

Section I

Proposals

A Comparison of Reform Plan Features

The first two pages of this table provide a side-by-side comparison of the features of the reform plans that are described in detail in the following chapters. The subsequent pages of the table summarize the features of the reform plans presented in the previous volume. The plans are identified by the names of the authors.

Kendall/Levine/Lemeiux	
General Approach	Tax credits to low- and middle-income individuals and families to be used in either individual or group market. States receive performance-based grants to improve coverage rates, access, quality, and outcomes.
Target Population	Low- and middle-income individuals and families.
Form of Public Programs	Advanceable and refundable tax credits for low- and middle-income people. Medicaid, S-CHIP, and Medicare would continue. Federal government provides grants to states to improve coverage, access, quality, and outcomes. States subsidize costs of coverage when credits are not large enough to make coverage affordable; may use purchasing pools or high-risk pools.
Mandates for Coverage	After five years, a commission would decide whether to establish an individual mandate.
Sources of Funding	Not specified; presumably general revenue, but alcohol and tobacco tax mentioned.
Major Tax Changes	None apart from tax credit for coverage.
Level of Benefits	Not regulated, but states have responsibility to prevent underinsurance; after five years, a commission would assess adequacy of benefits.
Role of Federal Government	Finances and oversees tax credits. Provides performance-based grants to states. Establishes commission to study health benefits and technology and a federal information exchange/clearinghouse to report and disseminate information on quality and outcomes.
Role of State Government	Uses federal grants to supplement tax credits, strengthens safety net, assures health plan choices (e.g., through pools), and measures quality and outcomes. Continues operating Medicaid and S-CHIP.
Effects on Existing Public Programs	Continue largely unchanged.
Role of Insurers/Health Plans	Essentially unchanged.
Role of Employers	Required to offer (but not pay for) a menu of health plans, facilitate an annual enrollment for employees, withhold premiums, and administer tax credits.
Risk Share/Purchasing Pools/Insurance Regulation	Purchasing pools are an option to meet the requirement that states assure that everyone has a choice of plans available at reasonable cost. States could use federal grants to subsidize high-risk people in the pool. Alternatively, states could impose community rating to spread risk.

Miller	Morone
Tax credits available to all to provide 30% subsidy for high-deductible coverage. Strengthen safety net and establish high-risk pools for the uninsurable. Strong incentives for consumers to economize.	“Single-payer” approach. All legal residents covered by Medicare, with expanded and rationalized benefits package and no copayments. Particular emphasis on community medicine. States could choose to opt out for residents under age 65 by designing their own system under federal guidelines.
Working uninsured, including individuals, and people who decline public coverage.	All legal residents.
Medicaid, S-CHIP, and Medicare would continue for the time being. Better-funded high-risk pools.	Medicare covers all legal residents, but Medicaid remains as a source of longer-term care, disability coverage, and wraparound coverage for Medicare. Many other programs (maternal and child benefits, for example) would be subsumed under new program.
None.	All legal residents covered by Medicare or state alternative.
Reductions in other federal health and non-health spending.	Earmarked federal value-added tax (VAT).
Advanceable tax credits as an option to exclusion of employer premium. More flexible tax treatment of MSAs and IRA-type health savings accounts to encourage growth.	Medicare payroll taxes and premiums abolished and replaced with VAT. Medicare’s claim on general revenues (Part B) ended. Tax relief for state Medicaid programs.
Minimum equal to services covered in minimum-cost FEHBP plan but with significant front-end deductible (e.g., 5% of income) and maximum out-of-pocket obligation; thus catastrophic coverage.	Similar to Medicare but with addition of prescription drugs, maternal and child health services, mental health services, emphasis on primary care, including neighborhood health centers and extensive new home health benefits.
Fund tax credits, help fund high-risk pools, and additional funding for safety net. Require guaranteed-renewal option for coverage eligible for tax credit.	New Department of Health organizes and runs expanded Medicare program. Oversees optional state waiver programs. IRS designs and implements a value added tax. Earned Income Tax Credit expanded to offset regressive effects of VAT.
Would compete for insurers by adopting attractive insurance regulation.	Long-term care portion of Medicaid remains. Have the option of designing and paying for 25% of costs to operate federally approved and monitored alternative to federal Medicare.
Medicaid, S-CHIP, and Medicare continue for the time being.	Medicare vastly expanded to all legal residents with expanded benefits. Medicaid continues for long-term care. Many other programs replaced by new Medicare.
Similar to present but with greater flexibility to sell MSAs and other new insurance products.	Can offer supplementary coverage to expand benefits beyond Medicare level.
Essentially unchanged.	Do not contribute toward Medicare coverage but could pay for supplemental benefits (with continued tax exclusion for employees).
Purchasing pools could accept all employers and individuals and risk-rate new entrants for two years. To further offset adverse selection, pools could require multi-year contracts of customers and impose penalties for early exit from pool. States would compete to be the single legal domicile for insurers by passing favorable insurance regulations.	Medicare is the single pool and the only insurer for all citizens for the standard benefits package, so there are no risk-sharing issues.

