Senate bill compared with the House bill (Exhibit ES-5).

A 60-year-old with income too high to qualify for a subsidy could spend about $7,900 on premiums under the Senate bill, compared with $6,339 in the House bill. In

contrast, under the House bill, a 20-year-old could spend about $3,169 on premiums, compared with $2,637 under the Senate bill.

**Exhibit ES-5. Annual Premium Amount Paid Out-of-Pocket by Individuals and Subsidies Under House and Senate Bills***




* For an individual in a medium-cost area in 2009. FPL refers to Federal Poverty Level. Premium estimates are based on: House Basic Plan, actuarial value = 0.70; Senate Silver Plan, actuarial value = 0.70. Actuarial value is the average percent of medical costs covered by a health plan.
Source: Premium estimates are from Kaiser Family Foundation Health Reform Subsidy Calculator – Premium Assistance for Coverage in Exchanges/Gateways, http://healthreform.kff.org/Subsidycalculator.aspx.

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## Out-of-Pocket Costs

The House and Senate bills would offer greater protection against out-of-pocket costs to families purchasing health insurance through the insurance exchanges, compared with the costs many families currently face in the individual market:

- New insurance market regulations would ensure that people in poor health could not be turned down or have a condition excluded from coverage.
- Essential benefit packages would ensure that people would have comprehensive health benefits without lifetime or annual limits, and with prohibitions against cancellation if someone becomes sick.
- The out-of-pocket spending limits in each of the bills would provide substantial protection from high out-of-pocket costs for people who have high medical costs in a given year, particularly those who become very sick.
- Each of the bills provides greater protection from out-of-pocket costs for people with low and moderate incomes by reducing cost-sharing and lowering out-of-pocket

spending limits. The House bill would provide greater protection from out-of-pocket costs for people with low and moderate incomes, compared with the Senate bill.

### INDIVIDUAL REQUIREMENT TO HAVE HEALTH INSURANCE

To ensure broad risk-pooling across health status and age and to prevent adverse selection into the new exchanges and Medicaid program, the bills require everyone in the United States to have health insurance, with some exemptions. The Senate bill would exempt many more people from the mandate than the House bill would.

- The House bill stipulates a penalty for not having insurance that would vary with income: 2.5 percent of the difference between an individual's modified adjusted gross income (modified to include tax-exempt interest and certain other sources of income) and the tax-filing threshold, up to the cost of the average national premium for the basic benefit plan. In practice, the penalty would amount to about $242 for a single person earning between $20,000 and $30,000, $703 for someone earning between $40,000 and $50,000, $1,570 for someone earning $75,000 to $100,000, and about $2,510 for someone earning between $100,000 and $200,000. The penalty is capped at about $3,500 per person.
- The Senate bill would require the greater of a flat penalty of $750 per person per year, or 2 percent of income in 2016, up to a cap of the national average "bronze" plan premium, phased in at $95 in 2014, $495 in 2015, and $750 in 2016.
- Financial hardship exemptions are provided in the Senate bill for those individuals for whom the premium would exceed 8 percent of income; there are unspecified exemptions for financial hardship in the House bill.

### EMPLOYER SHARED RESPONSIBILITY

The bills would require large employers to contribute to the cost of their employees' coverage, with the House bill specifying larger responsibilities for employers than the Senate bill.

- The House bill would require employers to contribute at least 72.5 percent of the premium cost for single coverage and 65 percent of the premium cost for family coverage of the lowest-cost plan that meets the bill's qualified health benefits plan requirements. This is substantially below the average contributed by employer plans now (84% for single coverage and 73% for family coverage).

- The Senate bill does not set standards on employer coverage but does require employers to contribute to the cost of covering uninsured workers who receive premium subsidies through the exchanges.

**Penalties and Small-Business Exemptions**

- The House bill requires employers with payrolls of $750,000 or more to meet the coverage requirements or pay 8 percent of payroll into a health insurance exchange trust fund. The penalty is less than the average share of payroll that employers currently spend on premium contributions, which is about 12 percent.
- The Senate bill would require larger firms (i.e., those with 50 or more workers) that do not offer coverage to pay $750 per full-time worker if any worker receives a subsidy through the exchange. Firms that do offer coverage, but have workers who contribute more than 9.8 percent of their income toward their premiums and are eligible to receive subsidies through the exchange, must pay the lesser of $3,000 for each full-time worker receiving a credit or $750 for every worker.
- The Senate bill also penalizes employers for imposing waiting periods for new employees. Large employers would pay $600 for each full-time worker in a waiting period of more than 60 days.

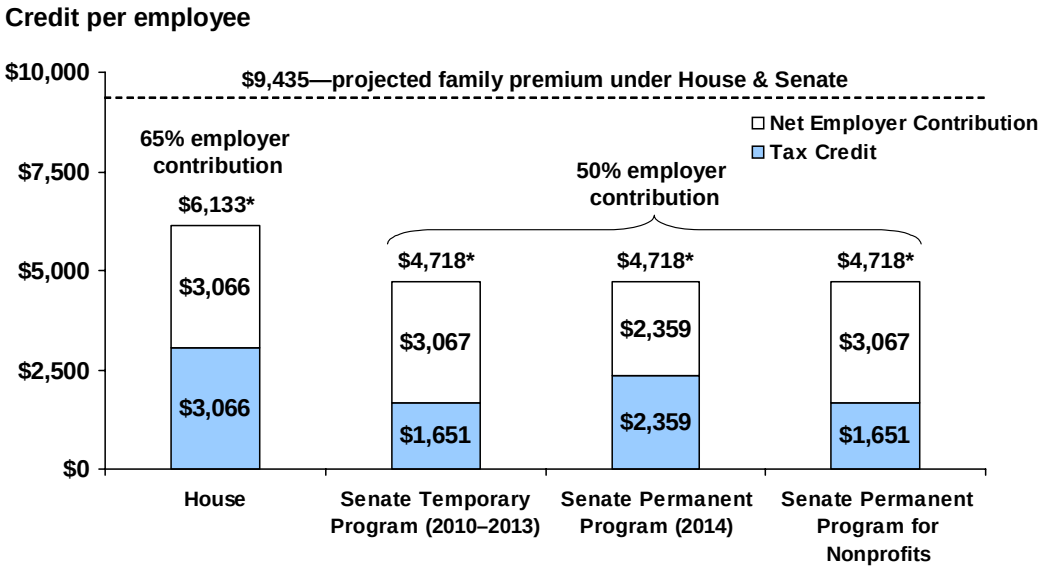
**Small-Business Tax Credits and Subsidies**

Each of the bills also helps small businesses by providing tax credits to employers who contribute a specified share of their employees' premiums. The Senate bill requires a lower premium contribution than the House bill for employers to be eligible for the tax credit, and it allows firms with somewhat higher average wages to qualify.

- Under the House bill, tax credits for up to two years would be available to employers with fewer than 10 employees or average wages of $20,000; these would then phase out for employers with up to 25 employees or average wages of $40,000 per year. The full credit would equal 50 percent of the premium paid by a small employer who is in compliance with the mandate or who is paying 72.5 percent of premium for single coverage and 65 percent of premium for family coverage, for up to two years. If a company is eligible for the full tax credit and offers the House basic plan and contributes 65 percent of the premium for families, it would receive a tax credit of about $3,066 per worker, leaving it with a balance of $3,066 (Exhibit ES-6).
- For firms that have 10 employees or fewer and average wages below $25,000, and that contribute 50 percent of their employees' premiums, the Senate bill would

provide tax credits for up to two years. These credits would be phased out for firms with up to 25 employees and average wages of $50,000. From 2010 to 2013, the bill would provide tax credits worth 35 percent of the premium contribution; beginning in 2014, the credits would be worth 50 percent of the contribution. Assuming that a company that is eligible for the full credit offers the Senate "silver plan" and contributes 50 percent of a family premium, it would be eligible for a tax credit of $1,651 per worker in the first two years, leaving it with a balance of $3,067, and a credit of $2,359 per worker after that, leaving it with a balance of $2,359.

**Exhibit ES-6. Small Business Tax Credits Under House and Senate Bills for Family Premiums**




* To be eligible for tax credits, firms must contribute 65% of premiums per family under the House plan, and 50% under the Senate plan. Firms receive 50% of their contribution in tax credits under House, and 35% and later 50% of contribution under Senate.
Note: Projected premium for a family of four in a medium-cost area in 2009 (age 40). Premium estimates are based on: House Basic Plan, actuarial value = 0.70; Senate Silver Plan, actuarial value = 0.70. Actuarial value is the average percent of medical costs covered by a health plan.
Under the House bill, small firms are defined as those with fewer than 25 employees with average wages below $40,000. The full credit is available to firms with fewer than 10 employees and average wages less than $20,000; credits phase out up to 25 employees average wages of $40,000. Under the Senate bill, small firms are defined as those with fewer than 25 employees with average wages below $50,000. The full credit is available to firms with 10 or fewer employees and average wages less than $25,000; credits phase out up to 25 employees average wages of $50,000.
Source: Commonwealth Fund analysis of proposals. Premium estimates are from Kaiser Family Foundation Health Reform Subsidy Calculator, http://healthreform.kff.org/Subsidycalculator.aspx.

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## INSURANCE MARKET REGULATIONS AND THE INSURANCE EXCHANGE

Each bill would bring sweeping change to the individual and small-group insurance markets through new national insurance market regulations. This would be combined with a reorganization of the markets, either by substituting a new national insurance exchange for the individual market in the case of the House bill, or the creation of state or regional exchanges in the Senate bill. The exchanges in the Senate bill would operate alongside the existing individual and small-group markets, under the same rules.

- There are key differences in the design of the exchanges in the bills, including the exclusivity of the exchange vis-à-vis other markets, the authority of the exchanges to review and reject premiums proposed by carriers, and consumer choice of a public plan. These differences have significant implications for the long-term ability of the exchange to increase price competition among carriers and providers and lower costs.
- The House bill establishes an insurance exchange with potentially greater regulatory and market power, and thus greater potential to reduce premiums and costs over time, than the Senate bill. This is due to provisions in the House bill for: full replacement of the individual insurance market; direct federal control of the exchange; the ability of the U.S. Secretary of Health and Human Services to review and reject premiums proposed by participating insurance carriers; and a new public health insurance plan.

**Conclusion**

The House and Senate bills would significantly reform the U.S. health insurance system, providing coverage to more than 30 million uninsured Americans and substantially improving the affordability of health insurance coverage for small businesses and for people currently buying health insurance on their own. Moreover, the system reform and revenue provisions in both bills would more than offset the federal costs of expanding and improving health insurance coverage: the CBO estimates that both bills would reduce the federal deficit by $132 billion to $138 billion over 10 years.

While the bills are largely similar in their approach to reforming health insurance, there are key differences that have implications for the number of people expected to gain heath insurance, the amount of premiums and out-of-pocket costs paid by families, and the cost of health insurance over time.

- **Insurance market reforms.** The two bills would prevent underwriting on the basis of health but would allow premiums to rise with age. However, the House bill would allow insurers to charge higher premiums to older people by a lower margin.
- **Individual requirement to have health insurance.** Both bills would require individuals to have coverage, but the Senate bill would exempt many more people from the mandate.
- **Financial protection for low- and moderate-income families.** The House bill expands Medicaid eligibility further up the income scale (to 150% of poverty) compared with the Senate bill (133% of poverty) and provides more affordable premiums and greater protection from out-of-pocket costs. As such, the CBO

estimates that the cost of premium and cost-sharing subsidies in the House bill are higher than in the Senate bill over 10 years ($602 billion vs. $436 billion, respectively).

- **Employer shared responsibility.** The House bill would require employers, except for small firms, to offer and contribute a specified share of their workers' coverage or pay a penalty. The Senate bill would not require employers to offer health insurance but would assess a flat, per-employee fee on employers, with workers receiving federal premium subsidies through the insurance exchanges. Employers will make a greater contribution overall to the House reform plan, providing an estimated $135 billion over 10 years, compared with $28 billion in the Senate.
- **Insurance exchanges.** Each bill establishes new insurance exchanges that would either substitute or complement existing individual and small-group markets and would be subject to the same market rules (e.g., underwriting and rating). The House bill would replace existing individual markets, but not small-group markets, with a national insurance exchange, although states can elect to run their own exchanges subject to strict rules. The Senate bill would create state or regional exchanges that would operate alongside existing individual and small-group markets. In both bills, all individual and family premium subsidies and cost-sharing subsidies would only apply to private or public plans sold through the exchanges.
- **Choice of public health plan through the exchange.** The House bill would provide a choice of public, private, and nonprofit cooperative plans sold through the exchange. The Senate bill would provide a choice of private plans, nonprofit cooperative plans, and multistate private plans that would be offered under contract with the federal Office of Personnel Management.
- **Risk equalization.** The bills include mechanisms aimed at equalizing risks across patients, thereby compensating insurance carriers for high-cost patients and reducing incentive for carriers to "cherry pick" patients who appear to be good health risks. Compared with the House version, the Senate bill provides a more detailed risk-equalization strategy.

Given the growing health insurance crisis facing the nation, it is imperative that Congress complete its historic work on reforms that will place the U.S. health system on the road to high performance.

# THE HEALTH INSURANCE PROVISIONS OF THE 2009 CONGRESSIONAL HEALTH REFORM BILLS: IMPLICATIONS FOR COVERAGE, AFFORDABILITY, AND COSTS

## INTRODUCTION

In September, the Census Bureau reported that 46.3 million people lacked health insurance in 2008, up from 45.7 million in 2007.[1] The Commonwealth Fund estimates that in 2007 an additional 25 million insured adults under age 65 had such high out-of-pocket costs relative to their income that they were effectively underinsured, an increase from 16 million people in 2003.[2] Both these trends have had serious financial and health consequences for U.S. families. An estimated 79 million adults, both with and without health insurance, reported problems paying their medical bills in 2007 and 80 million reported a time that they did not get needed health care because of cost.[3] The relentless growth in health care costs combined with the severe downturn in the economy has almost certainly deepened the health insurance crisis facing families across the country. At current cost trends, average family premiums in employer plans are expected to nearly double by 2020.[4]

The health insurance crisis is not felt by families alone; it is also a factor in the poor performance the U.S. health care system achieves relative to other countries and to benchmarks in access, quality and efficiency.[5] According to the Institute of Medicine, health insurance coverage is the most important determinant of access to health care.[6] Because so many people are uninsured or underinsured, access to care in the U.S. is highly unequal. Poor access to care is then linked to poor quality care. People who lack health insurance are much less likely to have a regular source of care, to receive timely preventive services, or to be able to manage their chronic conditions appropriately. They have poorer health status and shorter life expectancies than those with health insurance. People without coverage also create inefficiencies in the delivery of care in terms of duplicated tests and difficulty in tracking health records. A highly fragmented demand side in the health care system makes it difficult to control costs. The financing of care for uninsured and underinsured families is inefficient. There is also a lack of positive incentives in benefit design and insurance markets.

This year, policymakers in Washington have placed health care reform at the top of the nation's agenda. The five committees with jurisdiction over health care in the U.S. Senate and House of Representatives have voted to pass major health reform bills. In the House, jurisdiction is shared among three committees—Ways and Means, Education and

Labor, and Energy and Commerce. All three committees worked in concert to pass similar bills by July 31. On October 29, House Speaker Nancy Pelosi introduced the blended House bill, H.R. 3962, for floor consideration; the bill was passed by the full House on November 7. The Senate Health, Education, Labor, and Pensions (HELP) Committee and Finance Committee passed bills in July and October, respectively. On November 18, Senate Majority Leader Harry Reid introduced the blended Senate bill, H.R. 3590, for floor consideration. On December 19, Majority Leader Reid introduced the "manager's amendment" to the bill; the bill was passed by the full Senate on December 24.

This report analyzes provisions of the House bill H.R. 3962, The Affordable Health Care for America Act, and Senate bill H.R. 3590, The Patient Protection and Affordable Care Act, that are intended to expand and improve health insurance coverage in the United States. It builds on an earlier report published by The Commonwealth Fund that explains the provisions of the congressional health reform bills in detail.[7] This report will focus on the bills' implications for the number of people likely to gain coverage and under which program or plan they will get it, the insurance premium and out-of-pocket costs for families, the consequences of the bills for employers, and the degree to which the reorganization and regulation of insurance markets in the bills has the potential to stimulate price competition and lower costs. A companion Commonwealth Fund report analyzes the bills' implications for health system reform.[8]

## Overall Approach of the Congressional Health Reform Bills

The House and Senate bills aim to provide near-universal health insurance coverage by building on the strongest aspects of the insurance system—large employer insurance, Medicaid, and the Children's Health Insurance Program (CHIP). They will also work to regulate and reorganize the weakest part of the system, the individual and small group insurance markets, where so many small businesses and individuals are hurt by high premiums, high administrative costs, underwriting, and a lack of transparency in the content of benefit packages (Exhibit 1).

