Covering America

REAL REMEDIES FOR THE UNINSURED

ECONOMIC AND SOCIAL RESEARCH INSTITUTE

JUNE 2001

Jack A. Meyer
Project Director

Elliot K. Wicks
Editor and Project Manager

Advisory Panel

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Lynn M. Etheredge
Independent Consultant

Judith Feder
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Project Director
Economic and Social Research Institute (ESRI)
Jack A. Meyer

Editor and Project Manager, ESRI
Elliot K. Wicks

ESRI Project Staff
Sharon Silow-Carroll
Emily Waldman
Patricia Gepert-Guajardo
Stephanie Anthony
Todd Kutyla
Mark Legnini
Tarneice Hinton-Davis

Copy Editor
Jean Bernard

Cover and Book Design
Beth Schlenoff

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Economic and Social Research Institute
1015 18th Street, N.W., Suite 210
Washington, D.C. 20036
(202) 833-8877
Website: www.esresearch.org

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Introduction

This document is one product of a process established by the Economic and Social Research Institute to develop and evaluate a continuing series of major reform proposals to extend health care coverage to most, if not all, Americans. Supported by a grant from The Robert Wood Johnson Foundation, the project is designed to generate the kind of critical thinking and serious debate that will raise the visibility of the problem of inadequate coverage and lead to serious consideration of far-reaching solutions. We hope to inform, facilitate, and re-invigorate the debate over how best to provide health care coverage for the uninsured in the United States.

Approximately 43 million Americans—or 18.4 percent of the non-elderly population—are without any kind of health coverage, either public or private. This figure is evidence of a major social problem that needs to be resolved. It has serious negative consequences that include lack of access to needed care, declining health, and, for some people, the assumption of crushing financial burdens. Unfortunately, despite the recent long period of sustained prosperity and economic growth, the number of people without health insurance protection has increased appreciably in the last decade.

A major purpose of this project has been the production of a series of commissioned proposals for extending health care coverage to the uninsured. The hope is that policy makers will be able to draw upon the proposals generated through this process to formulate a set of comprehensive reforms. This document summarizes each of the 10 proposals, all of which have been published in their entirety in a separate volume that is available from the Economic and Social Research Institute.

This summary document and the book that includes the full proposals are the culmination of a year-long process designed to produce 10 thoughtful, contrasting approaches to move substantially toward universal coverage. We wanted the papers to represent the best, most innovative thinking on this important policy issue. And we sought to produce proposals that draw on the wisdom of people representing the full range of ideas and philosophical perspectives.

In issuing invitations to potential authors—all expert health analysts and researchers—we stressed that we were interested in rethinking our present approaches to providing health insurance. We indicated that we were looking for new, fresh ideas. Although political feasibility is obviously important, we wanted authors to consider approaches that involve fundamental reform and perhaps even a complete overhaul of many current structures. We asked authors to acknowledge the political difficulties and barriers that would need to be overcome to implement their proposals, but we said that they should not assume that current views cannot be changed.

Once the authors had completed a draft, they presented their reform proposals in person to a distinguished and diverse advisory panel of health policy analysts and researchers. These advisors, all widely respected experts experienced in analyzing health policy issues, represent a broad spectrum of philosophical perspectives. The advisory panel provided feedback, comments, and critiques for each paper. Their task was to help authors clarify and strengthen their proposals; no endorsement was asked for or given, nor should it be inferred.

The 10 proposals are summarized in this volume. In addition to a narrative summary of each proposal, at the end of the document is a table that provides side-by-side comparisons of various features of the proposals. The proposals cover a wide range of approaches to extending coverage to the uninsured. Some build on the current system in one way or another, while others would jettison major parts of it; still others fall somewhere in between. Some would move quickly to virtually universal coverage; others would progress more gradually toward that goal.

These proposals are just one step in an iterative process. They do not yet include cost estimates. A research firm is being commissioned to model the proposals for the purpose of providing estimates of their cost and impact on the uninsured. As part of this process, authors will have the opportunity to revise their proposals. So, in one sense, the proposals that are summarized here are provisional; authors reserve the right to amend them if they think it is prudent to do so. The cost estimates, along with the revised versions of the proposals, will be disseminated at a later date.

As the proposals put forth in this volume show, the barriers to solving the problem of the uninsured do not include a lack of viable solutions. There are a number of reform strategies that would solve the problem, but deciding on a particular one is difficult because all viable solutions require making difficult trade-offs. However, the fact that there are no easy or non-controversial solutions to the problem of the uninsured should not deter us from making a commitment to find a lasting solution. We hope that the proposals presented here will help to take us one step closer to achieving that end. ■

Reforming the Tax Treatment of Health Care to Achieve Universal Coverage

Stuart M. Butler has outlined a new proposal to achieve near universal coverage for health insurance that is built on the following key elements:

• A refundable tax credit available to working households would replace the current tax exclusion accorded to employees. Employees could no longer exclude from their taxable income the amount employers contribute on their behalf to health insurance premiums.