A Comparison of Features of Reform Plans in Volume I

	Butler	Feder/Levitt/O'Brien/Rowland	Gruber	Hacker	Holahan/Nichols/Blumberg
General Approach	Would make refundable tax credits available to working households. States would get grants to expand health coverage to more residents and make insurance more affordable. Coverage obtained at work or from a range of other organizations such as churches or unions.	Expand Medicaid and the State Children's Health Insurance Program for low-income people. Possible combination with tax credit to small, low-wage firms to expand employer offerings.	Establishment of purchasing pools in every state through which households with incomes up to 300% of the federal poverty level would be eligible for no-cost or reduced-cost coverage on a sliding-scale basis; automatic plan enrollment for lowest-income households.	A modified "play or pay" approach that creates incentives for workers and employers to buy into "Medicare Plus," a national program based on Medicare.	Extend the type of subsidized coverage that is currently available under S-CHIP to all lower-income people and subsidize insurance for the highest risk.
Target Population	Working uninsured individuals and families; the plan would achieve near-universal coverage for all working households of legal U.S. residents.	People below 150% of poverty level covered at no cost; those between 150% and 200% of poverty would pay some premiums and cost sharing. Higher-income people could buy-in to public coverage and pay a sliding-scale premium. Employees of small, low-wage firms benefit from tax credit.	Individuals and households under 300% of the federal poverty level would receive subsidies. Households with incomes below 150% of poverty level would be eligible for no-cost coverage.	All Americans not covered by Medicare or employer-sponsored insurance.	Individuals with incomes under 250% of the federal poverty level and those at high health risk. Subsidies available only to those who enroll through the state purchasing pool.
Form of Public Programs	Refundable tax credit, funded via repeal of federal income tax provision that makes employer contributions to employees' health insurance non-taxable income; federal tax revenues would fund grants to states to help low-income families buy coverage.	S-CHIP expansion, federally subsidized, with some state match, for those with limited incomes, and a federal tax credit subsidy for small employers to help cover workers.	Household income determines eligibility for no-premium plans (for households under 150% of poverty level) or reduced-premium plans (for households under 300% of the federal poverty level on a sliding-scale basis but premium not more than 10% of income).	Premiums for those buying into Medicare Plus would be scaled to income, with lower-income citizens paying only a small percent of income. Employers would be eligible for transitional subsidies and for reductions in their contribution rate based on firm income.	Increased federal-funding match to participating states; full subsidies to people below 150% of poverty; cost-sharing up to 7% of income for people between 150% and 200% of poverty and to 12% for people between 200% and 250% of poverty. Higher-risk individuals, regardless of income, pay no more than a statewide community rate.
Mandates for Coverage	None, but to receive tax credit, individual or family would have to buy a health plan that included a minimum set of benefits. High-level of voluntary compliance expected among most workers since employees required to tell employers which health plan they wished to join.	None.	None.	None initially but individual mandate would apply eventually if a nontrivial share of Americans remained uninsured.	After five years, states could mandate that everyone be covered.
Sources of Funding	Savings from elimination of existing tax exclusion, and federal general tax revenues.	Federal general revenues, with state matching payments.	Federal general revenues, savings from replacement of Medicaid and S-CHIP health programs, and limits on tax exclusion for employer-provided insurance.	Payroll contributions and premiums, general revenues, and other smaller sources.	Federal general revenues, and cuts in existing programs since the need would be reduced as health reform is implemented.