## Exhibit 1. Congressional Health Reform Bills as of December 2009

| | House of Representatives 11/7/09 | Senate 12/24/09 |
|---|---|---|
| **Insurance market regulations** | GI, adjusted CR 2:1; in 2010: meet 85% medical loss ratio; uninsured eligible for high-risk pools, no annual or lifetime limits or rescissions, dependent coverage to 27 | GI, adjusted CR 3:1; in 2011: health plans required to refund enrollees for non-claims costs >15% in large group market and >20% in small group & individual markets; uninsured eligible for high risk pools; no annual or lifetime limits or rescissions, dependent coverage to 26 |
| **Individual mandate** | Penalty: 2.5% of the difference between MAGI and the tax filing threshold up to the average national premium of the "basic" benefit package | Penalty: Greater of $750/year per adult in household or 2% of income in 2016 phased in at $95 in 2014, $495 in 2015, $750 in 2016, up to a cap of national average bronze plan premium; family penalty capped at $2,250; exempts premiums >8% of income |
| **Exchange** | National or state | Regional, state, or substate |
| **Plans offered** | Private, public, and co-op | Private and co-op; multistate plans with at least one nonprofit plan, supervised by OPM |
| **Eligibility for exchange** | Individuals and small businesses <25 in 2013; <50 by 2014; <100 by 2015: 100+ after 2015 | Individuals and small businesses 50–100, 100 by 2015, 100+ at state option |
| **Minimum benefit standard, tiers** | Essential health benefits 70%–95% actuarial value, four tiers | Essential health benefits 60%–90% actuarial value, Four tiers; catastrophic policy for young adults <30 and those exempt from individual mandate |
| **Premium/cost-sharing assistance** | Sliding scale 1.5%–12% of income up to 400% FPL; cost-sharing credits 133%–350% FPL | Sliding scale 2%–9.8% of income up to 300% FPL/ flat cap at 9.8% 300%–400% FPL; cost-sharing subsidies for 100%–200% FPL |
| **Medicaid/CHIP expansion** | Up to 150% FPL | Up to 133% FPL |
| **Shared responsibility/ Employer pay-or-play** | Play or pay; firms >$500,000 payroll 72.5% + prem. contribution for indiv./65% + for families; sliding scale phased-in from 2% to 8% of payroll at $750,000; small employer tax credit; young adults can stay on parent's health plan to age 27 | Firms >50 FTEs pay uncovered worker fee of $750; small employer tax credit; young adults can stay on parent's health plan to age 26 |

Note: GI = guaranteed issue; CR = community rating. Actuarial value is the average percent of medical costs covered by a health plan.
Source: Commonwealth Fund analysis of proposals.

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The bills would establish new federal rules that require insurance carriers in all markets to accept every individual and employer who applied for coverage (guaranteed issue) and prevents carriers from setting premiums based on health status (adjusted community rating). The bills would create a new health insurance exchange—an organized marketplace managed and regulated by government in which eligible individuals and businesses can choose among health plans (private, public, private multistate plans offered under contract by the U.S. Office of Personnel Management, and nonprofit cooperative plans) that meet the requirements of participation set by the exchange.[9] Premium and cost-sharing subsidies would be available on a sliding scale to offset the costs of plans purchased through the exchange and reduce out-of-pocket costs for middle-and lower-income families. An essential standard benefit package with different levels of cost-sharing would set a floor for plans offered through the exchange. Income eligibility for Medicaid would be expanded up to 133 percent or 150 percent of the federal poverty level, or about $29,300 and $33,000 for a family of four (Exhibit 2). Individuals would be required to have coverage and large employers would be required to either offer coverage or contribute to the cost of their employees' insurance.

**Exhibit 2. Federal Poverty Level, by Annual Income and Family Size, 2009**

| | Family Size | | | |
|---|---|---|---|---|
| % FPL | One Person | Two People | Three People | Four People |
| 100 | $10,830 | $14,570 | $18,310 | $22,050 |
| 133 | 14,404 | 19,378 | 24,352 | 29,327 |
| 150 | 16,245 | 21,885 | 27,465 | 33,075 |
| 200 | 21,660 | 29,140 | 36,620 | 44,100 |
| 250 | 27,075 | 36,425 | 45,775 | 55,125 |
| 300 | 32,490 | 43,710 | 54,930 | 66,150 |
| 350 | 37,905 | 50,995 | 64,085 | 77,175 |
| 400 | 43,320 | 58,280 | 73,240 | 88,200 |

Note: FPL refers to Federal Poverty Level.
Source: U.S. Census Bureau, 2009.

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## MAJOR DIFFERENCES BETWEEN THE TWO BILLS

While the bills are largely similar in their approaches to reforming health insurance, there are key differences that have implications for the number of people expected to gain heath insurance, the amount of premiums and out-of-pocket costs paid by families, and the cost of health insurance over time.

- **Insurance market reforms.** The bills would prevent underwriting on the basis of health but would allow premiums to rise with age. The House bill would allow insurers to charge higher premiums to older people by a lower margin than would the Senate bill. In other words, young adults who are not eligible for premium subsidies could be charged relatively higher premiums under the House bill and older adults could be charged relatively higher premiums under the Senate bill.
- **Insurance exchanges.** Each bill establishes new insurance exchanges that would either substitute or complement existing individual and small-group markets and would be subject to the same market rules (e.g., underwriting and rating). The House bill would replace existing individual markets with a national insurance exchange, although states can elect to run their own exchanges, subject to strict rules. The Senate bill would create state or regional exchanges that would operate

alongside existing individual markets. All individual and family premium subsidies and cost-sharing subsidies would only apply to private or public plans sold through the exchanges in both bills.

- **Choice of public health insurance plan in the exchange.** The House bill would provide a choice of public, private, and nonprofit cooperative plans sold through the exchange. The Senate bill would provide a choice of private plans, nonprofit cooperative plans, and multistate private plans offered under contract by the Office of Personnel Management.
- **Individual requirement to have health insurance.** The bills would require individuals to have coverage, but the Senate bill would exempt many more people from the mandate than would the House bill.
- **Financial protection for low- and moderate-income families.** The House bill expands Medicaid eligibility further up the income scale than does the Senate bill and provides more protection from out-of-pocket costs.
- **Employer shared responsibility.** The House bill would require employers, other than small employers, to offer and contribute a specified share of their employees' coverage or pay a penalty. The Senate bill would not require employers to offer health insurance but would assess a flat, per-employee fee on employers with employees receiving federal premium subsidies through the insurance exchanges.

## HOW MUCH WOULD THE PROPOSALS COST THE FEDERAL GOVERNMENT?

The Congressional Budget Office (CBO) has estimated that the net cost of coverage expansion in the House bill would total $891 billion between 2010 and 2019, while the coverage expansion in the Senate bill would total $763 billion (Exhibit 3).[10] The difference in cost is partly attributable to earlier implementation under the House bill (2013) than the Senate bill (2014). The House bill also expands Medicaid further up the income scale and would provide greater protection from premiums and out-of-pocket costs for low- and moderate-income families. The CBO estimates that the cost of premium and cost-sharing subsidies in the House bill are $602 billion over 10 years, compared with $436 billion in the Senate bill.

## Exhibit 3. Major Sources of Savings and Revenues Compared with Projected Spending, Net Cumulative Effect on Federal Deficit, 2010–2019

**Dollars in billions**

| | CBO estimate of House bill (H.R. 3962) | CBO estimate of Senate bill (H.R. 3590) |
|---|---|---|
| **Total Net Impact on Federal Deficit, 2010–2019** | **–$138** | **–$132** |
| **Total Federal Cost of Coverage Expansion and Improvement** | **$891** | **$763** |
| ***Gross Cost of Coverage Provisions*** | ***$1,052*** | ***$871*** |
| • Medicaid/CHIP outlays | 425 | 395 |
| • Exchange subsidies | 602 | 436 |
| • Small employer subsidies | 25 | 40 |
| ***Offsetting Revenues and Wage Effects*** | ***–$162*** | ***–$108*** |
| • Payments by uninsured individuals | –33 | –15 |
| • Play-or-pay payments by employers | –135 | –28 |
| • Associated effects on taxes and outlays | 6 | –65 |
| **Total Savings from Payment and System Reforms** | **–$456** | **–$483** |
| • Productivity updates/provider payment changes | –177 | –151 |
| • Medicare Advantage reform | –170 | –136 |
| • Other improvements and savings | –109 | –196 |
| **Total Revenues** | **–$574** | **–$413** |
| • Excise tax on high premium insurance plans | — | –149 |
| • Surtax on wealthy individuals and families | –461 | — |
| • Other revenues | –113 | –264 |

Note: Totals do not reflect net impact on deficit because of rounding.
Source: The Congressional Budget Office Cost Estimate of the Patient Protection and Affordable Care Act, Dec. 19, 2009, http://www.cbo.gov/doc.cfm?index=10868. The Congressional Budget Office Analysis of H.R. 3962, The Affordable Health Care for America Act, Nov. 20, 2009, http://www.cbo.gov/doc.cfm?index=10741.

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The bills would require employers to share in the costs of reform, but the House bill places more requirements on employers to offer coverage, meet essential benefit standards, and contribute to their employees' premiums. Consequently, employers contribute more overall under the House reform plan—providing an estimated $135 billion over 10 years—compared with $28 billion under the Senate plan.

While there are differences between the House and Senate approaches to financing health reform, both include a mixture of new revenue sources and savings from within the health system to develop comprehensive reform legislation that is deficit-neutral. In the House bill, the marginal income tax rate for families with very high income is increased; a tax surcharge would be placed on individuals with incomes over $500,000 and families with incomes over $1 million. In the Senate bill, the largest new revenue source is an excise tax of 40 percent on insurers that write policies costing more than $8,500 for an individual or $23,000 for a family.

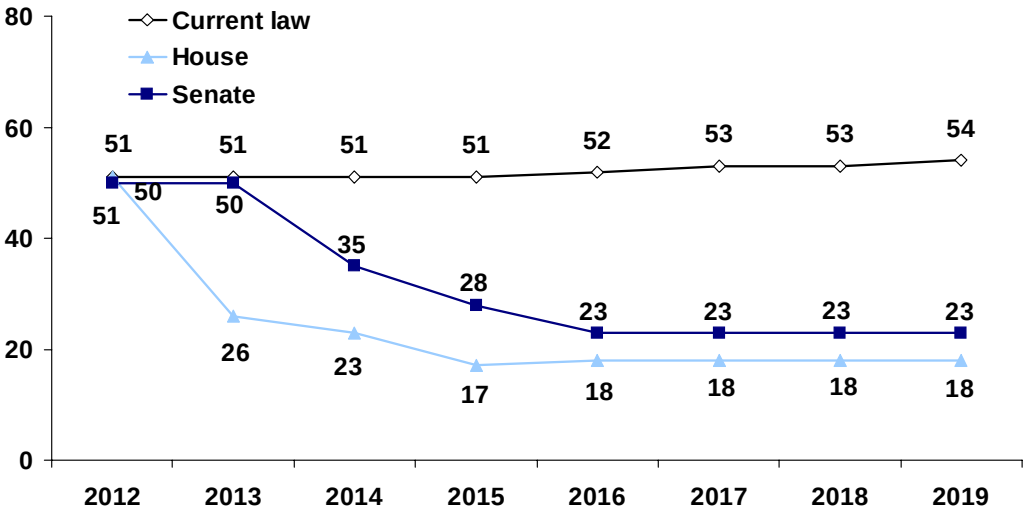
Under the House bill, the total net impact on the federal budget deficit between 2010 and 2019 is a reduction of $138 billion.[11] This figure reflects the net federal costs of $891 billion for expanding coverage, offset by reductions in health system spending of $456 billion and by increased total revenue of $574 billion.

In the Senate version, the total net impact on the federal budget deficit in the same 10-year period is a reduction of $132 billion. This figure reflects the net federal costs of expanding coverage ($763 billion), offset by reductions in health system spending ($483 billion) as well as new revenues ($413 billion).

### How Many People Would Gain Coverage Under the Bills?

The bills would substantially reduce the number of people who do not have health insurance in the United States. In the absence of health reform, the CBO estimates that the number of uninsured Americans will rise to 54 million by 2019 (Exhibit 4) from 46 million in 2008. CBO estimates the House bill would go farther than the Senate bill, reducing the number of people without coverage by 36 million and leaving 18 million people without health insurance in 2019.[12] When unauthorized immigrants, who are not eligible for coverage under the provisions in the bill, are excluded from the analysis, the proposal would cover about 96 percent of legal residents under age 65. The budget office estimates that the Senate bill would reduce the number of people without insurance by about 31 million, leaving 23 million people uninsured in 2019, covering 94 percent of legal residents.[13]

**Exhibit 4. Trend in the Number of Uninsured Nonelderly, 2012–2019 Under Current Law and House and Senate Bills**




Note: The uninsured includes unauthorized immigrants. With unauthorized immigrants excluded from the calculation, nearly 94% and 96% of legal nonelderly residents are projected to have insurance under the Senate and House proposals, respectively.
Data: Estimates by The Congressional Budget Office.

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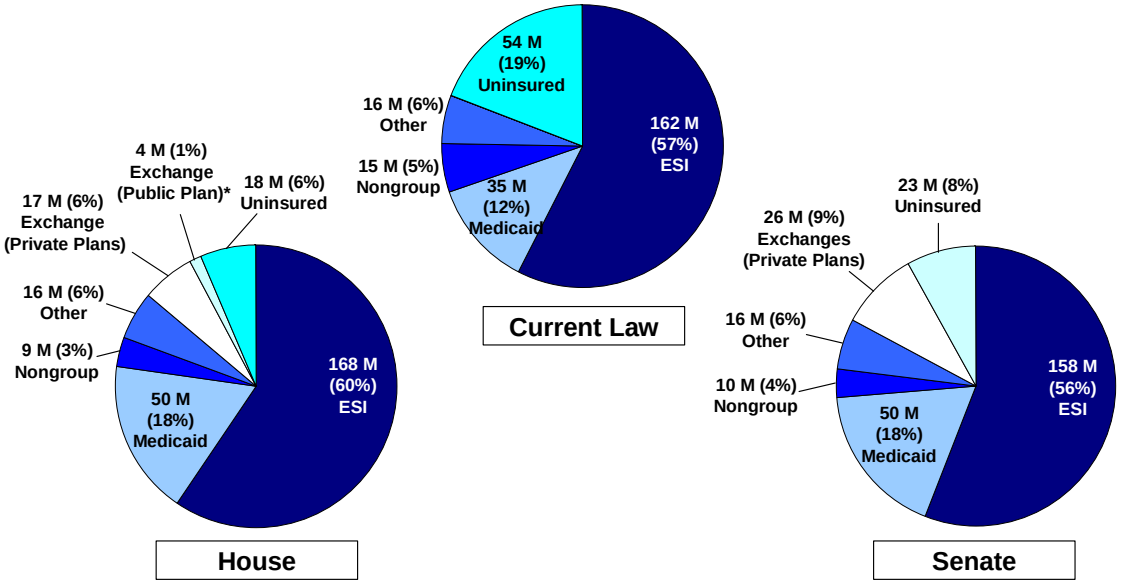
## WHERE WOULD PEOPLE GET HEALTH INSURANCE?

The CBO estimates that, under the House and Senate bills, employer-sponsored insurance will remain the primary source of insurance for most families by 2019, covering about 60 percent of the under-65 population, or 168 million people, in the House bill and 56 percent of the under-65 population, or 158 million people, in the Senate bill.[14] Of those, small employers would bring about 9 million workers into the insurance exchange in the House bill and about 5 million workers in the Senate bill.(Exhibit 5).

**Exhibit 5. Source of Insurance Coverage Under Current Law and House and Senate Bills, 2019**




**Among 282 million people under age 65**

* CBO estimates 20% of people enrolled in exchange will choose public plan under House bill. Employees whose employers provide coverage through the exchange are shown as covered by their employers (9 million in the House bill and 5 million in the Senate bill), thus about 30 million people would be enrolled through plans in the exchange under both bills. Note: ESI is Employer-Sponsored Insurance.
Source: Revised Estimate of the Affordable Health Care for America Act, Congressional Budget Office Letter to the Honorable John Dingell, November 20, 2009, http://www.cbo.gov/doc.cfm?index=10741. The Congressional Budget Office Analysis of the Patient Protection and Affordable Care Act, Incorporating the Manager's Amendment, Dec. 19, 2009, http://cbo.gov/doc.cfm?index=10868.