• Workers whose employers sponsor coverage would have to use the credit to get coverage at work. Other employees and individuals could use their tax credit to buy coverage from a range of additional sources. These would include plans offered by employers, association plans, and plans offered by affinity groups such as churches, unions, and so on.

• All employers, regardless of whether they sponsored coverage, would have to undertake a "clearinghouse" function, which could include adjusting employee tax withholdings to reflect their credit, creating an automatic enrollment mechanism for insurance, and setting up a payroll deduction and payment system for employees to pay their chosen plan.

• To receive a new federal grant to supplement the tax credits, states would have to develop a plan acceptable to the federal government to make coverage more affordable for low-income workers.

Overview

A growing number of legislators are eyeing the tax code as a way of alleviating the nation's uninsured problem. Today's tax treatment of health insurance provides more than $120 billion in tax breaks to help working families obtain health coverage. However, economist Stuart M. Butler at The Heritage Foundation argues that the system is neither a universally available nor equitable way to provide health care benefits. For example,millions of low-income workers and people who work in firms that do not offer health coverage do not benefit from today's tax code policy, and people with high incomes and generous health coverage benefit the most.

Butler proposes a new insurance coverage model that would make refundable tax credits available to households as a substitute for the historical tax treatment of health benefits. He views this as a way of achieving near-universal health coverage for working families, including self-employed people. At the same time, the plan would grant funds to states to expand health insurance coverage to more residents and would make insurance more affordable in the private market.

Refundable Tax Credits

The cornerstone of Butler's proposal is a fully refundable tax credit for working Americans that would be based on household income and medical costs, including premiums and out-of-pocket expenses. A major source of funding would be the repeal of the federal income tax provision that makes employer contributions to employees' health insurance a nontaxable form of income. The tax credit would be federally funded from general tax revenues.States would also receive grants to supplement the credits for low-income families for whom the credit might be insufficient to make coverage affordable.

To receive the tax credit, individuals or families would have to buy a health insurance plan that featured a minimum level of benefits. Butler does not mandate that everyone buy coverage, but workers whose employers offer coverage would be required to tell their employers which health plan they wish to join—or accept enrollment in a default plan or program selected by the state. Butler expects a high degree of voluntary compliance since any individual who avoids enrollment in a minimum plan would lose significant tax benefits for both health insurance premiums and expenditures for health care services.

Preserving the Employment Link

Butler says that key features of his plan include components that make it attractive in the current political arena. The plan would achieve near-universal coverage for working households through the private market rather than by creating a new federal entitlement program. He says that it would also preserve a link between health coverage and employment that many Americans take for granted—making the proposal familiar and feasible. Since enrollment and the financial transactions associated with insurance would typically be at the workplace, for many people the system would look very much as it does today. But people whose employers chose not to offer coverage would still be eligible for the same tax subsidy, even if they bought coverage on their own rather than through their employer. Butler sees this as an important step to achieve "horizontal equity" so that households with the same income and medical expenses receive the same tax benefit, regardless of where they obtain coverage.

Two forms of tax credits would be available. Low-income families could choose between a fixed flat amount or a refundable sliding-scale credit. The fixed credit, which Butler says would offer simplicity and predictability, would average about $1,000 per adult and $500 per child, up to a maximum of $2,500 per family. Households above a specific income threshold could use the sliding scale subsidy that would increase as health costs (including premiums and out-of-pocket medical expenses) rise as a percentage of income. These credits would replace the current subsidy that employees enjoy because they do not pay income tax on the amount their employer contributes to their insurance premiums. The proposed new tax credit structure is designed to leave most middle-income families with little change in their tax liability.

Expanding Options for Coverage

The workplace would continue to be where most workers receive their health insurance subsidies and make health plan choices, but they would still be eligible for the tax credit, even if their employers did not sponsor plans. Workers who are not in employer-sponsored plans could obtain coverage through other intermediaries, including other employers' plans, instead of trying to negotiate with insurers in the individual market. Butler's plan would remove many of the obstacles that make it difficult for families to obtain coverage through "affinity groups"—churches, unions, associations, or other organizations that may be more appealing than employers. Self-employed people or those who are temporarily out of work, as well as employees of firms not sponsoring insurance, could use the tax benefit to enroll in plans offered by such organizations.

These affinity groups would not be acting as insurers but as "buying agents" that reach agreements with insurance plans that would shoulder risk. The arrangement would be comparable to the way the Federal Employees Health Benefits Program works.

The Role of States

To supplement the federal tax credit for health expenses, Butler proposes that the federal government provide an additional $6 billion a year to states. State supplements funded with these grants would be particularly helpful for low-income workers, including those just leaving welfare. The combination of the federal credit and the additional state subsidies could enable low-income workers to afford a reasonable level of health insurance, he says. With the federal credit and grant, Butler says states would have greater flexibility to design programs that make insurance less expensive, including

expanding eligibility for Medicaid and their State Children's Health Insurance Program (S-CHIP).