Kronick/Rice	Pauly	Singer/Garber/ Enthoven	Weil	Wicks/Meyer/ Silow-Carroll
<p>All non-elderly legal residents would be guaranteed comprehensive health insurance as a “right” (at no direct cost) through a public insurance approach designed by each state and monitored by the federal government.</p>	<p>A refundable tax credit/voucher system would make some level of coverage affordable to lower-middle-income people who currently have no health insurance. Very-low-income households would initially be eligible for publicly financed zero-premium comprehensive insurance.</p>	<p>Combines refundable tax credits and insurance exchanges to promote lower-cost, higher-value health coverage while allowing employers and individuals to continue current arrangements if they desire.</p>	<p>A new Medical Security System would be created to provide universal coverage, making coverage a “right.”</p>	<p>Tax credits for all households, varying by income. Universal coverage achieved by mandating that everyone have or buy health coverage and having Medicare automatically cover anyone temporarily uninsured. Builds on present system of private health plans and employer-based coverage.</p>
<p>All non-elderly legal residents.</p>	<p>Principal target group is lower-middle income families and individuals with incomes above the federal poverty line, or about half of the uninsured. Very low-income families covered publicly, at least initially.</p>	<p>Low and moderate-income people who are not eligible for Medicare.</p>	<p>All legal U.S. residents under age 65.</p>	<p>All of the uninsured.</p>
<p>Federal subsidies to states to finance availability of no-cost coverage to all legal residents.</p>	<p>A voucher or tax credit large enough to cover one-half to two-thirds of the premium for moderately comprehensive coverage. The credits would be in the form of coupons worth \$1,500 for individual coverage and \$3,500 for family coverage. No-cost publicly financed coverage for very low income households.</p>	<p>Continuation of Medicaid/ S-CHIP for eligible individuals and families who choose to stay in these programs; refundable tax credits equal to 70% of median-cost health plan; federal payments to states equal to 50% of the tax credit to cover the costs of running “default plans” for people who do not enroll.</p>	<p>Payroll tax, Medicaid, and S-CHIP funds.</p>	<p>Refundable tax credits for all households but varying according to income—minimum credit approximately \$700 a year for an individual and \$1,200 a year for a family. People below 100% of poverty would get credit sufficient to buy coverage comparable to Medicaid. Those above that level up to median income would get gradually reduced subsidies.</p>
<p>All legal residents under age 65 automatically covered by comprehensive benefits. Everyone would have at least one health insurance option that would not require payment of premiums. There would be a mandatory payroll tax.</p>	<p>None.</p>	<p>None.</p>	<p>All employers and employees would pay a new payroll tax. All people would have to enroll or be enrolled by default.</p>	<p>Every individual and family would have to have health coverage at least as comprehensive as Medicare’s, plus prescription drugs and well-child care. Those who fail to show proof of purchase would pay a premium plus a penalty for Medicare backup coverage for every month without other coverage.</p>
<p>Primary revenue source would be a payroll tax levied on employers and employees, supplemented by federal general revenues, state revenues, and, in some states, premium payments from individuals.</p>	<p>Federal budget revenues; those who buy more expensive coverage would pay out-of-pocket. Full coverage for those with incomes below 125% of the federal poverty level would be financed through a combination of state and federal revenues.</p>	<p>Phased-in cap on current federal tax exclusion; general revenues; and savings over time from changing consumer behavior and increasing health plan competition.</p>	<p>Payroll tax, premiums, and federal subsidies.</p>	<p>Federal general revenues, but partially offsetting savings would be realized from the elimination of Medicaid and S-CHIP and from making employer-paid health premiums taxable income for employees.</p>