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The national or state health insurance exchanges would provide a new source of coverage to an estimated 30 million people in the House and Senate bills by 2019 (including those brought into the exchange by eligible small employers), or between 10 percent and 11 percent of the under-65 population.[15] In the House bill, people would choose between private and public heath plans. The CBO expects that 6 million of those purchasing coverage through the exchange under the House bill would choose the public plan (including those brought into the exchange by their employers), about 2 percent of the total under-65 population.

Coverage through the individual insurance market would decline from a projected 15 million in 2019 to 9 million in the House bill and 10 million in the Senate bill.[16] The House bill would replace the individual market with the insurance exchange, with premium subsidies tied to exchange plans, but would grandfather plans currently held by people who wanted to keep them. The Senate bill does not replace the individual market but would apply the same new market regulations and benefit standards to plans sold inside and outside the exchange and would also tie premium subsidies to plans sold through the exchange.

Coverage through the Medicaid program would increase under both bills from 35 million to about 50 million people by 2019. The House bill would expand income eligibility for Medicaid to up to 150 percent of poverty; the Senate bill would increase eligibility to 133 percent of poverty. Both represent substantial changes in the Medicaid program. Currently, income eligibility in Medicaid for adults in most states is very low (Exhibit 6)[17]. Although several states have expanded eligibility for parents of dependent children, in most states income eligibility thresholds are well below the federal poverty level. Childless adults in most states are not eligible for Medicaid regardless of income.

The Senate bill would also require states to use modified gross income to determine eligibility for Medicaid, similar to the way eligibility for premium subsidies in the exchanges will be determined. For most nondisabled people under age 65, states could no longer determine Medicaid eligibility by including resources like cars and savings accounts (commonly known as “asset tests”) and could no longer “disregard” certain types of income or expenses, such as child support received or paid (commonly known as “income disregards”). The House bill would also remove asset tests and would require the commissioner of the exchange to conduct a study of income disregards.

In the initial years of implementation of both the Senate and House legislation, the federal government would finance the full amount of the Medicaid expansion. The House bill would require state Medicaid programs to cover nondisabled, childless adults under age 65 who are not eligible for Medicare with incomes at or below 150 percent of the poverty level. The federal government would pay 100 percent of the costs of Medicaid coverage for this population in 2013 and 2014, then 91 percent in 2015 and beyond.

The bill would also require state Medicaid programs to cover children, parents, and individuals with disabilities under age 65 with income at or below 150 percent of poverty. For individuals in these categories who have incomes between the levels in effect in the state as of June 16, 2009, and 150 percent of poverty, the federal government

would pay 100 percent of the costs of Medicaid coverage in 2013 and 2014 and 91 percent in 2015 and beyond.

The Senate bill would provide full federal financing to states for the Medicaid expansion in the years 2014 to 2016. In the Senate bill, some states that were not eligible for the new federal funding, because they had already expanded Medicaid to adults with incomes over 133 percent of poverty, would receive an increase in their federal matching formula for Medicaid, known as the federal medical assistance percentage (FMAP). FMAP provides higher reimbursement to states with lower per-capita incomes relative to the national average. These states would receive an increase of 2.2 percentage points in their FMAP for parents and childless adults who are not newly eligible in 2014 to 2019, or a 0.5-percentage-point increase in 2014 to 2016. Beginning in 2017, financing of coverage for the newly eligible will be shared by states and the federal government through an increase in the federal matching formula for Medicaid.[18]

**Exhibit 6. Uninsured Rates and Medicaid/CHIP Income Eligibility Standards by State**

| | Percent Uninsured, 2007–08 | | Income Eligibility for Medicaid/CHIP (Percent of federal poverty levels), 2009 | | |
|---|---|---|---|---|---|
| | Children (under age 18) | Adults (ages 18–64) | Children | Parents | Childless Adults |
| Alabama | 5.5% | 17.0% | 200 | 25 | NA |
| Alaska | 12.9% | 24.1% | 175 | 85 | NA |
| Arizona | 14.9% | 23.6% | 200 | 200 | 100 |
| Arkansas | 7.7% | 24.0% | 200 | 17 | NA |
| California | 10.6% | 24.4% | 250 | 106 | NA |
| Colorado | 12.7% | 19.7% | 205 | 66 | NA |
| Connecticut | 5.3% | 13.3% | 300 | 191/300* | 300* |
| Delaware | 8.3% | 14.3% | 200 | 121 | 100 |
| District of Columbia | 6.2% | 12.0% | 300 | 207 | 200* |
| Florida | 18.0% | 25.9% | 200 | 55 | NA |
| Georgia | 11.0% | 22.8% | 235 | 52 | NA |
| Hawaii | 5.1% | 10.6% | 300 | 100/200* | 100^/200* |
| Idaho | 9.9% | 20.1% | 185 | 28 | NA |
| Illinois | 6.5% | 17.8% | 200 | 185 | NA |
| Indiana | 5.6% | 16.6% | 250 | 26/200* | 200*^ |
| Iowa | 5.0% | 12.8% | 200 | 86/200* | 200* |
| Kansas | 9.4% | 16.1% | 200 | 34 | NA |
| Kentucky | 9.0% | 19.9% | 200 | 62 | NA |
| Louisiana | 11.9% | 26.2% | 250 | 26 | NA |
| Maine | 5.4% | 13.3% | 200 | 206/300* | 100*^/300* |
| Maryland | 8.3% | 16.8% | 300 | 116 | 116* |
| Massachusetts | 3.2% | 7.2% | 300 | 133/300* | 133/300* |
| Michigan | 5.5% | 16.1% | 200 | 66 | 35* |
| Minnesota | 6.5% | 10.8% | 275 | 200/275* | 200* |
| Mississippi | 12.7% | 24.2% | 200 | 46 | NA |

| | | | | | |
|---|---|---|---|---|---|
| Missouri | 8.6% | 16.6% | 300 | 26 | NA |
| Montana | 11.6% | 21.1% | 175 | 58 | NA |
| Nebraska | 10.0% | 15.8% | 185 | 58 | NA |
| Nevada | 16.7% | 21.6% | 200 | 91 | NA |
| New Hampshire | 5.0% | 13.9% | 300 | 51 | NA |
| New Jersey | 12.1% | 18.8% | 350 | 200 | NA |
| New Mexico | 15.8% | 30.2% | 235 | 69/200* | 200* |
| New York | 8.0% | 18.0% | 250 | 150 | 100 |
| North Carolina | 10.7% | 21.1% | 200 | 51 | NA |
| North Dakota | 7.9% | 14.3% | 150 | 62 | NA |
| Ohio | 7.2% | 15.5% | 200 | 90 | NA |
| Oklahoma | 9.9% | 22.0% | 185 | 48/200* | 200* |
| Oregon | 11.1% | 21.6% | 185 | 42/100*^/185*^ | 100*^/185*^ |
| Pennsylvania | 7.1% | 12.9% | 300 | 36/200*^ | 200*^ |
| Rhode Island | 8.4% | 14.4% | 250 | 181 | NA |
| South Carolina | 13.5% | 20.6% | 200 | 90 | NA |
| South Dakota | 8.9% | 15.1% | 200 | 54 | NA |
| Tennessee | 9.3% | 20.1% | 250 | 134 | NA |
| Texas | 19.6% | 31.5% | 200 | 27 | NA |
| Utah | 10.0% | 16.2% | 200 | 68/150* | 150* |
| Vermont | 6.6% | 13.5% | 300 | 191/300* | 150/300* |
| Virginia | 8.5% | 17.9% | 200 | 30 | NA |
| Washington | 6.8% | 15.7% | 250 | 77/200*^ | 200*^ |
| West Virginia | 5.4% | 21.1% | 220 | 34 | NA |
| Wisconsin | 5.8% | 11.9% | 250 | 200 | 200* |
| Wyoming | 9.2% | 18.2% | 200 | 54 | NA |

* Denotes income eligibility for a waiver or state-funded program with more limited benefits and/or higher cost-sharing than Medicaid.

^ Denotes enrollment is closed to new applicants.

NA = Not applicable because state does not provide a waiver or state-funded coverage to childless adults.

Note: Income eligibility listed for children is the highest level reported among regular Medicaid, CHIP-funded Medicaid expansion program, or separate state program.

Data**:** Uninsured—2008–09 Current Population Survey ASEC Supplement; Children eligibility—Kaiser Commission on Medicaid and the Uninsured, *Challenges of Providing Health Coverage for Children and Parents in a Recession: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2009*, Jan. 2009; Parents and childless adults eligibility—Kaiser Commission on Medicaid and the Uninsured, *Expanding Health Coverage for Low-Income Adults: Filling the Gaps in Medicaid Eligibility*, May 2009.

Source: Commonwealth Fund State Scorecard on Health System Performance, 2009

### WOULD THE BILLS MAKE HEALTH INSURANCE AFFORDABLE?

Though the two bills vary in details, overall they would make health insurance coverage widely affordable and protective, especially compared with the current environment, for uninsured people, people who purchased coverage on the individual market, and small businesses. As the CBO estimates indicate, the bills will provide security to millions of people who have lost or will lose either their jobs or their job-based health benefits or both.

Specifically, improvements in the affordability and protection of health insurance would stem from the following provisions in the bills:

**Medicaid eligibility expansion** to 133 percent or 150 percent of poverty would provide individuals and families with incomes under $30,000 to $33,000 access to affordable, comprehensive health benefits, with minimal or no premium contributions or cost-sharing (Exhibits 1 and 2).

**New insurance market regulations** would prohibit underwriting on the basis of health in both bills, with some changes going into effect immediately. In 2010, the House bill would shorten the time that plans can look back for preexisting conditions from six months to 30 days and shorten the time plans may exclude coverage of certain benefits from 12 months to three months. The Senate bill would prohibit underwriting for children in the first year of implementation. Both bills would limit the amount that premiums could vary based on age. Currently, insurance carriers generally charge older people higher premiums in the individual market than younger people, because their expected medical expenses are higher. Similarly, insurance carriers will charge higher premiums to small companies that have older workforces. Premiums can vary by age by as much as 25 to 1 in the individual and small-group markets. [19]

Both the House and the Senate bills place limits, known as age bands, on the degree to which premiums can rise with age. The Senate bill specifies slightly wider age bands than the House bill (3:1 vs. 2:1). In addition, both bills would prohibit insurance carriers from imposing lifetime limits on the amount plans would pay and from cancelling medical coverage after policyholders have become sick or injured (rescissions), with both provisions going into effect immediately. In the first year of implementation, the House bill would prohibit annual limits; the Senate bill would restrict the use of annual limits in the first year and prohibit annual limits by 2014. These provisions would ensure that older people or those in poor health could not be denied coverage, charged an excessive premium, or have a condition excluded from coverage because of a preexisting condition. This would be a major improvement for people who must purchase coverage on their own (e.g., those without employer coverage or people who may lose such coverage in future) and small businesses, particularly older people or those with health conditions, including conditions as common as pregnancy and asthma.[20] The new market regulations would extend to all health plans sold in the United States.

**New essential benefit standards** with three to four levels of cost-sharing and annual out-of-pocket limits would ensure that families do not become bankrupt because of medical costs (Exhibit 7). They will also encourage the use of timely preventive services and protect against catastrophic costs in the event of a serious accident or injury.

Standardized benefits will also allow consumers to compare prices of similar health plans and provide incentives for insurers to compete on price.[21] Uniform standards across markets will prevent adverse selection into the exchange, provide transparency of information for people purchasing coverage through the exchange, and ensure that the cost of premium subsidies paid by the federal government does not vary by the type of benefit package offered.

In the House bill, employers will be required to provide at least the basic benefit package to be in compliance with the employer mandate. The Senate bill uses its bronze-level plan as a minimum threshold for determining eligibility for premium subsidies through the exchange for people with employer coverage. Under both bills, essential benefits are intended to be comparable to the scope of benefits typically offered by large employers. To achieve this goal, both bills require the U.S. Secretary of Labor to survey employers in 2010 and identify the scope of benefits typically offered.

## Exhibit 7. Essential Benefit Package Requirements Under House and Senate Bills

| House | Senate |
|---|---|
| **Four levels of cost-sharing** | **Four levels of cost-sharing** |
| **1st tier (Basic) actuarial value: 70%**<br>**2nd tier (Enhanced) actuarial value: 85%**<br>**3rd tier (Premium) actuarial value: 95%**<br>**4th tier (Premium-Plus) actuarial value: 95% plus oral health and vision care** | **1st tier (Bronze) actuarial value: 60%**<br>**2nd tier (Silver) actuarial value: 70%**<br>**3rd tier (Gold) actuarial value: 80%**<br>**4th tier (Platinum) actuarial value: 90%** |
| **Annual out-of-pocket maximum $5,000 for individuals, $10,000 for families** | **Out-of-pocket maximum capped at HSA level of $5,950 for individuals and $11,900 for families** |
| | **Young adult catastrophic policy, covering preventive services, would be available** |

Note: Actuarial values is the average percent of medical costs covered by a health plan.
Source: Commonwealth Fund analysis of health reform proposals.

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The House bill establishes a health benefits advisory committee, chaired by the surgeon general, to advise the secretary on which services should be included in the essential benefits package. The essential benefit package must include hospitalization;

outpatient hospital and outpatient clinic services, including emergency department services; professional services of physicians and other health professionals; medical equipment; prescription drugs; rehabilitative services; mental health and substance use disorder services, including behavioral health; preventive services, including services recommended by the Task Force on Clinical Preventive Services and vaccines recommended by the director of the Centers for Disease Control and Prevention; maternity care; well-child care; oral health, vision, and hearing services; and durable medical equipment, prosthetics, and orthotics.

Under the Senate bill, the package will be determined by the U.S. Secretary of Health and Human Services (HHS). This package must include, at a minimum, ambulatory patient services; emergency services; hospitalizations; maternity and newborn care; mental health and substance use disorder services, including behavioral health; prescription drugs; rehabilitative services and devices; laboratory services; preventive services, including services recommended by the Task Force on Clinical Preventive Services and vaccines recommended by the director of the Centers for Disease Control and Prevention; and chronic disease management. In addition, the plans must cover pediatric services, including vision and oral care.

**Premium subsidies** will be provided to lower- and middle-income people without employer-based coverage or Medicaid and who must purchase coverage on their own (Exhibit 8). The bills would cap premium costs at a share of income for those earning up to $88,000 for a family of four, but the caps would likely rise over time as the cost of premiums grew. The premium subsidies in the House bill would make premiums more affordable for lower-income families than would those in the Senate bill, while the Senate bill provides premium subsidies that make premiums somewhat more affordable for families further up the income scale. Premium subsidies would also be available for small, low-wage companies.

## Exhibit 8. Premium Subsidies Under House and Senate Bills

| House | Senate |
|---|---|
| Premium subsidy for purchase through exchange so contribution is limited, as share of income, to:<br>133%–150% FPL: 1.5%–3.0%<br>150%–200% FPL: 3.0%–5.5%<br>200%–250% FPL: 5.5%–8.0%<br>250%–300% FPL: 8.0%–10.0%<br>300%–350% FPL: 10.0%–11.0%<br>350%–400% FPL: 11.0%–12.0%<br>(based on average premium of 3 lowest cost plans)<br>If employer coverage contribution is <12% of income, not eligible for subsidies | Sliding-scale credits based on second-lowest-cost silver plan such that premium contributions are no greater than 2% of income for 100% FPL or less to 9.8% of income for 300%–400% FPL; if employer coverage contribution is <9.8% of income, not eligible for subsidies |

Note: FPL refers to Federal Poverty Level.
Source: Commonwealth Fund analysis of health reform proposals.

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**Cost-sharing subsidies and out-of-pocket limits** would be instituted to reduce out-of-pocket expenses substantially for lower-income families and protect those who become sick (Exhibit 9). The House bill provides more protection against out-of-pocket costs than the Senate bill.