Butler acknowledges that ensuring that attractive and affordable health plans would be available to individuals and families is essential to making this proposal work. The federal government would work closely with states to make sure that new and affordable plans are available to families within a stable insurance market, and that plans are affordable for people with high medical costs. Butler seeks to do this through a "federal-state" partnership designed to make new kinds of group plans available at "reasonable" prices. The federal government would negotiate with states to either accept "default" insurance regulation,including limitations on premium underwriting, or implement an alternative insurance arrangement that would meet the federal goal of reasonably priced health insurance. This set of policies is designed to reduce the numbers of uninsured.

Outlook

Butler says his proposal incorporates elements to engender support from people with different political perspectives. For example, the tax credit feature is likely to appeal to those who are attracted to market-based solutions that encourage people to buy in the private insurance market. Yet the plan promises to achieve essentially universal coverage by ensuring that subsidies would be available to virtually everyone, with the size of the subsidy being related to financial need. The approach would preserve Medicaid and S-CHIP and assign important responsibilities to federal and state governments, while maintaining some flexibility for states.

Recognizing that his approach would be a fundamental change from today's system, Butler proposes phasing in the tax credit to make the transition gradual and politically appealing. He notes that a logical and politically feasible first step for tax credits would be to target households without access to employer-sponsored coverage. The last step would be to eliminate the tax exclusion of employer-paid health premiums. ■

Stuart M. Butler, Ph.D., is Vice President, Domestic and Economic Policy Studies, at The Heritage Foundation.

Assessing the Combination of Public Programs and Tax Credits

Judith Feder, Larry Levitt, Ellen O'Brien, and **Diane Rowland** outline an expansion of Medicaid and the State Children's Health Insurance Program (S-CHIP) and explore its interaction with tax credits for individuals or employers. Specifically, they conclude that:

• Coverage for low-income people is best achieved by extending eligibility for public programs without cost sharing or premiums to all individuals with incomes below 150 percent of the federal poverty level, and, as in S-CHIP, extending eligibility for public programs with modest premiums and cost sharing (up to a maximum of 5 percent of income) to people with incomes between 150 percent and 200 percent of poverty. People with incomes above 200 percent of poverty could also be allowed to "buy in" to public coverage by paying a sliding-scale premium based on income.

• A tax credit that is targeted to small, low-wage employers for providing coverage to their employees is a more effective and less disruptive complement to a public program than a tax credit directed at individuals to purchase non-group coverage.

Overview

In designing this approach, professors Judith Feder and Ellen O'Brien, at the Georgetown University Institute for Health Care Research and Policy, and Larry Levitt and Diane Rowland, executives at the Henry J. Kaiser Family Foundation, argue that in the absence of comprehensive reform, it is most appropriate to target expansions to the population least able to afford coverage, and to avoid disrupting either the public insurance system that works quite well for low-income people or the popular employer-sponsored system that provides coverage for many Americans. They choose to focus their attention on ensuring that the low-income population has access to publicly subsidized insurance, and then explore the use of a tax credit to encourage higher-income people to obtain private insurance. They believe that a "layered"approach—with public coverage for the lowest-income population and some form of tax credit for modest income people—will be more effective than other combinations in expanding coverage while minimizing the potential that new subsidies will substitute for existing public or private coverage.

Multiple Policy Instruments

Since the uninsured population is a heterogeneous group, the authors believe that different policy strategies will be more or less effective in reaching different segments of the uninsured population (those with lower versus higher incomes). Therefore, they suggest Medicaid/S-CHIP expansion for those with incomes below 200 percent of the poverty level,and that any tax credit be targeted only to people with incomes above that level.

The authors outline several reasons for relying on an expansion of public programs rather than a tax credit for the low-income population.First,many of the low-income uninsured do not have any income tax liability and would need a subsidy provided in advance to purchase coverage. Any credit,therefore, would need to be refundable, payable in advance, and not reconciled for income changes over the course of the year. This would add considerable complexity to the use of tax credits for lower-income people. Second,since about 70 percent of the uninsured lack access to employer-sponsored insurance, most of the uninsured using the credit would be

forced into the non-group market, which the authors believe is riddled with problems. Finally, the size of the tax credits generally proposed would not come close to covering the actual cost of health insurance, and low-income people are the least likely of the uninsured to be able to make up the difference.

The authors believe that targeting each policy instrument to a different income group within the uninsured population would be more effective than establishing a tax credit alongside existing or new public coverage. They worry that consumers would not be able to make a meaningful choice between a tax credit or a public program because of the difficulty in obtaining information about plans and the complexity of the insurance market. In addition, having tax programs alongside public programs may create incentives for states to pull back or limit public coverage, given that fully federally financed tax credits are available as an alternative.

In choosing to layer a tax credit on top of a public expansion, the authors must determine a "cutoff" point of income eligibility for public coverage, balancing affordability of coverage with displacement of private coverage. To maximize coverage and minimize disruption, the authors believe that 200 percent of the federal poverty line should be the cutoff point for a public coverage expansion. They note, however, that abruptly cutting off generous credits at a defined income level creates inequities for those just above the cutoff point. Extending eligibility to higher income levels and phasing out the credit more gradually mitigates the problem, but the program then becomes more costly. The authors point out that smooth integration between the two policy instruments requires attention to the availability and characteristics of insurance products in the private market. As one way to address this problem, the authors would, with appropriate attention to design, favor allowing people with incomes above 200 percent of the poverty line to "buy in" to the public program.