A Comparison of Features of Reform Plans in Volume I

	Butler	Feder/Levitt/O'Brien/Rowland	Gruber	Hacker	Holahan/Nichols/Blumberg
Major Tax Changes	Repeal of the federal income tax provision that makes employer contributions to employees' health insurance a non-taxable form of income.	Explores tax credits to individuals or employers, the latter to subsidize the offering of coverage to uninsured workers with modest incomes.	Limits the tax exclusion for employer-provided insurance equal to no more than the cost of the median-cost plan in each purchasing pool.	Cap on tax exclusion of employer-provided health insurance at level of twice the average premium of Medicare Plus coverage.	Federal taxes would be increased if surplus not available.
Level of Benefits	To qualify for the tax credit, families would have to enroll in a health plan that included at least the minimum insurance package, which would be primarily catastrophic coverage.	Comprehensive but not specifically delineated.	Physician services, inpatient and outpatient hospital, prescription drugs, nominal payments for well-child care, prenatal care, and immunizations.	A defined benefit package similar to Medicare plus outpatient prescription drugs, preventive services, mental health benefits, and maternal and child health care.	States determine a new standard benefit package—within federal guidelines—for everyone under 250% of poverty and those at high health risk.
Role of Federal Government	Would establish a default system of health insurance regulation to encourage availability of affordable insurance; would establish a benchmark health plan with basic features and catastrophic protection. Would monitor state compliance and work with states on a plan to eliminate uninsurance.	Would make federal funds available at enhanced Medicaid matching rates to states willing to cover targeted uninsured.	Funds subsidies, sets minimal rules, provides oversight of purchasing pool administration.	The Health Care Financing Administration would have primary responsibility for administering Medicare Plus. In addition to offering standard fee-for-service coverage, Medicare Plus would also allow beneficiaries to enroll in private health plans that contracted with the program.	Financial support, monitor state compliance of minimum rules, oversee state spending and enforcement.
Role of State Government	Would develop a mechanism to supplement federal tax credit for eligible workers and help cover those who did not purchase minimum insurance. Would have to use additional federal funds to expand existing or develop new programs to achieve target levels of coverage. Would work with health insurers on insurance reform that keeps benefits affordable.	Would provide coverage to low-income uninsured residents, consistent with federal rules affecting eligibility, benefits, administration, and other program aspects.	Not addressed, except for continued responsibility for remaining parts of Medicaid.	Would transform from provider of insurance to a portal for coverage under the new Medicare Plus system. States would continue to finance care for the eligible aged, blind and disabled. In addition, they would have to reach out to and enroll non-workers, provide wraparound coverage for those who would have been in Medicaid, and subsidize premiums for unemployed people.	Increases role of states significantly while granting more flexibility.