## Exhibit 9. Cost-Sharing Credits and Limits Under House and Senate Bills

| House | Senate |
|---|---|
| **Cost-sharing credits limit cost-sharing thus increasing actuarial value of essential benefits to:**<br>**133%–150% FPL: 97%**<br>**150%–200% FPL: 93%**<br>**200%–250% FPL: 85%**<br>**250%–300% FPL: 78%**<br>**300%–350% FPL: 72%**<br>**350%–400% FPL: 70%** | **Cost-sharing subsidies limit cost-sharing thus increasing actuarial value of essential benefits to:**<br>**100%–150% FPL: 90%**<br>**150%–200% FPL: 80%** |
| **Annual OOP limits (individual/family)**<br>**133%–150% FPL: $500/$1,000**<br>**150%–200% FPL: $1,000/$2,000**<br>**200%–250% FPL: $2,000/$4,000**<br>**250%–300% FPL: $4,000/$8,000**<br>**300%–350% FPL: $4,500/$9,000**<br>**350%–400% FPL: $5,000/$10,000** | **Annual OOP limits (individual/family)**<br>**100%–200% FPL: 1/3 HSA limit, $1,983/$3,967**<br>**200%–300% FPL: 1/2 HSA limit, $2,975/$5,950**<br>**300%–400% FPL: 2/3 HSA limit, $3,967/$7,933** |
| **Cost-sharing is eliminated for preventive services** | **Cost-sharing is eliminated for preventive services** |

Note: FPL refers to Federal Poverty Level. OOP is defined as "out-of-pocket" costs. Actuarial value is the average percent of medical costs covered by a health plan.
Source: Commonwealth Fund analysis of health reform proposals.

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**Provisions aimed at slowing the overall rate of growth in health care costs and premiums** would be established. These would include: lower administrative costs due to restrictions on underwriting and lower marketing costs as a result of greater transparency; restrictions on the share of premiums that can go to non-claims costs, a public plan option with the potential to lower premiums and introduce new competition into highly concentrated insurance markets; and conditions placed on carriers who participate in the exchange (especially in the House bill).

### Affordability of Premiums

Provisions in the bills would affect the premiums paid by families, including the degree of cost-sharing in the benefit package, the size of the premium subsidies and the benefit tiers they are based on, the degree to which premiums are allowed to vary by age, and how the premium subsidies are allowed to grow over time through the exchange. The combined effect of these provisions would be more affordable premiums and out-of-pocket costs for low- and moderate-income families and older adults. The effect would be greater in the House bill than the Senate bill.

*Levels of Cost-Sharing in Benefit Packages*

The essential standard benefit package in each of the bills would be allowed to vary by cost-sharing. Cost-sharing could include a combination of deductibles, copayments, and out-of-pocket limits subject to the limits in the bills. The bills define the variation allowed by setting cost-sharing levels or tiers, or the percent of medical costs that would be paid by the health plan on average, known as actuarial value (Exhibit 7). The House bill defines four tiers ranging from 70 percent of costs covered to 95 percent; and the Senate bill specifies four tiers that range from 60 percent of costs covered to 90 percent. For comparison, the average actuarial value in employer-based plans is an estimated 80 percent.[22] In the Blue Cross Blue Shield standard option in the Federal Employees Health Benefits Program, it is about 84 percent to 87 percent.[23] A forthcoming Commonwealth Fund report finds that, in Medicare, actuarial value ranges from an estimated 64 percent for Medicare Parts A and B to 90 percent for Medicare Parts A, B, and D, and a supplemental (Medigap) policy.[24]

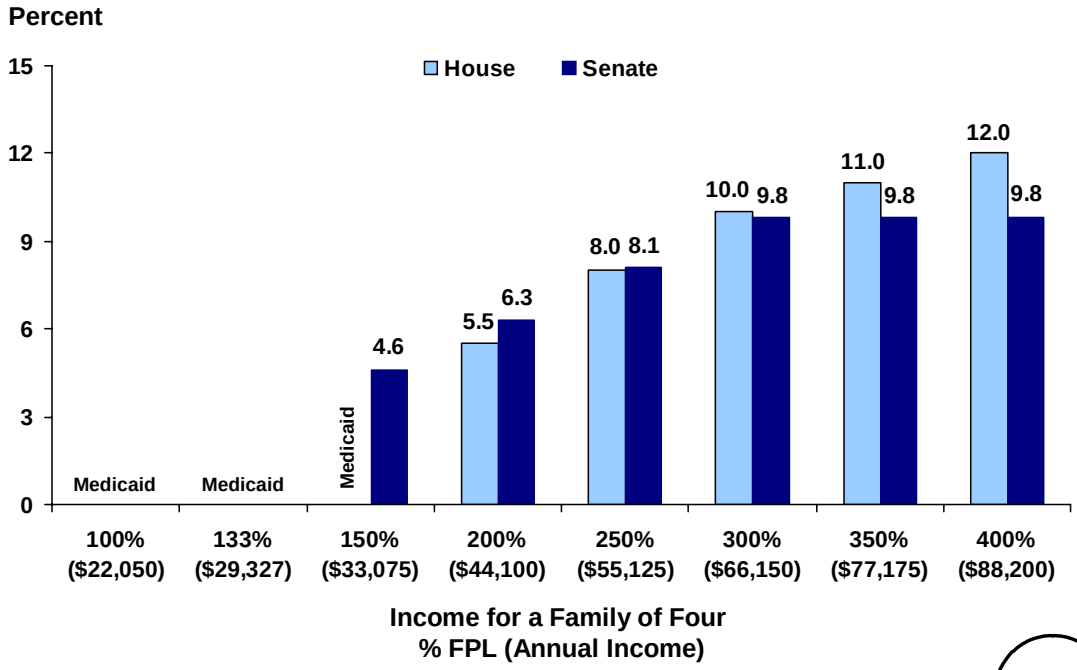
Each of the bills places limits on annual out-of-pocket spending. The Senate bill caps out-of-pocket spending at limits specified for health saving account-eligible high deductible health plans (i.e., the HSA limit) or $5,950 for individuals and $11,900 for families. The House bill limits out-of-pocket spending to $5,000 for individuals and $10,000 for families.

*Premium Subsidies*

For families earning less than 400 percent of poverty who are eligible to purchase health insurance through the exchange (i.e., they have no affordable offer of employer coverage that meets the requirements of the bills and are not eligible for Medicaid), both bills would provide premium subsidies that would cap premium costs as a share of income (Exhibit 8). Premium subsidies in the Senate bill would be based on the lowest-cost plan in the "silver" tier category with an actuarial value of 0.70. The House bill would base premium subsidies on the lowest premiums for its basic tier plan, also with an actuarial value of 0.70.

Lower-income families would pay a larger share of their incomes on premiums in the Senate bill than in the House bill (Exhibit 10). For a family of four with income between 150 percent and 400 percent of poverty (or $33,075 and $88,200), the Senate bill subsidies would start at a cap of 4.6 percent of income and rise to 9.8 percent. The House bill would start at 3 percent of income at just over 150 percent of poverty (those at 150% of poverty would be eligible for Medicaid) and rise to 12 percent. Under the Senate bill, families would exceed the 8 percent affordability standard at about 250 percent of poverty and thus be exempted from the individual mandate (Exhibit 11).

## Exhibit 10. Premium Caps as a Share of Income Under House and Senate Bills




Note: FPL refers to Federal Poverty Level (2009). Under the House bill, people are eligible for Medicaid up to 150% FPL; under the Senate bill, people are eligible for Medicaid up to 133% FPL.
Source: Commonwealth Fund analysis of proposals.

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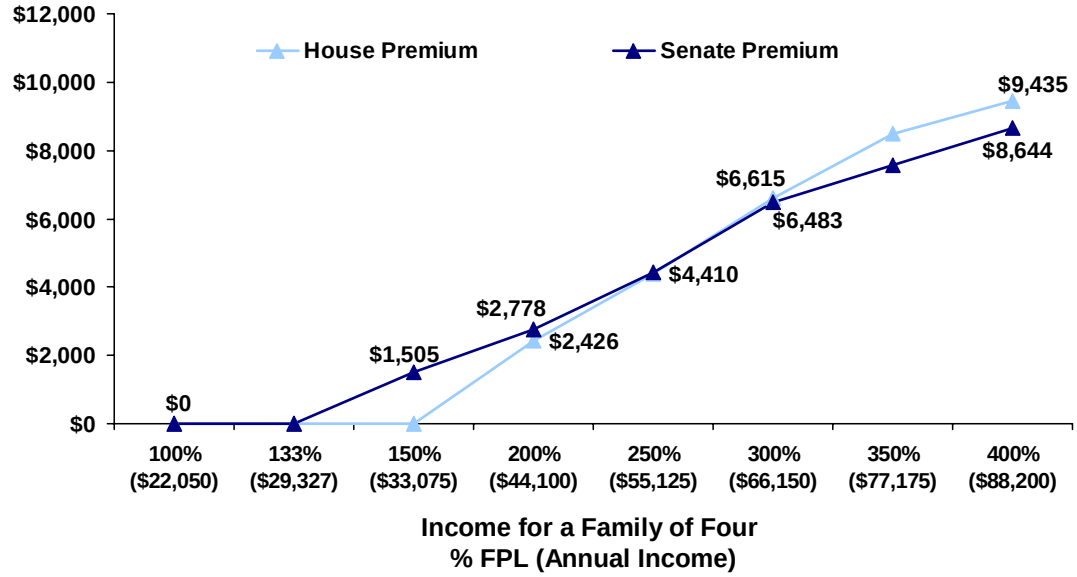
## Exhibit 11. Family Premiums Under House and Senate Bills* After Premium Subsidies




* For a family of four in a medium-cost area in 2009 (age 40). Premium estimates are based on: Senate Silver Plan, actuarial value = 0.70; House Basic Plan, actuarial value = 0.70. Actuarial value is the average percent of medical costs covered by a health plan.
** Senate bill exempts individuals with premium contributions in excess of 8 percent of income from requirement to buy insurance.
Note: FPL refers to Federal Poverty Level. Under the Senate bill, people are eligible for Medicaid up to 133% FPL; under the House bill, people are eligible for Medicaid up to 150% FPL. CBO estimated an average family premium of $14,400 in 2016 for the Senate Finance bill, approximately $10,000 in 2009.
Source: Commonwealth Fund analysis of proposals. Premium estimates are from Kaiser Family Foundation Health Reform Subsidy Calculator – Premium Assistance for Coverage in Exchanges/Gateways, http://healthreform.kff.org/Subsidycalculator.aspx.

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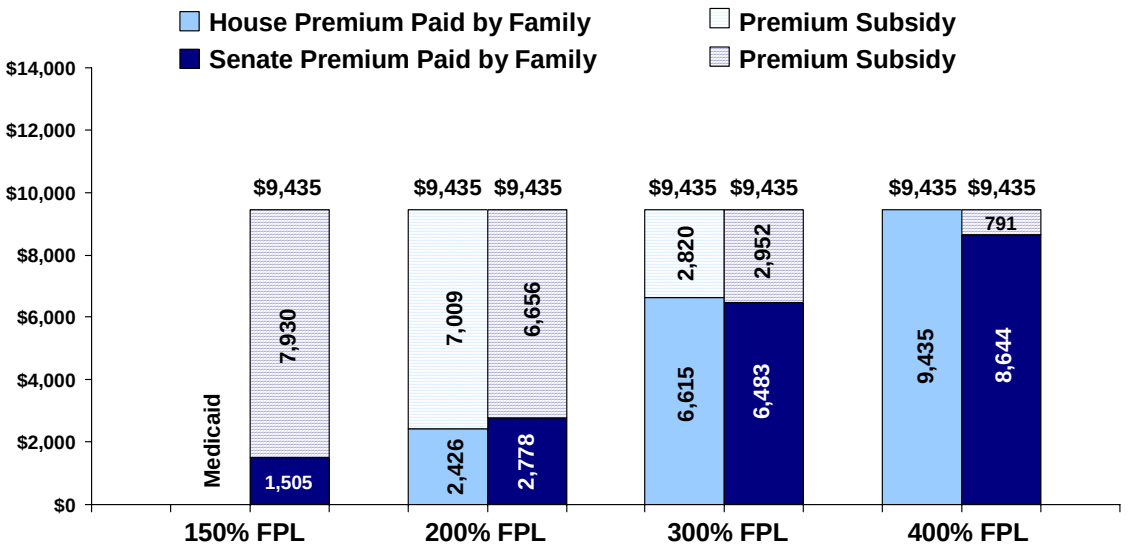
This difference in premium caps translates into higher overall premium spending for families with low incomes in the Senate bill and higher overall spending for families with more moderate incomes in the House bill (Exhibit 11). For example, a family of four with 40-year-old parents and an annual income of $44,100 (200% of the poverty level) would pay $2,778 in premiums under the Senate bill, compared with $2,426 in the House bill (Exhibit 12 and Appendix A).[25] In contrast, the same family earning about $77,175 (350% of poverty) would pay $8,489 in premiums under the House bill compared with $7,563 under the Senate bill.

**Exhibit 12. Annual Premium Amount Paid Out-of-Pocket by Families and Subsidies Under House and Senate Bills***




* For a family of four in a medium-cost area in 2009 (age 40). Premium estimates are based on: House Basic Plan, actuarial value = 0.70; Senate Silver Plan, actuarial value = 0.70. FPL refers to Federal Poverty Level. Actuarial value is the average percent of medical costs covered by a health plan.
Source: Premium estimates are from Kaiser Family Foundation Health Reform Subsidy Calculator – Premium Assistance for Coverage in Exchanges/Gateways, http://healthreform.kff.org/Subsidycalculator.aspx.

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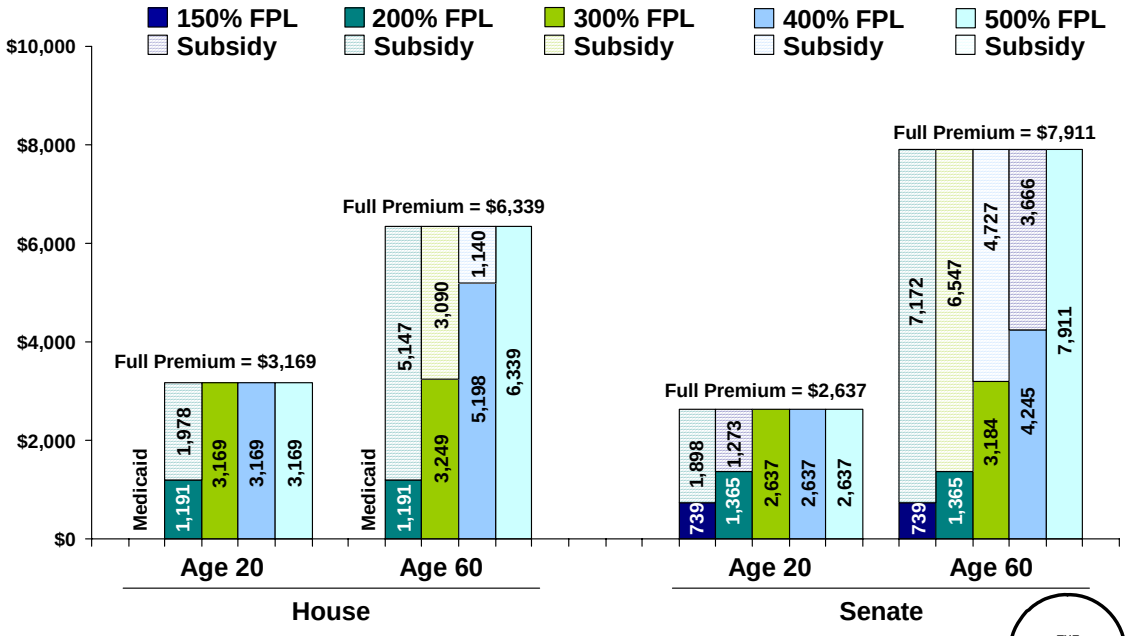
*Premiums for Older Adults*

As noted previously, both the House and the Senate bills create age bands limiting the degree to which premiums can rise with age. The Senate bill specifies wider age bands (3:1) than the House bill (2:1). Under the Senate bill, older adults would face higher premiums and young adults would face lower premiums than under the House bill. For example, a 60-year-old with income too high to qualify for a subsidy would spend $7,911 on premiums in the Senate bill compared with $6,339 in the House bill (Exhibit 13). In contrast, a 20-year-old would spend about $3,169 on premiums in the House bill, compared with $2,637 in the Senate bill.

**Exhibit 13. Annual Premium Amount Paid Out-of-Pocket by Individuals and Subsidies Under House and Senate Bills***




* For an individual in a medium-cost area in 2009. FPL refers to Federal Poverty Level. Premium estimates are based on: House Basic Plan, actuarial value = 0.70; Senate Silver Plan, actuarial value = 0.70. Actuarial value is the average percent of medical costs covered by a health plan.
Source: Premium estimates are from Kaiser Family Foundation Health Reform Subsidy Calculator – Premium Assistance for Coverage in Exchanges/Gateways, http://healthreform.kff.org/Subsidycalculator.aspx.