Features of a Medicaid/S-CHIP Expansion

Because of the limitations of a tax credit for the low-income population, the authors advocate extending comprehensive benefits to the low-income uninsured through a Medicaid and S-CHIP expansion—basing eligibility solely on income rather than on income and family status. Medicaid and S-CHIP have been proven effective, in the authors' view, at serving the low-income population, so they would rely on the existing delivery, outreach, and eligibility-determination systems in the program expansion. Additional administrative structures would be unnecessary. The authors would prefer that eligibility be an entitlement, as with Medicaid, rather than being dependent on annual state appropriation decisions, as with S-CHIP. However, as in S-CHIP, enrollees with incomes between 150 and 200 percent of the federal poverty level would pay some premiums and cost sharing.

Designing the Tax Credit

In describing the tax subsidies available for people with incomes above 200 percent of the poverty level, the authors outline the way in which various design features would affect the cost and effectiveness of a tax credit in expanding coverage. One issue is whether the tax credit should be available to individuals or to employers. The authors suggest that it is difficult to design a modest *individual* tax credit that is simultaneously effective and well-targeted, while at the same time avoiding "crowd-out" of existing publicly sponsored and employer-sponsored insurance. A better approach, they indicate, may be tax credits provided to *employers* to encourage greater offering of insurance. An employer tax credit could be targeted to those small, low-wage employers least likely to offer coverage. Although the success of an employer tax credit depends on employers' willingness to expand coverage, in the authors' view that disadvantage is outweighed by the advantages of better targeting and less disruption of existing insurance arrangements.

Outlook

The authors believe that their approach has an important political and policy advantage: it minimizes disruption to the current system of private and public coverage. Many Americans obtain cover-

age through their employer, and surveys show that they value this approach. In addition, employer-sponsored coverage allows risk to be spread across people with different incomes and health status. Finally, work-based coverage provides an easy enrollment and payment mechanism, which is particularly useful for low-income people who might face cash flow problems if they had to purchase coverage on their own.

With respect to public coverage, the authors argue that low-income people will always need more public support than others if they are to have affordable access to coverage and services. Despite some barriers to participation (most predominantly, the administration of means-tested eligibility requirements), Medicaid has well-established administrative and legal structures that facilitate access to benefits and protect beneficiaries' rights. It is unclear that a new program would be able to provide the same level of support—in benefits, administrative arrangements, or legal foundation. The authors conclude that mixing a public program expansion with tax credits, while paying close attention to design issues, may be an effective way to expand coverage in the current policy climate. ■

Judith Feder, Ph.D., is Professor and Dean of Policy Studies at Georgetown University.

Larry Levitt, M.P.P., is Vice President and Director of the Changing Health Care Marketplace Project and California Health Policy for the Henry J. Kaiser Family Foundation.

Ellen O'Brien, Ph.D., is Assistant Research Professor at Georgetown University's Institute for Health Care Research and Policy.

Diane Rowland, Sc.D., is Executive Vice President of the Henry J. Kaiser Family Foundation and the Executive Director of the Kaiser Commission on Medicaid and the Uninsured.

A Private/Public Partnership for National Health Insurance

Jonathan Gruber has outlined a proposal to substantially reduce the nation's uninsured rate and allow nearly all households to obtain affordable health coverage under a voluntary initiative relying heavily on the private insurance market. The program includes the following elements:

• Voluntary state-based purchasing pools that would offer a menu of health plan choices to all individuals and employers.

• Federal subsidies that would be provided on a sliding-scale basis to individuals with incomes up to 300 percent of the federal poverty level buying insurance in the pool; most families with higher incomes could obtain coverage for 10 percent or less of their income.

• Partial financing would be achieved by limiting the tax exclusion for employer-provided health insurance to the cost of a median-cost health plan and by phasing out the Medicaid program—and accompanying federal subsidies—for those families who qualify on the basis of income alone (while the program remains in place for the elderly and disabled).

• Health plans and insurers would be paid on both a prospective and retrospective, risk-adjusted basis that would spread health risk across entire purchasing pools so that higher-risk individuals could obtain affordable coverage.

Overview

Health policy researcher Jonathan Gruber, a faculty member at the Massachusetts Institute of Technology, addresses what he sees as two failings of the current health system within the context of today's political environment. Gruber believes that the employer-sponsored insurance approach, which provides coverage to more than 90 percent of the privately insured and two-thirds of the nation's non-elderly population, is seriously flawed because it leaves people who are unemployed, are self-employed, or work in small businesses without an efficient pooling mechanism in which to buy affordable coverage. And while publicly subsidized programs extend coverage to the elderly, poor children, and certain other vulnerable populations, major holes remain in the public safety net, leaving millions of Americans beyond reach of coverage.