Kronick/Rice	Pauly	Singer/Garber/ Enthoven	Weil	Wicks/Meyer/ Silow-Carroll
<p>Payroll tax substitutes for employer and employee premiums, which has implications for tax exclusion provision of employer premium contributions.</p>	<p>No major tax code changes, but tax credits in the form of coupons would help people purchase qualified health insurance. The new vouchers would be viewed and treated as tax reductions for those who use them.</p>	<p>Phased-in cap on current federal tax exclusion for employer-paid premiums.</p>	<p>New payroll tax would be established for employers and employees.</p>	<p>The tax exclusion for employer-paid health premiums would be eliminated.</p>
<p>A federally-defined standard benefit package. Benefits would include prescription drug coverage; dental and long-term care would not be required.</p>	<p>To qualify for the credit, the plan would have to cover effective medical and surgical services, prescription drugs, and medical devices based on a standard definition. Patient cost sharing would be permitted, as would managed care.</p>	<p>Generally determined by the market, with minimum standards set by the Insurance Exchange Commission, including goods and services known to be medically effective and provided at reasonable cost.</p>	<p>Guarantee is for basic coverage, but individual may supplement with own funds to buy more comprehensive.</p>	<p>A package of benefits comparable to Medicare's plus a prescription drug benefit and well-child care coverage.</p>
<p>Would impose payroll taxes on employers and employees, calculate money needed and provide funds to each state health care system, monitor state implementation of expansions, measure quality and health outcomes, determine and update standard benefit package, monitor and regulate quality of care in states.</p>	<p>Would make information about insurance purchasing and plans available, including price and quality and could subsidize the production and distribution of such information. It also would be (or contract with) an insurer of last resort.</p>	<p>Establish the Insurance Exchange Commission to oversee insurance exchanges, distribute tax credits and make default plan payments. Establishes U.S. Insurance Exchange as backup in markets without private exchanges.</p>	<p>Would set up and regulate insurance exchanges, forward tax revenues, and determine size of payroll tax.</p>	<p>Would fund all tax credits. Would establish general guidelines for states setting up the aggregate purchasing arrangements (APA). Would continue to operate Medicare, for the elderly and as a temporary back-up plan for people who do not have proof of private coverage.</p>
<p>States would have much flexibility in designing a system — how to pay health care providers (e.g., single payer vs. competing health plans), be responsible for raising revenue to supplement federal financing, meet federal requirements, and enroll residents in health plans. Would provide information on enrollment options and procedures, negotiate with health plans and providers, regulate health plans, and collect data to evaluate the system.</p>	<p>Would have primary role of selecting or managing the public plan for poor people not currently covered by Medicaid. Could continue to regulate individual insurance and regulate risk-rating. In addition, states could choose to provide payments for people with high medical expenses, possibly allowing smaller deductibles or less-constraining upper limits in low-cost plans.</p>	<p>Continue to provide Medicaid and S-CHIP; use new federal funds to pay for care under default plans by reimbursing safety-net providers.</p>	<p>States would continue to pay some Medicaid costs to keep coverage at current levels; would subsidize copayments under basic plan for low-income residents.</p>	<p>Each state would be required to establish an aggregate purchasing arrangement through which small employers and individuals would purchase coverage. In exchange for no longer financing the acute portion of Medicaid or S-CHIP, states would assume greater responsibility for long-term care services under Medicaid.</p>

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Effects on Existing Public Programs	Medicaid and S-CHIP would continue as now.	Medicaid and S-CHIP would continue and be expanded.	Gradual phase out of Medicaid and S-CHIP (and accompanying federal subsidies) for those families who qualify on income alone. Medicaid remains in place for the elderly and disabled.	Would eventually replace existing public programs for the uninsured with a single national program based on Medicare. Medicaid and S-CHIP would be phased out with eligibles automatically enrolled in the new Medicare program or employer-sponsored plans.	Participating states would receive enhanced federal S-CHIP matching rate for all current Medicaid and S-CHIP beneficiaries under 250% of poverty; all states must continue smaller, residual Medicaid program for children and adults with special needs as well as all long term care services; would eliminate federal payments to states covering individuals with incomes above 250% of poverty. No change in non-participating states.
Role of Insurers/Health Plans	Would continue to be a major source of coverage. Would have to bring premium rates into line with federal or state underwriting and benefit requirements, but would benefit from administrative savings associated with the automatic enrollment system.	Would stay the same as today, although some market reforms might be necessary.	Could participate in state-established purchasing pool or continue to operate outside of such arrangements.	Would stay the same as today; would compete for business from Medicare Plus system.	Health plans participating in the new state plan would be required to accept all applicants, with premiums set at a statewide community rate. Payments to plans would be risk adjusted. Insurers would not be subject to any new federal market regulations outside the state purchasing pool.
Role of Employers	Similar to present but would have to inform employees about the tax credit program and deliver the tax credit. Would serve as a clearing-house, creating automatic enrollment mechanisms for insurance, setting up payroll deduction and payment systems for employees and providing proof of insurance for each worker.	Similar to present. If tax credit were pursued, small low-wage employers would be encouraged to offer insurance to their employees; employers would receive the tax credit if they provided insurance.	Would continue to offer health coverage to workers, but could do so within the purchasing pool or outside of it.	Employers would enroll workers at workplace. They could choose to sponsor coverage at least as generous as the new program's or pay a modest payroll-based contribution to fund public coverage.	Would continue to have choice to offer health coverage to their workers. If they offer, they must make state plans available, but they can also offer plans outside the state pool.
Risk Share/Purchasing Pools/Insurance Regulation	Insurance industry and states would have to work together to develop a means for adjusting risk among plans.	Possible reforms in the individual insurance market unless tax credits could be applied to a publicly managed insurance product.	Purchasing pools are foundation of proposal: subsidies are available only for coverage purchased through the pools.	To avoid adverse selection, measures are imposed to make it more difficult for employers to shift between public and private coverage. 50% to 70% of the population might eventually enroll in Medicare Plus, providing strong bargaining leverage and broad pooling of risk. No new regulations are imposed on private insurance, and there are no insurance pools.	State-established purchasing pools are foundation of proposal. Medicaid (except the disabled and elderly) and S-CHIP enrollees and state employees would be included in the pool. The pool would be open to individuals and employers, and insurers could offer standard benefit package at a statewide community rate, plus add-on products priced separately.