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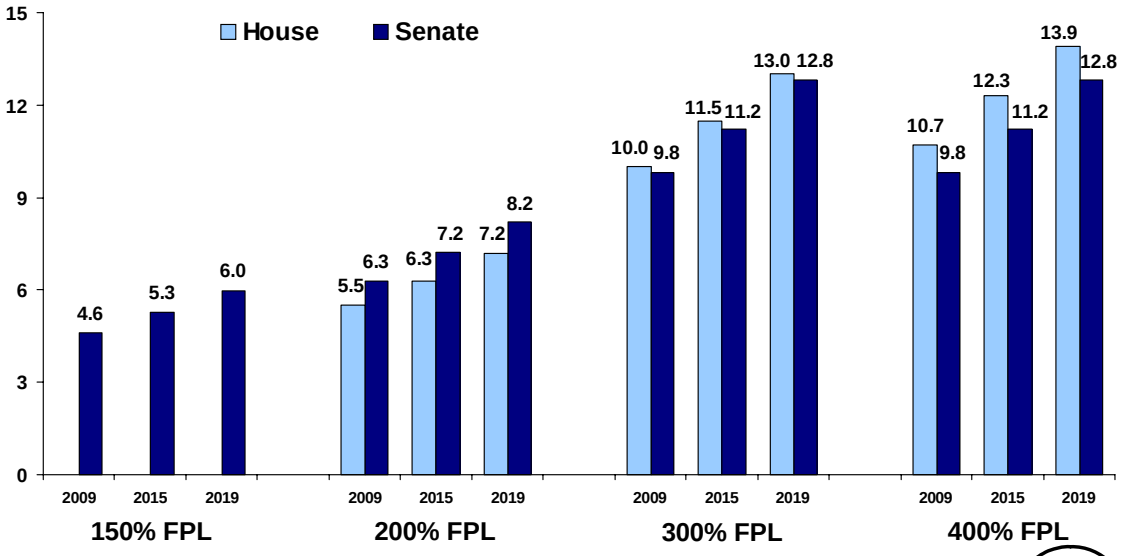
*Adjustments to Premium Subsidies for Cost Growth*

The bills would adjust premium subsidies over time so the share of premiums for individuals and the federal government would remain the same over time (i.e., both would share in the costs of premium growth). This means that a family of four earning about $44,100, or 200 percent of poverty, with premium capped at 6.3 percent of income under the Senate bill, would pay 29 percent of the costs of their premium in the first year, assumed to be 2009 in this analysis. As premiums grew over time—depending on growth in overall heath care expenditures and other factors—the premium share would remain the same for the family, but the amount of the premium would increase thus increasing the family's share of income spent on premiums. In the Senate bill, at current premium and income growth rates, the share of income spent on premiums would climb from 6.3 percent to 8.2 percent for this same family by 2019 (Exhibit 14 and Appendix A). Under the House bill, the share of income spent by the family on premiums would climb from 5.5 percent in 2009 to 7.2 percent in 2019.

**Exhibit 14. Percent of Income Spent on Premiums 2009–2019**
**If the Percent of Total Premiums Paid by Families Remains Constant, House and Senate Bills***




* For a family of four in a medium-cost area in 2009 (age 40). FPL refers to Federal Poverty Level. Premium estimates are based on House Basic Plan, actuarial value = 0.70, Senate Silver Plan, actuarial value = 0.70; Actuarial value is the average percent of medical costs covered by a health plan. 2009 premium estimates are from Kaiser Family Foundation Health Reform Subsidy Calculator – Premium Assistance for Coverage in Exchanges/Gateways, http://healthreform.kff.org/Subsidycalculator.aspx.
Source: Commonwealth Fund analysis of the proposals.

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*Estimated Effects of Health Reform on Future Premiums*

In November, the CBO estimated the potential effect of the provisions in the Senate bill on health insurance premiums in the individual market (including the new insurance exchange), small-group market, and large-group market compared with trends under current law.[26] While the version that CBO analyzed was somewhat different than the bill ultimately passed in December, the effects on premiums would likely be very similar, according to the CBO.[27]

**Individual market and insurance exchanges.** CBO estimates that premiums for coverage purchased either through the new insurance exchanges or the individual market will be a net of 10 percent to 13 percent higher in 2016 than they would have been under current law. But all of the increase is attributable to the fact that the essential benefit package makes health plans more comprehensive and protective from out-of-pocket costs than those currently available in the individual market. Because of this improvement in benefits, premiums would rise by 27 percent to 30 percent. But this increase in premiums as a result of better benefits would be offset by reduced costs, including economies of scale from broader risk-pooling and lower administrative costs from benefit standardization and prohibition of underwriting. Collectively, these features are estimated

to lower premiums by 7 percent to 10 percent compared with levels under the current law. Premiums would decline by an additional 7 percent to 10 percent because of an influx of younger and healthier enrollees as a result of the premium subsidies and the individual mandate. In addition, 57 percent of enrollees would receive a premium subsidy through the exchange, which CBO estimates would reduce their premiums by 56 percent to 59 percent relative to premiums under current law.

**Small-group market**. CBO estimates that the effect of the Senate bill on premiums for companies with fewer than 50 workers would range from an increase of 1 percent to a decrease of 2 percent in 2016, relative to current law. This does not include the effects of the small business tax credit, which CBO estimates would further reduce premiums by 8 percent to 11 percent for eligible firms (this would affect an estimated 12 percent of employees who have coverage through small firms).

**Large-group market.** Premiums at companies with 50 or more workers are estimated to be unchanged or to fall by up to 3 percent, relative to current law. This does not include the effect of the proposed excise tax on high-premium insurance policies, which would affect an estimated 19 percent of workers with employment-based health benefits in both small and large firms. CBO assumes that most employees would choose lower-cost plans. As a result, premiums would decline by about 9 percent to 12 percent relative to current law for workers who had policies that were subject to the excise tax.

**Out-of-Pocket Costs**

The provisions in the bills that would affect out-of-pocket costs paid by families purchasing health insurance through the insurance exchanges include the actuarial values of the benefit levels, cost-sharing subsidies, and out-of-pocket limits. The combined effect of these provisions leads to lower out-of-pocket costs, on average, for low- and moderate-income families in the House bill compared with the Senate bill.

*Levels of Cost-Sharing in Benefit Packages*

In general, the lower a health plan's actuarial value is, the lower is its premium and the higher are the costs borne by the policyholder. But there are important caveats. Premiums will vary significantly because of regional differences in health care spending, administrative costs and profits, the concentration of insurance and provider markets, the age of the policy holder, and the degree to which the risk pool has higher- or lower-than-average health risks. In addition, it is important to note that actuarial values are averages. Actuarial value, as well as out-of-pocket spending, will vary by the medical expenses

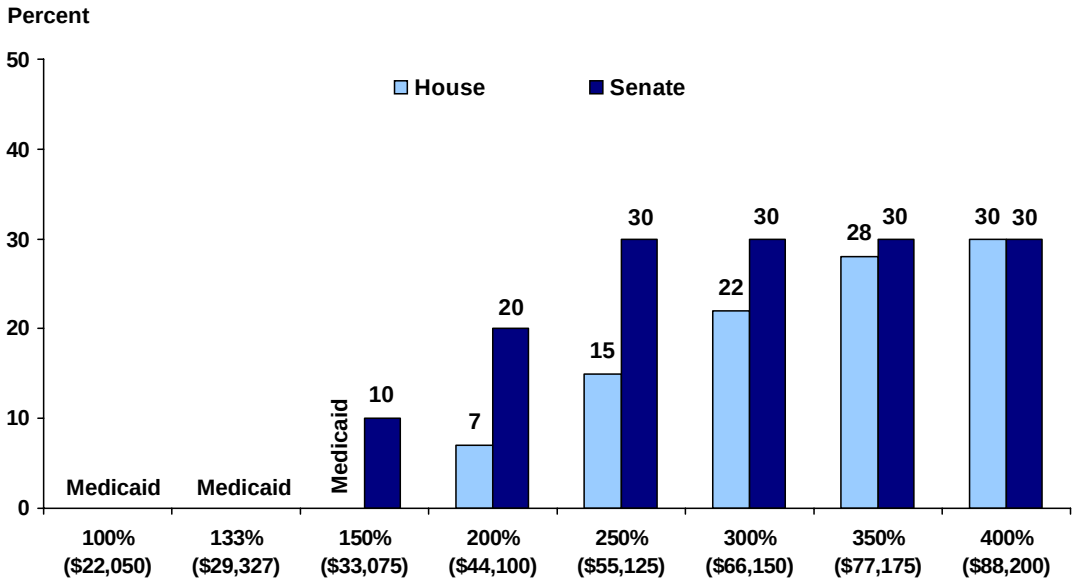
incurred by the policy holder and by the combination of deductibles, out-of-pocket maximums, and copayments or coinsurance in the policy.[28]

*Cost-Sharing Subsidies*

Each bill limits out-of-pocket spending for people with low and moderate incomes, but the provisions in the Senate bill are less protective (Exhibit 9). The House bill would reduce cost-sharing from 30 percent of total medical spending under the basic plan to 3 percent for those at or below 150 percent of poverty (at this income level, people would be eligible for Medicaid). Cost-sharing would increase to 7 percent for people with incomes at 200 percent of poverty, and then to 15 percent, 22 percent, and 28 percent up to 350 percent of poverty (Exhibit 15). The House bill also specifies sliding-scale annual out-of-pocket limits (Exhibit 9).

The Senate bill would lower cost-sharing for people earning up to 200 percent of the poverty level, from 30 percent of total spending under the silver plan to 10 percent for those with incomes at or below 150 percent of poverty and 20 percent for those with incomes between 151 percent and 200 percent of poverty (Exhibit 15). For families with higher incomes, the bill would set lower limits on annual out-of-pocket spending. Those earning between 200 percent and 300 percent of poverty would have out-of-pocket limits set at 50 percent of the HSA limit or $2,975 for individuals and $5,950 for families; those between 300 percent and 400 percent of poverty would see a limit of two-thirds the HSA limit, or $3,967 and $7,933.

**Exhibit 15. Percent of Total Annual Medical Costs, Excluding Premiums, Paid by Enrollee Net of Subsidies Under House and Senate Bills***




* For a family of four in a medium-cost area in 2009 (age 40). FPL refers to Federal Poverty Level. Cost-sharing estimates are based on: House Basic Plan, actuarial value = 0.70; Senate Silver Plan, actuarial value = 0.70. Actuarial value is the average percent of medical costs covered by a health plan.
Under the Senate bill, people are eligible for Medicaid up to 133% FPL; under the House bill, people are eligible for Medicaid up to 150% FPL.
Note: CBO estimated an average family premium of $14,400 in 2016 for the Senate Finance bill, approximately $10,000 in 2009.
Source: Commonwealth Fund analysis of proposals. Premium estimates are from Kaiser Family Foundation Health Reform Subsidy Calculator – Premium Assistance for Coverage in Exchanges/Gateways, http://healthreform.kff.org/Subsidycalculator.aspx.

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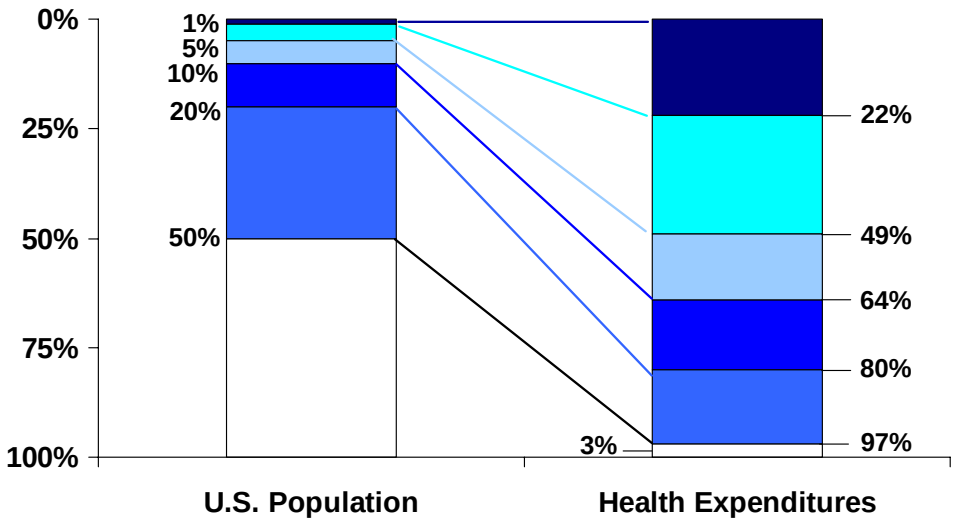
*Net Cost-Sharing*

Determining out-of-pocket cost exposure under the provisions in the bills depends on what a person's annual medical expenditures will be in a given year. Spending on medical care in the United States is concentrated among the sickest, generally a small percentage of the population. An analysis by researchers at the Agency for Healthcare Research and Quality (AHRQ) found that the top 1 percent of the population accounted for 22 percent of total health care spending in 2002 (Exhibit 16). Half of the population accounted for 97 percent of total spending.[29]

**Exhibit 16. Distribution of Health Expenditures for the U.S. Population, by Magnitude of Expenditure, 2002**




Source: L. J. Conwell and J. W. Cohen, *Characteristics of People with High Medical Expenses in the U.S. Civilian Noninstitutionalized Population, 2002,* Statistical Brief #73 (Washington, D.C.: Agency for Healthcare Research and Quality, March 2005).

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For purposes of illustration, we assumed this spending distribution would apply to people enrolled in the plans outlined in the two bills—meaning that half the enrollees in the plans, as in the total population, are assumed to have very low medical costs, on average. Using the actuarial values specified in the House basic plan (0.70) and the Senate's silver plan (0.70), and the out-of-pocket spending limits specified in the two bills, we assumed a combination of deductibles and coinsurance that would yield plans for individuals with those actuarial values across a population with the AHRQ spending distribution (see Appendix A). Several different combinations of deductibles and coinsurance can be used to arrive at similar actuarial values.

Under the Senate bill, the silver plan is specified to have an out-of-pocket limit of $5,950 (Exhibit 17). To meet the 0.70 actuarial value of the plan, we assumed a deductible of $900 and coinsurance of 20 percent. Half the enrollees in the plans are expected to have very low medical expenses, about $246 per person. They would spend that amount out-of-pocket, given the deductible of $900, with the exception of preventive services, which would be excluded from the deductible under both bills. For those with higher medical costs during the year, out-of-pocket spending would rise but would be limited by the deductible, coinsurance, and out-of-pocket maximum. For those in the top

1 percent of the spending distribution, for whom medical costs might be more than $90,000, the out-of-pocket maximum would cap spending for the individual at $5,950.

## Exhibit 17. Estimated Out-of-Pocket Exposure Under Senate Bill, Single Policy, by U.S. Spending Distribution and Income

| | Expenditure Percentile | Average Expenditures Per Person | Silver Plan: Estimated Out-of-Pocket Expense: Silver Plan | 100%–150% FPL | 150%–200% FPL | 200%–300% FPL | 300%–400% FPL |
|---|---|---|---|---|---|---|---|
| Top | 99%–100% | $90,200 | $5,950 | $1,983 | $1,983 | $2,975 | $3,967 |
| | 96%–98% | $27,675 | $5,950 | $1,983 | $1,983 | $2,975 | $3,967 |
| | 91%–95% | $12,300 | $3,360 | $1,330 | $1,983 | $2,975 | $3,360 |
| | 81%–90% | $6,560 | $2,212 | $756 | $1,912 | $2,212 | $2,212 |
| | 51%–80% | $2,323 | $1,365 | $332 | $1,065 | $1,365 | $1,365 |
| Bottom | <50% | $246 | $246 | $125 | $246 | $246 | $246 |
| | Actuarial Value | | 70% | 90% | 80% | 74% | 73% |
| | Out-of-Pocket Maximum | | $5,950 | $1,983 | $1,983 | $2,975 | $3,967 |
| | Deductible | | $900 | $100 | $600 | $900 | $900 |
| | Coinsurance | | 20% | 10% | 20% | 20% | 20% |

Note: Since the Senate bill caps out-of-pocket spending for people at 200–400% of poverty at $2,975 and $3,967, this analysis assumes a Silver plan of .70 actuarial value with the out-of-pocket maximums, which increase the actuarial value of the plan. FPL refers to Federal Poverty Level. Actuarial value is the average percent of medical costs covered by a health plan.
The out-of-pocket maximums are provisions in the bill, deductibles and coinsurance rates are assumed.
Source: Commonwealth Fund analysis of health reform proposals.