To address these issues, Gruber proposes to build on the voluntary, private system in place today while "rationalizing" public safety net programs to ensure broader coverage to needy populations. He proposes a significant redistribution of federal health outlays, seeks to level the playing field on which individuals purchase insurance, and tries to harness the powers of competition to address rising health care premiums for nearly all Americans.

Using state-based purchasing pools as the plan's foundation, Gruber tries to address certain problems that he believes exist in the current employer-provided insurance system. These problems include high uninsured rates among Americans working for small businesses, "job lock," which leaves workers stuck in unsatisfying jobs for fear of losing coverage, and the inhospitable environment for higher-risk individuals and others in the non-group market, who pay significantly more for coverage than do employees in group plans. Gruber's reforms would not provide universal coverage, but he predicts that almost all

U.S. families would be able to obtain coverage for 10 percent of their income or less. He also acknowledges that his plan would require significant federal expenditures to help provide subsidies to the low-income insured. But he uses a voluntary and private system to extend insurance to millions of uninsured, rather than advocating a major public expansion.

Eligibility and Subsidy Structure

A set of 51 voluntary purchasing pools would be established, with one in each state and the District of Columbia. All individuals or employers could purchase insurance from any plan in their local pool. Most, if not all, insurers would be expected to participate, because subsidies would be available only if coverage were purchased through the pool. Gruber's approach differs from many others' in the form of the subsidy. People would not receive vouchers or tax credits. Rather, once they were determined to be eligible based on their income, they would be eligible for reduced-premium or no-premium coverage.

Health plan purchases would be subsidized for both low-income and lower-income households. Those eligible for subsidies could apply them toward coverage that they purchase individually or through their employers. All persons with incomes below 150 percent of the federal poverty level would be automatically enrolled in a median-cost plan in the pool at no cost to them. In addition, their liability for cost sharing—deductibles and copayments—would be limited to 5 percent of income. A second subsidy group would include those in families between 150 percent and 300 percent of the federal poverty level (which for a family of four includes those making between $25,000 and $50,000 annually). The subsidy for this income group varies with income—from 0 percent of income for those with incomes at 150 percent of poverty to 10 percent for those at 300 percent of poverty (assuming they chose a median-cost plan).

People in both subsidy groups could enroll in plans costing more than the median plan, but they would be responsible for the cost difference between the median-cost plan and the higher-cost plan. Families in the 150 percent to 300 percent subsidy group that chose a plan costing less than the median-cost plan would get half the difference back in a check from the government as an incentive to choose lower-cost plans. However, to prevent fraud associated with the sale of plans that do not provide adequate coverage,individuals in the lowest-income subsidy bracket would not see any savings if they opted for plans costing less than the median plan. Persons with incomes above 300 percent of the federal poverty level would not receive a subsidy, but their insurance costs could decrease because they could purchase through the pool.

Employers would be allowed to purchase insurance through the pool and could offer workers plan options both in and outside the pool. But to minimize the adverse selection that often results when employers have an incentive to encourage just their high-risk employees to use the pool, the proposal includes strong incentives for employers to select the pool as their sole source of coverage. The most important incentive is that low-income workers would not be eligible for subsidies unless the employer chose the pool as their exclusive source of coverage. As a further incentive for employers to choose the pool exclusively, the plan would waive both the requirement that employers offer continuation coverage through COBRA and cover other state mandates.

Financing

The plan would be financed from three sources. Some federal general fund revenues would be required, but the new program would generate some savings to offset the increased costs. Savings would be realized by putting a cap—equal to the cost of the median-cost plan—on the amount of employer-paid premiums that could be excluded from employees' taxable income. Savings also would be generated by phasing out S-CHIP and the acute care component of Medicaid. Under this approach, after a transition period, Medicaid would become a program only for elderly and disabled people, and the remainder of the Medicaid and S-CHIP populations would be moved into the new subsidy program.

Administration, Regulation, and Risk Adjustment

The federal government would administer the program out of a new "Private/Public Partnership Health Insurance Agency." This new agency would be responsible for establishing and overseeing new purchasing pools and coordinating subsidy payments. The agency would ensure that only "true" insurance products are offered, while encouraging individuals to choose efficient, low-cost plans. A minimal set of regulations would require only that each plan be financially sound and that each offer guaranteed-issue coverage and renewability, a minimal benefits package, and free or nominal co-pays for one well-child visit annually, prenatal care, and immunizations. Before an annual open-enrollment period, individuals would get information on costs, benefits, and quality-related data on plans for selection purposes. Each plan would be required to charge community-rated premiums. The effects of adverse selection would be minimized through risk-adjusted payments to plans using a mix of factors, including demographic and health-condition factors and retrospective risk adjustment based on actual costs of certain cases.

Outlook

Gruber acknowledges that his proposal represents "a fairly radical departure" from the current private and public systems of providing health insurance. He notes that his plan would upset many stakeholders—including businesses, unions, conservatives, certain insurers, and Medicaid program advocates. These players would likely balk at an approach that would reduce the tax subsidy to employer-provided health insurance,increase government spending and bureaucracy, create competition among insurers,and reduce the Medicaid entitlement.