Kronick/Rice	Pauly	Singer/Garber/ Enthoven	Weil	Wicks/Meyer/ Silow-Carroll
<p>Would vary by state, but new state program could replace S-CHIP and portions of Medicaid.</p>	<p>Medicaid and S-CHIP would continue, and more low-income people would be subsidized to enroll in these programs or some other public program.</p>	<p>Medicare remains intact; people enrolled in Medicaid and S-CHIP may stay in these programs or opt instead for tax credits to be used in the private market.</p>	<p>S-CHIP would be subsumed; Medicaid would be mostly subsumed.</p>	<p>S-CHIP and Medicaid largely replaced, except for disabled and elderly.</p>
<p>In some states, plans would compete for business from states and would have to include services specified in a federally-defined benefits package. Some states might choose to pay providers directly and eliminate the role of insurers/health plans.</p>	<p>Would continue to be major source of coverage. Would be required to guarantee renewability in the individual market and to set premiums on modified community-rating basis in the small-group market. Insurers would redeem vouchers or certificates.</p>	<p>Would compete to provide low-cost, high-quality care; collect and report quality of care and health outcomes data.</p>	<p>Plans would contract with health insurance exchanges to offer range of plans, including a “no-cost” plan (that is, no enrollee contribution); would market plans and monitor quality of care.</p>	<p>Would continue to be major source of coverage but would be required to offer a policy that covers the services comparable to Medicare plus prescription drugs and well-child care, to participate in purchasing pools, and to community rate in individual and small-group markets.</p>
<p>Employers would no longer provide or buy health coverage for their workers. Although employer role would be eliminated, both employers and employees would have to contribute to financing coverage.</p>	<p>Similar to current role.</p>	<p>May become their own insurance exchange; continue to offer benefits to employees; or purchase coverage from exchanges.</p>	<p>Employers would collect payroll tax but could opt out by offering own generous plans to employees.</p>	<p>Employers would be required to offer (but not necessarily pay for) coverage for employees and dependents. Benefits must be at least comparable to Medicare plus a prescription drug benefit and well-child care. Employers with 10 or fewer employees would have to offer coverage through the purchasing pool.</p>
<p>Since coverage in no-cost plan is automatic, everyone is pooled together, though states would have latitude to decide specifics.</p>	<p>Few restrictions would be placed on qualifying coverage. But all policies must have a guaranteed renewability clause, and low-cost policies must be sold under modified community rating. Plans with more generous coverage could charge higher premiums to high-risk people. Insurers could impose modest waiting periods for people who did not enroll during open season.</p>	<p>The Federal Insurance Exchange Commission would develop risk-adjustment strategies. Payments would be risk-adjusted both between health plans within an exchange and across exchanges.</p>	<p>Insurers selling through insurance exchanges would be required to offer guaranteed-issue, community rated standard benefit packages.</p>	<p>All health plans would have to accept all individual and small-group applicants and provide immediate and full coverage for all covered benefits with no waiting periods or exclusions for prior conditions. Insurers selling individual and small-group coverage would have to price premiums on a community-rated basis. Purchasing pools (APAs) open to all individuals and groups.</p>