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The Senate bill lowers out-of-pocket exposure for people with lower incomes, which reduces out-of-pocket costs for both healthy people and those who become very ill (Exhibit 17). For people earning up to 150 percent of poverty, the bill increases the actuarial value of the plan to 0.90 and reduces the out-of-pocket spending limit to $1,983. We assumed a deductible of $100 and a coinsurance rate of 10 percent. The greater protection would reduce out-of-pocket spending from $246 to $125 for the healthiest half of enrollees and reduce out-of-pocket spending for the sickest enrollees from $5,950 to $1,983. Among people earning between 150 percent and 200 percent of poverty, the actuarial value would be increased to 0.80, with an out-of-pocket spending limit of $1,983, the same as for people earning up to 150 percent of poverty. We assumed a deductible of $600 and a coinsurance rate of 20 percent to meet the lower actuarial value. Out-of-pocket costs for the healthiest people in this income range would be about $246. Those with medical costs of about $2,300 would spend about $1,065 out-of-pocket and those with total medical costs of $6,560 would spend $1,912.

The House bill's basic plan has the same actuarial value as the silver plan in the Senate bill, with most people facing similar out-of-pocket costs (Exhibit 18). But the House bill specifies greater protection for low- and moderate-income families compared with the Senate bill. Among people earning between 150 percent and 200 percent of poverty, the bill specifies a higher actuarial value plan of 0.93, compared with 0.80 in the Senate bill, with a lower out-of-pocket spending limit of $1,000, compared with $1,983 in the Senate. We assumed a $50 deductible and a 10 percent coinsurance rate to meet the actuarial value. Under this plan, out-of-pocket spending for the healthiest people in this income group would decline to $75, compared with $246 under the Senate bill. For those with expenditures of $2,300, out-of-pocket spending would be limited to $282 versus $1,065 under the Senate bill. For those with total medical costs of $6,560, out-of-pocket spending would be about $706 versus $1,912 under the Senate bill.

## Exhibit 18. Estimated Out-of-Pocket Exposure Under House Bill, Single Policy, by U.S. Spending Distribution and Income

| | Expenditure Percentile | Average Expenditures Per Person | Basic Plan: Estimated Out-of-Pocket Expense | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | Basic Plan | 133%–150% FPL | 150%–200% FPL | 200%–250% FPL | 250%–300% FPL | 300%–350% FPL |
| Top | 99%–100% | $90,200 | $5,000 | $500 | $1,000 | $2,000 | $4,000 | $5,000 |
| | 96%–98% | $27,675 | $5,000 | $500 | $1,000 | $2,000 | $4,000 | $5,000 |
| | 91%–95% | $12,300 | $3,460 | $492 | $1,000 | $2,000 | $2,910 | $3,310 |
| | 81%–90% | $6,560 | $2,312 | $262 | $706 | $1,234 | $1,762 | $2,162 |
| | 51%–80% | $2,323 | $1,465 | $93 | $282 | $599 | $915 | $1,315 |
| Bottom | <50% | $246 | $246 | $10 | $75 | $246 | $246 | $246 |
| | | Actuarial Value | 70% | 97% | 93% | 85% | 78% | 72% |
| | | Out-of-Pocket Maximum | $5,000 | $500 | $1,000 | $2,000 | $4,000 | $5,000 |
| | | Deductible | $1,000 | — | $50 | $250 | $450 | $850 |
| | | Coinsurance | 20% | 4% | 10% | 15% | 20% | 20% |

Note: FPL refers to Federal Poverty Level.
The out-of-pocket maximums are provisions in the bill, deductibles and coinsurance rates are assumed.
Actuarial value is the average percent of medical costs covered by a health plan.
Source: Commonwealth Fund analysis of health reform proposals.

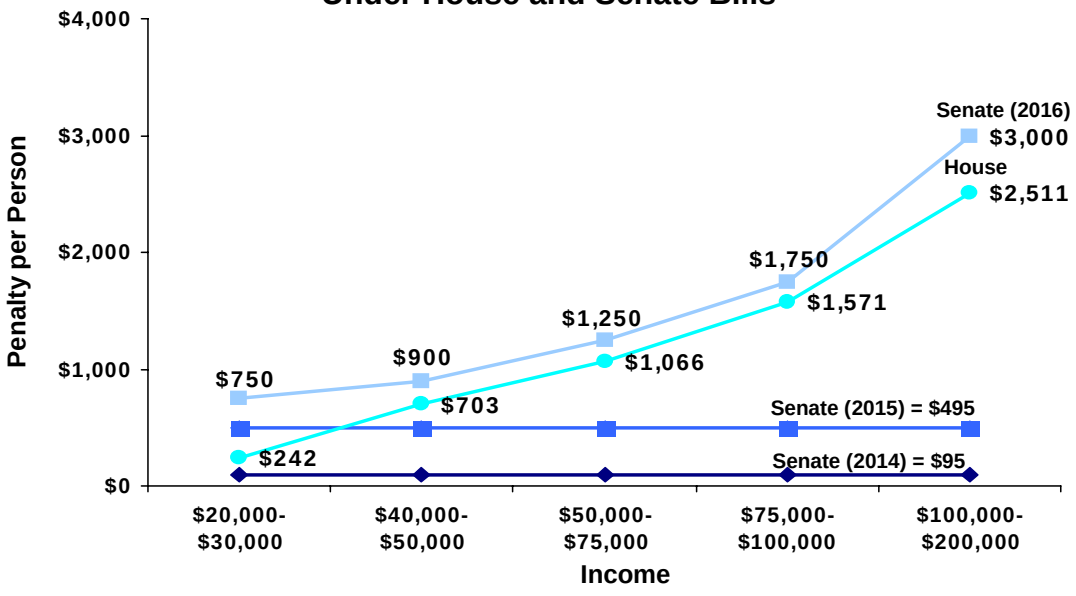

### INDIVIDUAL REQUIREMENT TO HAVE HEALTH INSURANCE

To ensure broad risk pooling across health status and age and prevent adverse selection in the new exchanges and Medicaid program, the bills require everyone in the United States to have health insurance, with some exemptions. Indeed, the success of the mixed public–private approach to universal coverage depends critically on the coverage requirement.

The requirement is the glue that binds together the three major risk pools that will form the basis of the reorganized system: employer coverage, insurance exchanges, and Medicaid. The success of the mandate will depend on the affordability of health plans, ease of enrollment, and auto-enrollment or penalties for not enrolling.[30]

The Senate bill would require the greater of either a flat penalty of $750 per person per year or 2 percent of income in 2016, up to a cap of the national average bronze plan premium. The penalty would be phased in at $95 in 2014, increase to $495 in 2015, and rise to $750 in 2016 (Exhibit 19). The House bill stipulates a penalty that would rise with income: 2.5 percent of the difference between modified adjusted gross income (modified to include tax-exempt interest and certain other sources of income) and the tax-filing threshold, up to the cost of the average national premium for the basic benefit plan. For a single person, the penalty would be about $242 in the House bill and $750 in the Senate bill for those earning between $20,000 and $30,000, $703 in the House bill and $900 in the Senate bill for those earning $40,000 to $50,000, $1,570 in the House bill and $1,750 in the Senate bill for those earning $75,000 to 100,000, and about $2,510 in the House bill and $3,000 in the Senate bill for those earning between $100,000 and $200,000 (or the amount of the bronze plan premium if less).[31]

**Exhibit 19. Penalties for Noncompliance with the Individual Mandate Under House and Senate Bills**




Note: The penalty under the Senate bill is implemented at $95 in 2014 and increases to $495 in 2015 and the greater of $750 or up to 2% of income, capped at the average national bronze plan premium, in 2016. The House penalty is calculated as 2.5% of the difference between average modified adjusted gross income (MAGI) and the tax filing threshold, capped at the average national premium of the basic benefit package. Calculations begin at $20,000 because that is the point where MAGI exceeds the tax filing threshold. People are exempt if they have household incomes under 100% FPL or if premiums are greater than 8% (Senate). Projected premiums are under House and Senate proposals.
Source: Commonwealth Fund analysis of the proposals; Urban-Brookings Tax Policy Center, "Average Modified Gross Income and Average Modified Adjusted Gross Income Across Cash Income Levels, 2009", Oct 15, 2009 available at http://www.taxpolicycenter.org/numbers/displayatab.cfm?Docid=2486&DocTypeID=1.

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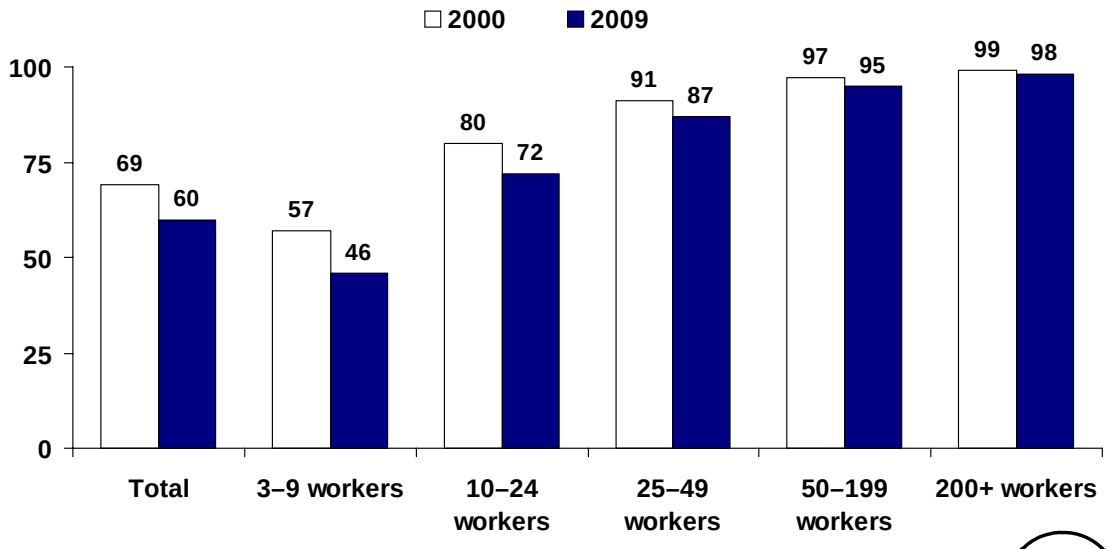
Financial hardship exemptions are provided in the Senate bill for those individuals for whom the premium would exceed 8 percent of their income. There are unspecified exceptions for financial hardship in the House bill.

### EMPLOYER SHARED RESPONSIBILITY

Employer-based health benefits are the prevailing source of health insurance in the U.S. More than 160 million people, or more than 60 percent of the under-65 population, have health benefits through an employer. Nearly all employers with more than 200 employees offer their employees coverage (Exhibit 20).[32] Employers contribute, on average, 73 percent of family premiums and 84 percent of single policies, shouldering an estimated $500 billion of the overall financing of the U.S. health system. [33] Employer-based coverage has imbedded efficiencies and equities. Risk pools are formed naturally—people enroll when they take a job rather than when they are sick, reducing the potential for adverse selection and the need for underwriting. In addition, most surveys indicate that both employers and their workers place a high value on job-based health benefits.[34]

**Exhibit 20. Employer Coverage Continues to Be Major Source of Coverage for Employees of Larger Firms But Has Declined Among Small Firms**




Source: The Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits*, 2000 and 2009 Annual Surveys.

Preserving the broad risk pools of large employers at the start of health reform will reduce the costs of reform to the federal government and allow employers and

workers to continue offering and enrolling in the health coverage they are comfortable with. If employers were to drop their health benefits and let workers buy coverage with premium subsidies, the costs of health reform to the federal government would increase substantially. In addition, giving employers a financial stake in their employees' health insurance encourages them to invest in employee wellness and prevention programs. Some innovations in payment and delivery system reform, such as pay-for-performance incentives, originated in employer plans. Employers have also been at the forefront of public reporting of quality data.[35]

In contrast, small employers have suffered from purchasing health insurance in the small-group market—they pay, on average, up to 18 percent more in premiums than large firms do for the same policy.[36] This reflects higher per-employee costs of writing and administering insurance plans in small companies, higher insurance broker fees, and underwriting and age rating that lead to more costly premiums for sicker or older workforces.[37] The ability of small firms to purchase coverage through the new regulated insurance exchanges, along with the new market regulations, will address the serious problems that have plagued small firms and reduced the number who have offered health insurance over the last decade. Because most uninsured workers are employed in small firms, exempting small firms from a requirement to offer health insurance would increase the cost of health reform to the federal government. The share of small employers who offer health insurance ranges from 87 percent of employers with 25 to 49 workers to 72 percent of firms with 10 to 24 employers to fewer than half (46%) of firms with fewer than 10 workers (Exhibit 20). If exemptions to the mandate are made on the basis of size, exempting only the smallest employers would maintain the high rates of benefit provision among larger small employers. Combining small firm size with low average wages of the workforce would preserve the higher coverage rates of employees of small firms that have higher average wages, such as physician and attorneys offices.[38]

The House bill would require large employers to either offer health insurance coverage that meets benefit standards or contribute a specified share of the cost of their employees' insurance. The House bill would exempt small, low-wage employers with average payrolls of $500,000 or less. The Senate bill requires employers with 50 or more employees to contribute to the cost of coverage of uninsured workers who receive premium subsidies through the exchanges.

**Employer Coverage Requirements**

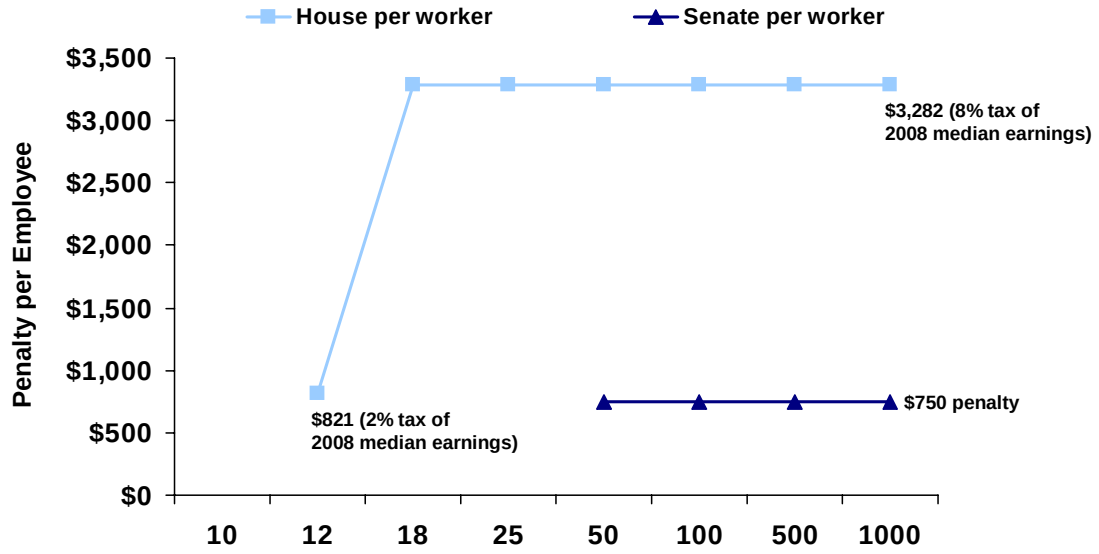
The House bill would require employers to contribute at least 72.5 percent of the premium cost for single coverage and 65 percent of the premium cost for family coverage

of the lowest-cost plan that meets the bill's qualified health benefits plan requirements. This contribution requirement is lower than the current average in employer plans: about 84 percent for single policies and 73 percent for family policies.[39] A qualified health plan would have to offer at least the basic essential benefits package, with an actuarial value of at least 0.70. Again, this is below the 0.80 actuarial value of employer plans nationally.[40] The bill also requires employers (and all other health plans) to include dependents up to age 27.

**Penalties and Small Business Exemptions**

The House bill requires all but very small employers to meet the coverage requirements or pay 8 percent of payroll into a health insurance exchange trust fund (Exhibit 21). Still, the 8 percent penalty is less than the average share of payroll—about 12 percent—that employers currently spend on premium contributions.[41] In addition, the House bill exempts small businesses with payrolls of less than $500,000, with contributions phasing up gradually to 8 percent for those firms with payrolls above $750,000. Assuming median worker earnings of $41,030 in 2008, this is approximately equivalent to exempting firms with fewer than 12 employees and phasing in the full penalty up to firms with 18 workers.[42]

**Exhibit 21. Penalties for Noncompliance with the Employer Mandate Under House and Senate Bills**




Note: House bill penalty is based on aggregate payroll. It is illustrated here using 2008 median earnings to estimate firm size. A firm with an aggregate payroll of $500,000 will have an average of 12 workers and a firm with an aggregate payroll of $750,000 will have an average of 18 workers. The payroll tax is implemented on a sliding scale from 2%–8% for payrolls between $500,000 and $750,000. The Senate bill penalty requires any employer with more than 50 full-time employees that does not offer coverage and has at least one full-time employee receiving the premium assistance tax credit to make a payment of $750 per full-time employee. An employer with more than 50 employees that offers coverage that is deemed unaffordable or does not meet the minimum benefit standard and has at least one full-time employee receiving the premium assistance tax credit must pay the lesser of $3,000 for each of those employees receiving the credit or $750 for each of their full-time employees total. Firms are exempt if they have: a payroll less than $500,000 (House), or fewer than 50 workers (Senate).
Data: Median earnings among workers working 50–52 weeks annually was $41,030 (Table P–43, Historical Income Data, Current Population Survey).
Source: Commonwealth Fund analysis of the proposals.