Gruber says, however, that his approach would achieve a meaningful reduction in the number of uninsured under a market-oriented strategy that relies on competition as the best way to control medical costs. In addition, Gruber believes that advocates for the poor would recognize the important income redistribution inherent in the approach. He also thinks that employers would like the fact that the proposal drops certain mandates, and group insurers should favor an approach that expands their products.

Finally, Gruber views his approach as more politically palatable than many other alternatives. It would rely on a private solution to address a major national problem and would be cheaper than tax credit-based proposals. And while the plan would not lead to universal health insurance coverage, it would guarantee universally affordable coverage. ■

Jonathan Gruber, Ph.D., is Professor of Economics at the Massachusetts Institute of Technology and the Director of the Program on Children at the National Bureau of Economic Research, where he is a Research Associate.

Medicare Plus: Increasing Health Coverage by Expanding Medicare

Jacob S. Hacker has proposed a plan to achieve universal coverage by building on the Medicare program. The proposal includes the following elements:

• Employers could choose either to offer and automatically enroll employees in a plan at least as generous as that available under an enhanced Medicare benefits package or to pay a modest payroll-based contribution to help fund enrollment of their employees in Medicare Plus.

• Workers whose employers paid the contribution instead of providing their own plan would be enrolled automatically in Medicare Plus at their workplace, although they could use their employers' contributions (minus a penalty) to purchase other coverage that met the same standards as the workplace plans.

• States would have strong financial incentives to use outreach efforts to enroll non-workers in Medicare Plus, which would effectively replace Medicaid and the State Children's Health Insurance Program (S-CHIP).

• Individuals outside the workforce who are not enrolled by their state would have an individual buy-in option available, with the premium based on income.

Overview

The current policy debate around health care coverage expansion centers largely on either expanding public programs, such as Medicaid and S-CHIP, or using the tax system to encourage more individuals to purchase health coverage in the private market. Jacob S. Hacker, a Junior Fellow of the Harvard University Society of Fellows, outlines a proposal that differs from these policy options. He would replace the current scattered patchwork of voluntary private coverage and residual public programs with an employer mandate and enrollment of much of the population in an expanded Medicare program called "Medicare Plus."

This is a variation of a "play or pay" employer mandate model with the following twist: for many employers, the pay option would be far less costly than the play option, so most firms would pay the payroll tax and automatically enroll their employees in Medicare Plus. Hacker believes that, as a result, Medicare Plus could eventually cover as much as 70 percent of the population—a result that he argues is desirable.

Medicare Plus

Medicare Plus is designed to provide a mechanism by which all Americans would have access to affordable,guaranteed coverage with a defined package of benefits. In addition to the standard Medicare benefits package, Medicare Plus would cover outpatient prescription drugs, preventive services, mental health services, and maternal and child health services. Additionally, Medicare Plus would have a single deductible and coinsurance rate and an out-of-pocket spending cap.

Although Medicaid and S-CHIP would be phased out and former program participants enrolled in Medicare Plus,low-income families and children and the working disabled would continue to receive "wraparound" coverage for additional services now

provided by state Medicaid programs. In addition,the non-working disabled and the elderly would continue to receive their current Medicaid benefits package.

Role of Employers

Under this plan, employers would be responsible for ensuring that employees and their dependents are enrolled in health insurance. Employers would be required either (1) to provide and contribute to the cost of private coverage at least equivalent to Medicare Plus and automatically enroll their employees and dependents in the plan, or (2) to pay a modest payroll tax (a minimum of 2 percent for low-wage employers and a maximum of 5 percent) and enroll their employees in Medicare Plus. Because the payroll tax is less than the amount that most employers would pay for other coverage—especially small employers, low-wage firms, and those with higher-risk employees—the Medicare option would be less costly and, thus, attractive to many employers.

Employer-sponsored insurance would retain its favored tax status, with two exceptions. The tax exclusion for employer-paid premiums would be capped at twice the value of a Medicare Plus plan, and no tax-exclusion would be permitted if employers offered only benefits that "wrapped around" Medicare Plus (to prevent employers from economizing by dropping standard coverage and offering only add-on coverage).

Role of Employees

Working Americans would be enrolled through their employer (as described above),and non-working individuals could buy into Medicare Plus on their own.

All enrollees would pay a premium toward their Medicare Plus coverage, based on family size and income. The level of premium would be set to keep the nominal division of employer and employee responsibilities similar to what it is today in firms that do sponsor coverage. To protect poor and near-poor individuals, enrollees would not contribute anything to premiums if their incomes were less than 200 percent of the federal poverty level, would pay a sliding-scale premium if their incomes were between 200 and 300 percent of the poverty level, and would pay the full premium if their incomes were above 300 percent of the poverty level. Cost-sharing (deductibles and copayments) would also be strictly limited for poor enrollees and gradually increased between 100 and 150 percent of the poverty level.

Hacker also suggests that after an initial period with the new system, an individual mandate should be put in place to ensure universal coverage.