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The Senate bill would require larger firms (i.e., those with 50 or more workers) that do not offer coverage to pay $750 per full-time worker if any worker receives a subsidy through the exchange. Firms that do offer coverage, but have workers who contribute more than 9.8 percent of their income toward their premiums and are eligible to receive subsidies through the exchange, must pay the lesser of $3,000 for each full-time worker receiving a credit or $750 for every worker. The Senate bill also penalizes employers for imposing waiting periods for new employees. Large employers would pay $600 for each full-time worker in a waiting period of more than 60 days. The bill also requires employers to include dependents up to age 26.

The Senate bill includes an additional provision that would require employers that offer coverage and make a contribution to offer "free-choice vouchers" to qualified employees, so they can purchase health plans through exchange. The voucher must be equal to the contribution that the employer would have made to its own plan. Employees qualify if their required contribution under the employer's plan would be between 8 percent and 9.8 percent of their income. Free-choice vouchers are excluded from taxation, and voucher recipients are not eligible for tax credits. The CBO estimates that only about 100,000 workers would take advantage of the option.[43]

**Small Business Tax Credits and Subsidies**

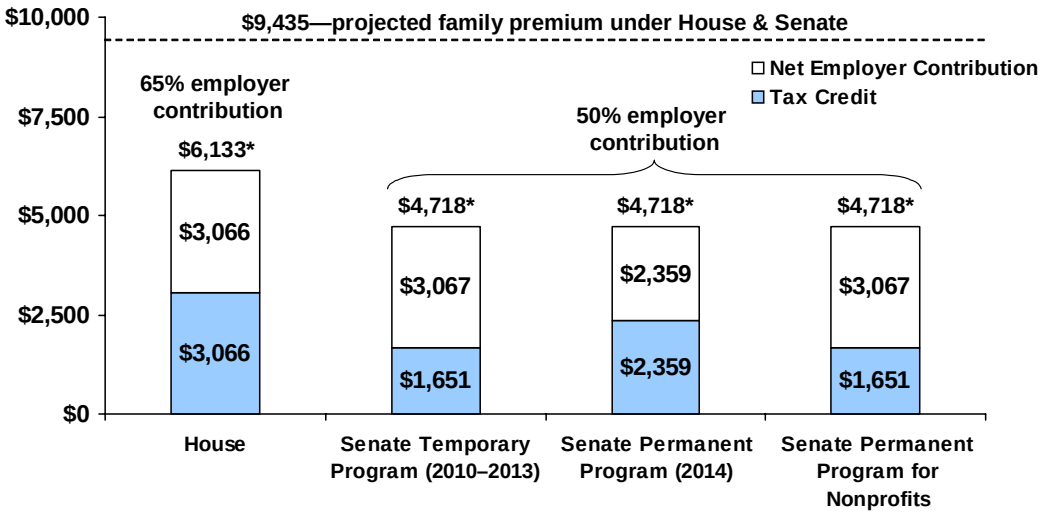
Each bill allows small employers to purchase health insurance for their employees through the exchange in the first year of implementation and phases in larger employers over time.

The House bill would open the exchange to companies with fewer than 25 employees and, after 2015, phase in larger companies with over 100 workers. The Senate bill would open the exchange to companies with 50 to 100 employees. Until 2016, states could opt to limit enrollment to companies with 50 or fewer employees. States would have the option to allow companies with more than 100 employees to purchase coverage in 2017.

In addition to the ability to purchase coverage through the exchange, small businesses with low average wages are further aided through federal premium subsidies or tax credits in each of the bills. Firms with fewer than 10 employees or average wages of $20,000 per year would be entitled to the full tax credit under the House bill. It would phase out for employers with up to 25 employees or average wages of $40,000 per year. The full credit would equal 50 percent of the premium paid by a small employer who is in compliance with the mandate or paying 72.5 percent of premium for single coverage

and 65 percent of premium for family coverage, for up to two years. If a company eligible for the full tax credit offers the House basic plan with an actuarial value of 0.70 and contributes 65 percent of the premium for families, it would receive a tax credit of about $3,066 per worker, leaving it with a balance of $3,066 per worker (Exhibit 22).

**Exhibit 22. Small Business Tax Credits Under House and Senate Bills for Family Premiums**




* To be eligible for tax credits, firms must contribute 65% of premiums per family under the House plan, and 50% under the Senate plan. Firms receive 50% of their contribution in tax credits under House, and 35% and later 50% of contribution under Senate.
Note: Projected premium for a family of four in a medium-cost area in 2009 (age 40). Premium estimates are based on: House Basic Plan, actuarial value = 0.70; Senate Silver Plan, actuarial value = 0.70. Actuarial value is the average percent of medical costs covered by a health plan.
Under the House bill, small firms are defined as those with fewer than 25 employees with average wages below $40,000. The full credit is available to firms with fewer than 10 employees and average wages less than $20,000; credits phase out up to 25 employees average wages of $40,000. Under the Senate bill, small firms are defined as those with fewer than 25 employees with average wages below $50,000. The full credit is available to firms with 10 or fewer employees and average wages less than $25,000; credits phase out up to 25 employees average wages of $50,000.
Source: Commonwealth Fund analysis of proposals. Premium estimates are from Kaiser Family Foundation Health Reform Subsidy Calculator, http://healthreform.kff.org/Subsidycalculator.aspx.

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The Senate bill would provide tax credits to qualifying small businesses for a maximum of two years and is targeted to small, low-wage firms like the House bill, but with somewhat higher average wage limits. The Senate bill tax credits would also be available beginning in 2010. The bill would require lower premium contributions on the part of employers compared with the House bill. In phase 1 (2010–2013), a tax credit up to 35 percent of employer premium contribution (the employer share must be at least 50% of premium costs) would be available for employers with fewer than 25 employees and average wages below $50,000. The full amount of credit is available to employers with 10 employees or average wages of $25,000, and phases out.

In phase 2 (beginning in 2014), a tax credit up to 50 percent of the employer premium contribution (the employer share must be at least 50% of premium costs) would be available for employers with fewer than 25 employees and average wages below

$50,000, for employers who buy plans through the exchange. The full amount of the credit is available for employers with fewer than 10 full-time employees and average wages below $25,000. The credit phases out for firms with 10 to 25 employees (at a rate of 6% of base credit percentage for each additional employee above 10) and average wages of $25,000 to $50,000 (at a rate of 5% for each $1,000 increase of average wages above $25,000). Tax-exempt organizations are eligible to receive small-business tax credits, though they are somewhat lower: 25 percent of employer contribution to premium in Phase I (2010–13) compared with 35 percent for other companies; and 35 percent in Phase II, beginning in 2014, compared with 50 percent for other companies.

Assuming that a company is eligible for the full credit and offers the Senate silver plan with an actuarial value of 0.70 and contributes 50 percent of a family premium, it would be eligible for a tax credit of $1,651 per worker in Phase I, leaving it with a balance of $3,067 (Exhibit 22). In Phase II, such a company would receive a credit of $2,359, leaving it with a balance of $2,359. A tax-exempt organization would receive a slightly lower credit of $1,651 per worker.

### INSURANCE MARKET REGULATIONS AND THE INSURANCE EXCHANGE

Each bill would bring sweeping changes to the nation's individual and small-group insurance markets, which have previously fallen nearly exclusively under the regulatory purview of states. Such changes would include new market regulations combined with a reorganization of the markets, either by substituting the existing market with a new national insurance exchange (in the case of the House bill) or creating state, sub-state, or regional exchanges (in the Senate bill) that would operate alongside the existing individual and small-group markets, under the same rules. The House bill would also allow states to create and manage their own exchanges, subject to strict rules. All premium and cost-sharing subsidies would apply only to plans sold through the exchanges in both bills.

There are key differences between the two bills, however, in the design of the exchanges, including the exclusivity of the exchange vis-à-vis other markets, the authority of the exchanges to review and reject premiums proposed by carriers, and consumer choice of a public plan. These differences have implications for the long-term ability of the exchange to lower premium costs.

#### New National Insurance Regulations

New market regulations outlined in the bills would bring an end to underwriting by insurers on the basis of health and also place new limits on variation in rating based on

age. The Senate bill allows more age-based variation than the bill, and it also allows rating based on tobacco use. Both bills would eliminate limits on annual or lifetime benefits, as well as the use of rescissions, provisions that would go into effect immediately. In the Senate bill, annual limits would be restricted beginning in 2010 and prohibited beginning in 2014.

The bills would also impose new regulations on the share of insurance premiums that could be used for nonmedical expenses. Currently, nonmedical costs, including administration and profits, consume an estimated 25 percent to 40 percent of premiums in the individual market. In companies with fewer than 50 employees, these expenses comprise 15 percent to 25 percent of premiums, compared with 5 percent to 15 percent for firms with more than 50 employees.[44] In the small-group market—where brokers play a key role in helping firms that lack human resources departments find insurance policies—the costs of commission alone may run from 4 percent to 11 percent of premiums.[45] Beginning in 2010, the House bill would require that medical-loss ratios not fall below 85 percent—that is, not less than 85 percent of premiums could be used for medical costs and not more than 15 percent for nonmedical purposes, including administration and profits.

The Senate bill would require plans offering coverage in the group and individual markets (including grandfathered plans but excluding self-insured plans) to report to the HHS secretary the amount of premium revenues spent on clinical services, activities to improve quality, and all other non-claims costs as defined by the National Association of Insurance Commissioners and certified by the HHS secretary. Beginning in 2011, large-group plans that spend less than 85 percent of premium revenue and small-group and individual market plans that spend less than 80 percent of premium revenue on clinical services and quality must provide a rebate to enrollees.

With their greater transparency of health plan information and internet portals to facilitate consumer and employer choices, the insurance exchanges may substantially reduce the need for insurance brokers. Commissions for insurance brokers currently claim a large share of premium dollars in the small-group market.[46] Neither bill regulates commissions, but the Senate bill directs the secretary to establish procedures for agents or brokers to enroll employers in qualified health plans.

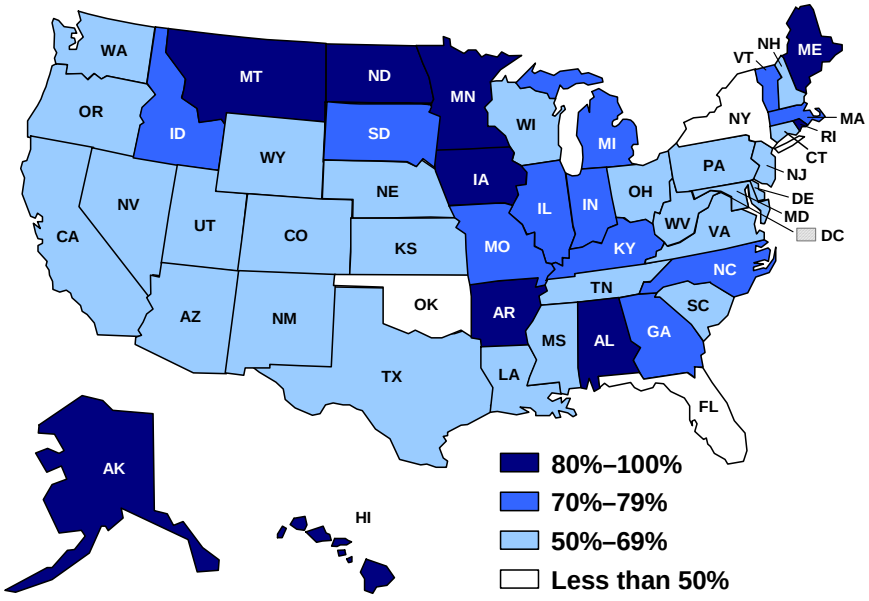
The House bill would require insurers and employers to allow young adults up to age 27 to remain on their parents' policies. In the Senate bill, this age limit would be 26. This provision would go into effect immediately in both bills. Twenty-six states have

passed similar laws, but because of federal law governing self-insured plans, the laws have only applied to non-self-insured companies. [47] The bills would federalize the requirement and make it apply to all carriers and employers. This policy change could reduce gaps in health insurance coverage currently experienced by young adults when they age off their parents' policies at high school or college graduation. The provisions could also reduce costs of health insurance to families and to the federal government, relative to purchasing coverage on the exchange.

**Strength of the Insurance Exchange**

Extensive consolidation in insurance markets and hospital markets across the country has substantially reduced price competition.[48] There are only three states where the two largest health plans dominate less than 50 percent of the market (Exhibit 23). If insurance companies are unable to negotiate lower rates with providers, the lack of competition means that carriers can pass on costs to employers and consumers in the form of higher premiums. Granting the exchange the authority to review and reject premiums proposed by carriers selling plans through the exchange could increase competition among carriers and place downward pressure on provider prices, as well. The provision of a public plan option could increase competition further, by allowing the HHS secretary to negotiate lower provider prices.

**Exhibit 23. Concentrated Insurance Markets: Market Share of Two Largest Health Plans, by State, 2006**




Note: Market shares include combined HMO+PPO products. For MS and PA share = top 3 insurers 2002–2003. No data are available for Washington, D.C.

Source: American Medical Association, *Competition in Health Insurance: A Comprehensive Study of U.S. Markets, 2008 Update*; MS and PA from J. Robinson, "Consolidation and the Transformation of Competition in Health Insurance," *Health Affairs*, Nov/Dec 2004; ND from D. McCarthy et al., "The North Dakota Experience: Achieving High-Performance Health Care Through Rural Innovation and Cooperation," The Commonwealth Fund, May 2008.

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In addition to including a choice of public plan in the exchange, the House bill establishes an insurance exchange with potentially greater regulatory and market power and thus greater potential to reduce premiums than the Senate bill for three reasons: 1) full replacement of the individual insurance market, 2) direct federal control, and 3) ability of the HHS secretary to enter into contracts and negotiate premiums.[49]

*Full Replacement of the Individual Market*

Each bill creates an exclusive exchange for subsidized direct-purchase insurance coverage. That is, premium subsidies could only be used to purchase a plan through the exchange. The House bill goes further by replacing the individual insurance market with the exchange, which could ultimately increase the market share of the exchange relative to the Senate bill, under which the individual market will be allowed to continue operation for non-subsidized coverage. This is similar to the Massachusetts health reform law. In that system, people who are ineligible for a subsidy because their income is too high can purchase coverage outside the state's exchange (or "connector"), which has the effect of reducing the connector's potential share of the individual market and its leverage over pricing.[50]

The House bill would have leverage over the entire nongroup market through the insurance exchange. However, as in the Senate bill, the small-group market would be allowed to continue outside the exchange. Enrollment in the exchanges in both bills would remain far lower than in the large employer group market, which could limit the negotiating strength of the exchange.[51] The CBO estimates that enrollment in the exchange under both bills would be about 30 million by 2019.

*Federal vs. State Control*

In the House bill, the federal government would have direct control of the exchange, with state insurance regulators working with the federal government to oversee and enforce requirements for participating plans, as well as those that do not sell policies through the exchange. The bill would allow states to apply for a waiver to run their own exchanges under the same rules and requirements established for the national exchange. But the nationally operated exchange would provide greater leverage over carriers from a regulatory standpoint and more control over premiums and costs.[52] The limited resources of many states could limit their effectiveness in regulating state markets dominated by large insurers.[53]

In addition, a national exchange would likely have lower overall administrative costs than 50 different exchanges, which would duplicate resources and administrative

processes.[54] As Jost and Enthoven and colleagues point out, some states may end up with very low enrollment in the exchanges, particularly if the individual and small-group markets are allowed to continue operation outside the exchange.[55] Experts consider 100,000 to be the minimum size for a stable risk pool. Some states with small populations will be unable to reach this size. In addition, Enthoven and colleagues argue that an exchange should have at least 25 percent of the private insurance market to reduce adverse selection and attract carriers to participate in the pool.[56] Still, there are benefits to state-based exchanges. Because Medicaid will continue to be a federal–state program operated by states, state-run exchanges could have the advantage over a national exchange in creating seamless transitions between Medicaid and subsidized private insurance.