Role of States and Federal Government

Many working Americans currently eligible for public programs would be automatically enrolled in Medicare Plus through their workplace. The state would be responsible for enrolling the remaining uninsured. In addition, states would maintain their financial role in coverage through maintenance-of-effort payments to Medicare Plus equal to their existing and projected spending on Medicare and S-CHIP benefits for children, non-elderly adults, and the working disabled. States would, however, be given federal financial incentives (in the form of reduced state maintenance-of-effort payments), to enroll the uninsured. In addition, states would be encouraged to subsidize Medicare Plus premiums for the unemployed.

The federal government, through the Health Care Financing Administration, would be responsible for administering Medicare Plus. The author estimates that 50 percent to 70 percent of the population could eventually enroll in Medicare Plus, which would give the program bargaining leverage and ensure broad pooling of risk. Hacker believes that this approach would move the country toward inclusive social insurance in health care. But because the role of the private insurance sector would be retained, and because employers and individuals would be free to purchase qualified coverage on their own,the proposal should not be construed as a "single-payer"plan. The federal government would be largely responsible for financing the program, with the principal financing sources being payroll-based

contributions, beneficiary premiums,state maintenance-of-effort payments, and general income tax revenues.

Outlook

Hacker concedes that this proposal cuts against the grain of the current political debate because it presents an integrated approach to universal coverage rather than a series of incremental steps. Moreover, it shifts primary responsibility for public coverage to the federal government, and dramatically expands an established federal program. But the immediate political and economic climate that seems to support only incremental reform may shift. As times change, Hacker believes that current policy options may be less appealing, and a plan like his may be viewed in a more favorable light, for three reasons.First,his plan builds on Medicare and works through the employer-based system of insurance, both of which are popular and familiar institutions. Second, there would be few new costs for employers that currently do not provide coverage, and costs would be reduced for most employers that currently do offer coverage. Third, private health insurers would retain their role, and those insurers choosing not to contract with Medicare Plus would not face extensive regulation. To show how the proposal could become reality, Hacker outlines a long-term, step-by-step policy agenda that could create self-reinforcing political pressures encouraging full implementation. ■

Jacob S. Hacker, Ph.D., is a Junior Fellow of the Harvard University Society of Fellows.

Expanding Health Insurance Coverage: A New Federal/State Approach

John F. Holahan, Len M. Nichols, and **Linda J. Blumberg** have outlined a new proposal to cover the uninsured that would extend the subsidized coverage that is available under the State Children's Health Insurance Program (S-CHIP) to all lower-income people. The proposal is built on the following key elements:

• The federal government would provide financial incentives to states to expand health coverage subsidies to all families and individuals with incomes below 250 percent of the federal poverty level and those facing higher-than-average health expenses, regardless of income. Subsidized coverage could be purchased only through purchasing pools, which states would have broad discretion to design.

• Federal funding would be in the form of a match amounting to 30 percent more than the current Medicaid match, provided to states in exchange for meeting minimum federal standards. States choosing to participate would have to provide coverage to those meeting the eligibility rules, but could specify a minimum benefits package consistent with federal guidelines, as in the S-CHIP program. Non-participating states would continue their Medicaid and S-CHIP programs.

• The new program would effectively replace Medicaid and S-CHIP. People below 150 percent of poverty would get full subsidies, while those between 150 and 250 percent of poverty would get partial subsidies, and the high-risk (regardless of income) would be subsidized as well. A set of uniform federal rules would apply nationally.

• All individuals, including those with high health costs, could buy insurance through a state-designed purchasing pool at a premium no higher than a statewide community rate for a standard benefit package. Employers must offer employees the state pool coverage as an option, but they could choose whether to buy coverage exclusively through the pool.

• The state purchasing pool would combine existing Medicaid, S-CHIP, state employees' purchasing programs, and willing participants from the private sector to create administrative efficiencies, pool insurance risks, and improve bargaining clout for those within the pool.

Overview

Health policy researchers John F. Holahan, Len M. Nichols, and Linda J. Blumberg, at the Urban Institute, propose a new insurance coverage model that,like S-CHIP, would give states increased federal funding and considerable flexibility to extend coverage to families with incomes below 250 percent of poverty and those with high health risks at any income level. The foundation of this new model is a purchasing pool organized by combining current Medicaid and S-CHIP recipients, those newly eligible for subsidies, and others. To receive subsidies, people would have to purchase coverage through the state purchasing pool, but the pool would be open to all. Participants would be assured of paying no more than the statewide community rate. Any health plan operating through the pool would be required to accept all enrollees. The federal government would establish a minimum set of required benefits and cost-sharing provisions, but states would have flexibility to design their own standard benefit packages. The new higher federal match (30 percent higher than the current Medicaid match)

would go to participating states to help fund coverage for everyone below 250 percent of poverty, including previous Medicaid enrollees.

The authors argue that a purely federal expansion of coverage is politically impossible. They eschew that approach in favor of what they see as a more acceptable federal-state partnership. The researchers acknowledge that the program would be expensive in terms of government dollars, but they say that would be the case with any program that extends coverage broadly. The federal government would assume the bulk of the burden for the new spending.