*Authority to Review and Reject Premiums*

Under the House bill, the commissioner of the exchange would establish a process to obtain bids from private carriers, negotiate and enter into contracts with qualified plans, and enforce the adequacy of provider networks including the provision of out-of-network services at no greater cost if networks are deemed inadequate. The commissioner is given the authority to approve premiums and premium increases and can deny excessive premiums or premium increases.

The Senate bill instructs state exchanges to require insurance carriers seeking certification as qualified health plans to submit a justification for any premium increase prior to implementation of the increase. The exchange is then required to take the information into consideration when determining whether to allow the sale of the plan through the exchange. The Senate bill would also require state insurance commissioners to provide data on premium trends and to make recommendations to the HHS secretary about whether certain insurance carriers should be excluded from the exchange based on a pattern of excessive premium increases. In addition, states and the secretary are instructed to monitor premium increases inside and outside the exchange beginning in 2014. The federal government would also provide states with premium-review grants between 2010 and 2014 to review and approve, subject to state law, premium increases.

In addition, the Senate bill includes a set of quality improvement reporting requirements for plans inside and outside the exchange. Activities to be reported on would include: improving health outcomes through care coordination and medical home models; preventing hospital readmissions through a comprehensive program for hospital discharge; and implementing activities to improve patient safety, reduce medical errors, and promote health and wellness. The secretary would make reports by health plans available to the public. By 2015, qualified health plans would only be allowed to enter

into contracts with hospitals with fewer than 50 beds if the hospitals use a patient safety evaluation system and have implemented a comprehensive program for hospital discharge.

*Public Plan Option*

The House bill would offer a choice of public plan in the insurance exchange. In the Senate bill, a similar public plan choice was replaced with private multistate plans offered under contract with the federal Office of Personnel Management. Both bills also provide funding for the establishment of nonprofit health insurance cooperatives. The CBO estimated that neither the multistate plan option under the Senate bill or the nonprofit health insurance cooperative would have much of an effect on either coverage or costs.[57] CBO estimates that the cooperatives would have difficulty competing in most state markets dominated by one or two large carriers. [58]

While the House bill includes a public option, it is not the robust public option that would allow the HHS secretary to set provider prices at rates at or near Medicare levels and require that providers participating in Medicare also participate in the public plan. The bill allows providers participating in Medicare to opt out of the public plan and, rather than instructing the secretary to set provider prices, would have the secretary negotiate prices. This weakening of the public plan option led CBO to estimate that the public option in the House bill would not lead to a reduction in premiums relative to private plans. Only about 6 million out of 30 million people in the exchange would enroll in the public plan in the House bill.[59]

Still, the public option in the House bill remains an important part of the insurance exchange for three reasons. First, public insurance plans operate with significantly lower administrative overhead than private plans and do not have profit margins imbedded in their premiums. Administrative costs in the Medicare program, for example, are estimated to account for 2 percent to 5 percent of premiums compared with 25 percent to 40 percent of premiums in the individual insurance market.[60] The public plan premiums may be lower relative to private plans, providing an incentive for competing private plans to minimize costs. This would reduce the cost of premiums for people who do not qualify for premium subsides as well as the cost of subsidies to the federal government and potentially help to lower the rate of overall cost growth in the health system.[61] Second, the public plan option is the only vehicle in the House or Senate bills by which the federal government can exercise some direct control over provider prices for care of the under-65 population. Third, the public plan option within the exchange would enable the development and proliferation of innovative provider payment reforms that reward quality and efficiency beyond those efforts currently

underway in the Medicare program. This dynamic could encourage similar innovations among carriers and provide a competitive edge to integrated delivery systems that are already pursuing new models of patient-centered care coordination, disease management, and payment reform.

*Risk Adjustment and Reinsurance*

Guaranteed issue and community rating, coupled with an individual mandate, will reduce the incentive and the ability of insurers to cherry-pick the healthiest patients, but it will not eliminate them. Carriers will still have an incentive to avoid potentially high-cost patients. Indeed, one of the goals of health reform is to encourage the development of innovative care models for people with chronic illnesses, such as diabetes and heart disease. To reduce the incentive to cherry-pick and increase incentives for insurers to attract and care for chronically ill enrollees, the exchange will need to implement a mechanism to equalize risks across patients, thereby compensating insurance carriers for high-cost patients. The Senate bill provides a more detailed risk-equalization strategy than the House bill.

The House bill addresses risk adjustment by instructing the commissioner of the exchange to establish a mechanism to pay higher premium amounts to insurance carriers that sell plans that attract patients with greater health risks. The Senate bill includes two temporary and one permanent risk-equalization programs: a state transitional reinsurance pool, a temporary federal risk corridor program, and a permanent state risk-adjustment program.

**Transitional reinsurance.** The Senate bill requires all states to establish a nonprofit reinsurance entity for 2014, 2015, and 2016 that would collect payments from all insurers in the individual and group markets and make payments to insurers in the individual market that cover high-risk individuals. The HHS secretary would be required to establish federal standards for the determination of high-risk individuals, a formula for payment amounts, and contributions required of insurers. The standards would be invisible to individuals but would define individuals as high risk by using a limited list of 50 to 100 high-risk conditions or other comparable method recommended by the American Academy of Actuaries. Contributions from insurers must amount to $25 billion over the three years. This is designed to counter adverse selection problems in the early years of the exchange. In addition, $5 billion would be added to the fund for employer-sponsored early retiree coverage.

The nonprofit entity would use funds from insurers to support a reinsurance mechanism directed at individuals enrolled in plans offered through state exchanges. For retiree coverage, the program would reimburse any eligible employers or insurers for 80 percent of claims between $15,000 and $90,000 for nonactive workers ages 55 to 64 and their dependents. The funds must be used to lower the costs borne directly by beneficiaries, and the program provides incentives to plans to implement programs and procedures to better manage chronic conditions.

**Risk corridors.** The bill requires the HHS secretary to establish and administer a risk-corridor program for qualified health plans offered in the individual and small-group markets in 2014, 2015, and 2016. The program would be modeled after those applied to regional participating provider organizations in Medicare Part D. If "allowable costs" (total amount of costs that the plan incurred in providing covered benefits, reduced by administrative expenses) are between 97 percent and 103 percent of the "target amount" (the total annual premium, including subsidies, minus administrative expenses) plans would receive no payment. If allowable costs were higher than 103 percent of the target amount for the plan and year, the secretary would make a payment to the plan.[62] Alternatively, if allowable costs were lower than 97 percent of the target amount, the plan would make a payment to the secretary.[63]

**Risk adjustment.** Under this permanent program, the Senate bill would require states to develop methods and criteria with the secretary by which they would require payments from health plans offered in the individual and small group markets that had lower health risks among enrollees compared with all plans (excluding self-insured plans). In addition, the states would pay those health plans with higher risks (also excluding self-insured plans). The risk adjustment would apply to plans in individual and small-group markets but not grandfathered plans.

## CONCLUSION

The House and Senate bills would significantly reform the U.S. health insurance system, providing coverage to more than 30 million uninsured Americans and substantially improving the affordability of health insurance coverage for small businesses and for people currently buying health insurance on their own. The bills would build on the broadest risk pools in the system—large employer coverage, Medicaid, and CHIP—while bringing fundamental change to markets that currently perform very poorly in the provision of health insurance. Moreover, the system reform and revenue provisions in the bills would more than offset the federal costs of expanding and improving health

insurance coverage: the CBO estimates that the bills would reduce the federal deficit by $132 to $138 billion over 10 years.

While the bills are largely similar in their approach to reforming health insurance, there are key differences that have implications for the number of people expected to gain heath insurance, the amount of premiums and out-of-pocket costs paid by families, and the cost of health insurance over time.

**Insurance market reforms.** The bills would prevent underwriting on the basis of health but would allow premiums to rise with age. Under the Senate bill, older adults could face somewhat higher premiums than they would under the House bill, but younger adults would face somewhat lower premiums.

**Individual requirement to have health insurance.** The bills would require individuals to have coverage, but the Senate bill would exempt many more people from the mandate than would the House bill.

**Financial protection for low- and moderate-income families.** The House bill expands Medicaid eligibility further up the income scale (to 150% of poverty) than does the Senate bill (133% of poverty) and provides more affordable premiums and greater protection from out-of-pocket costs. Because of this expansion, the CBO estimates that the cost of premium and cost-sharing subsidies over 10 years in the House bill are higher than in the Senate bill ($602 billion vs. $436 billion).

**Employer shared responsibility.** The House bill would require employers, except for small employers, to offer and contribute a specified share of their workers' coverage or pay a penalty. The Senate bill would not require employers to offer health insurance but would assess a flat, per-employee fee on employers, with employees receiving federal premium subsidies through the insurance exchanges. Employers consequently provide a greater contribution overall to the House reform plan, providing an estimated $135 billion over 10 years, compared with $28 billion in the Senate bill.

**Insurance exchanges.** Each bill establishes new insurance exchanges that would either substitute or complement existing individual and small-group markets and would be subject to the same market rules (e.g., underwriting and rating). The House bill would replace existing individual markets, but not small-group markets, with a national insurance exchange, although states can elect to run their own exchanges subject to strict rules. The Senate bill would create state or regional exchanges that would operate

alongside existing individual and small group markets. Under both bills, all individual and family premium and cost-sharing subsidies would only apply to private or public plans sold through the exchanges.

**Choice of public health plan through the exchange.** The House bill would provide a choice of public, private, and nonprofit cooperative plans sold through the exchange. The Senate bill would provide a choice of private plans, nonprofit cooperative plans, and multistate private plans that would be offered under contract with the Office of Personnel Management.

**Risk equalization.** The bills include mechanisms aimed at equalizing risks across patients, thereby compensating insurance carriers for high-cost patients and reducing the incentive for carriers to cherry-pick patients with good health risks. The Senate bill provides a more detailed risk-equalization strategy than the House bill.

Given the growing health insurance crisis facing the nation, it is imperative that Congress complete its historic work on reforms to place the U.S. health system on the road to high performance.

## APPENDIX A

## METHODOLOGY

We estimated average premiums for the House and Senate bills for a set of federal poverty levels (FPL), ranging from 100 percent of FPL to 400 percent of FPL. For each bill, we estimated the premium amount that would be paid by the family based on the income-specific premium cap as a share of income. Premium estimates are from Kaiser Family Foundation Health Reform Subsidy Calculator—Premium Assistance for Coverage in Exchanges/Gateways (http://healthreform.kff.org/Subsidycalculator.aspx). Premium estimates are based on coverage for a family of four with the primary beneficiary age 40.

For the Senate bill, the family premium for the silver plan (which is what the premium subsidies are based on) is estimated at $9,435, with an actuarial value of 0.70. For the House bill, the family premium for the basic plan (which is what the premium subsidies are based on) is estimated at $9,435, with an actuarial value of 0.70.

For purposes of illustration and comparison of the bills' cost-sharing provisions, the analysis assumes that the premiums of health plans, less administrative costs and profits, are equal to their actuarial values. The Congressional Budget Office assumes that health plans sold through the exchanges under the Senate bill would have an administrative cost load of 18 percent; we assume the same for this analysis.[64] Thus, a single policy for a 40-year-old is estimated to have a premium of $3,500 in the Senate and House bills for a plan with 0.70 actuarial value.[65] After removing administrative costs, the actuarial value of the plans is estimated to be $2,870 in the Senate and House bills.

We projected family premiums for the Senate and House bills to 2019, based on estimated premiums of $9,435 for family coverage if the reforms were to be implemented in 2009. To estimate premiums to 2010, we used the average growth rate for family insurance premiums over the 2006–2008 period from the Kaiser/HRET Survey of Employer-Sponsored Health Benefits and applied this average rate to inflate to 2010. We estimated premiums for each year up to 2019 using the average annual growth rate in the Centers for Medicare and Medicaid Services' estimates of growth in national health expenditures per capita. We projected incomes out to 2019 using the average median family income growth rate over 2000–2008 (2.9% per year). For each income level, we calculated the percent of the total premium that would be paid by the family. Both the

Senate Finance and House bills stipulate that the percent of the total premium paid by the enrollee would remain constant each year, even as the total premiums increase. We applied this rate to each income level to determine the percent of a family's income that would be spent on the premium for each year.

## NOTES

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[2] 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. Underinsured adults are insured all year and report spending 10% or more of their income (5% if their incomes are under 200% of poverty) on out-of-pocket health costs, excluding premiums; or having deductibles that amount to 5% or more of their income.

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[9] P. B. Ginsburg, "Employment-Based Health Benefits Under Universal Coverage," *Health Affairs*, May/June 2008 27(3):675–85.

[10] Under the Congressional Budget Act of 1974, the Congressional Budget Office (CBO) is directed to score the effect that legislation has on the federal deficit relative to federal baseline projections. Under the law, the Joint Committee on Taxation (JCT) is also required to estimate the effect on revenues when legislation involves the tax code and CBO is required to incorporate JCT estimates into its analysis. All estimates in this description are in billions, unless otherwise noted, and refer to cumulative savings over the 10-year window, 2019–2019.

[11] Although the individually listed costs, savings, and revenue sum to $139 billion, the CBO estimate lists the reduction in the federal deficit as $138 billion. This is likely due to rounding.

[12] Congressional Budget Office, Letter to the Honorable John Dingell, Nov. 20, 2009, http://cbo.gov/ftpdocs/107xx/doc10741/hr3962Revised.pdf.

[13] Congressional Budget Office, Letter to the Honorable Harry Reid, Nov. 18, 2009, http://cbo.gov/ftpdocs/107xx/doc10731/Reid_letter_11_18_09.pdf.

[14] Congressional Budget Office, Letter to the Honorable Charles Rangel, Oct. 29, 2009, http://cbo.gov/ftpdocs/106xx/doc10688/hr3962Rangel.pdf.

Congressional Budget Office, Letter to the Honorable Harry Reid, Nov. 18, 2009, http://cbo.gov/ftpdocs/107xx/doc10731/Reid_letter_11_18_09.pdf.

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Congressional Budget Office, Letter to the Honorable Harry Reid, Nov. 18, 2009, http://cbo.gov/ftpdocs/107xx/doc10731/Reid_letter_11_18_09.pdf.

[16] Congressional Budget Office, Letter to the Honorable John Dingell, Nov. 20, 2009, http://cbo.gov/ftpdocs/107xx/doc10741/hr3962Revised.pdf; Congressional Budget Office, Letter to the Honorable Harry Reid, Nov. 18, 2009, http://cbo.gov/ftpdocs/107xx/doc10731/Reid_letter_11_18_09.pdf.

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[19] National Association of Insurance Commissioners and Center for Insurance Policy Research, *Health Insurance Rate Regulation*, http://www.insurance.naic.org/documents/topics_health_insurance_rate_regulation_brief.pdf.

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[21] L. J. Blumberg and K. Pollitz, *Health Insurance Exchanges: Organizing Health Insurance Marketplaces to Promote Health Reform Goals* (Washington, D.C.: The Urban Institute, April 2009).

[22] J. R. Gabel, R. McDevitt, R. Lore et al., "Trends in Underinsurance and The Affordability of Employer Coverage, 2004–2007," *Health Affairs* Web Exclusive, June 2, 2009, w595–w606.

[23] Gabel, McDevitt, Lore et al., "Trends in Underinsurance," 2009; J. Gabel, R. McDevitt, R. Lore et al., *Comparing Medicare's Benefit Package with the Blue Cross Blue Shield Standard Option Federal Employees' Plan* (New York: The Commonwealth Fund, forthcoming Jan. 2010).

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[25] Kaiser Family Foundation Health Reform Subsidy Calculator—Premium Assistance for Coverage in Exchanges/Gateways, http://healthreform.kff.org/Subsidycalculator.aspx.

[26] Congressional Budget Office, Letter to the Honorable Evan Bayh, Nov. 30, 2009.

[27] Congressional Budget Office, Letter to the Honorable Harry Reid, Dec. 19, 2009, pg. 19, http://www.cbo.gov/ftpdocs/108xx/doc10868/12-19-Reid_Letter_Managers.pdf. According to CBO, the substitution of the public health plan with the multistate health plans under contract with OPM would likely make little difference in premiums. The new provision limiting medical

loss ratios would tend to lower premiums somewhat, while the restrictions on insurers' ability to place annual limits on what plans will pay might slightly increase premiums.

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[63] If allowable costs were between 97% and 92% of the target amount, the plan would make a payment to the HHS secretary equal to 50% of the difference between 97% of the target amount and the allowable costs. If allowable costs were below 92% of the target amount, the plan would make a payment to the secretary equal to the sum of 2.5% of the target amount and 80% of the difference between 92% of the target amount and allowable costs.

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