Coverage and Subsidies

The authors have devised a structure that creates strong incentives for states to participate but does not force them to do so. Participating states would receive an infusion of federal funds to pay for the bulk of the subsidies—at a rate equivalent to the current higher S-CHIP federal match. In return for these funds, states would have to meet minimum standards. They would have to offer a standard benefits package and conform to federal rules that simplify current complex and differing program rules. They would implement nationally uniform eligibility standards that are based on income alone. The authors argue that this provision would greatly increase fairness: the subsidy to which needy people are entitled would not depend on the state where they live or whether they fall into some category that makes them eligible for S-CHIP rather than Medicaid or vice versa. States would provide fully subsidized coverage to those below 150 percent of poverty. People between 150 percent and 250 percent of poverty also would be subsidized, but would pay more in premiums, co-payments, and deductibles up to a specified federal limit.

The authors believe that the features of their approach would ensure that affordable coverage would be available to everyone. Health plans participating in the pool would be required to accept all who apply for coverage and provide coverage at a premium reflecting the statewide community rate. People with incomes below 150 percent of poverty could enroll at any time. Others could buy coverage during the open-enrollment period or at other times by paying a penalty. States opting for the new model would automatically enroll individuals currently insured by Medicaid and S-CHIP and could enroll state employees.

The authors expect many of the uninsured to enroll. The generous subsidies would provide a strong incentive for low-income people to join the pool. And because of the guarantee of being able to buy coverage at the community-rated premium, higher-risk people not eligible for income-related subsidies also could be expected to use the pool. These higher-risk participants include both those who are now uninsured because they cannot afford to pay the high-risk rates and those who are now covered but could save by buying through the pool. Individuals currently covered under costly private individual coverage also would be expected to join the new state pool. The authors would not require employers to offer coverage, but if they did, they could rely on the pool as the sole source for coverage or make other arrangements. In the latter case, they would still have to give employees the option of choosing pool-based coverage, because subsidies would be available only inside the pool. Although subsidized coverage would not be limited to people who have been without insurance, the authors contend that features of the system make it unlikely that a large number of employers would drop coverage.

The authors acknowledge that the financial incentives would not persuade everyone to buy coverage. So, after five years, they would permit states to mandate that everyone obtain health insurance coverage.

Federal/State Relations

Accepting federal dollars would obligate states to carry out a number of responsibilities: meeting federal standards for eligibility determination, outreach, and enrollment; incorporating Medicaid and S-CHIP and other groups of individuals into purchasing pools;establishing procedures for informing enrollees about plan choices; establishing quality

standards and provider payments; and developing a plan for adjusting premiums based on risk. Furthermore, states would have to develop a standard benefits package; set equitable subsidy schedules; organize purchasing pools and negotiate with health plans or establish competitive bidding mechanisms; operate or contract for a discounted fee-for-service (FFS) program to ensure beneficiary choice; and operate a residual Medicaid program to cover all groups and benefits required under Medicaid but not incorporated into the new program.

Financing

The authors acknowledge that a public program to cover many currently uninsured people would be expensive. States and the federal government would jointly finance the new program, but the bulk of the new money would come from federal coffers. The authors note that states would save money for several reasons: the new higher federal match would apply to former Medicaid eligibles, as well as to remaining Medicaid expenditures on long-term care not incorporated into the new program, and states would be paying out less for safety-net providers. On the other hand, they would be covering many more people. The new federal spending would come out of general revenues.

Outlook

This proposal relies on a state-federal partnership. The authors acknowledge that such an approach has its weaknesses, but they believe that a federally focused approach is "politically unrealistic" at this point. When the momentum of the nation is toward greater reliance on state government in partnership with the federal government, building on the S-CHIP model is the right approach, the authors contend. Unlike Medicaid, S-CHIP has combined higher federal matching payments with more state flexibility, which makes the approach attractive to states, politicians, and citizens who prefer to see program administration at the state level. Finally, the authors believe that their proposal is less likely than some alternatives to generate opposition because it would not require employers and consumers who are happy with their current coverage arrangements to change the way they obtain coverage. ■

John F. Holahan, Ph.D., is Director of the Health Policy Research Center at the Urban Institute.

Len M. Nichols, Ph.D., is Principal Research Associate at the Urban Institute.

Linda J. Blumberg, Ph.D., is Senior Research Associate at the Urban Institute.

A State-Based Proposal for Achieving Universal Coverage

Richard Kronick and **Thomas Rice** propose that the United States adopt a health care financing system that would:

• Give all legal U.S. residents a "right" to comprehensive health insurance coverage. Health insurance would be a social insurance program, not a means-tested program.

• Make states responsible for designing and administering the health care financing system, allowing them the flexibility to create systems that meet the needs of their residents. To receive federal funding, states would need to assure that nearly all legal residents would be covered and have access to at least one zero-premium plan that includes a federally defined standardized benefits package.

• Replace the current health care financing system, which largely relies on employment-based health insurance, with one relying on a payroll tax levied on employers and employees. This tax would be supplemented by federal general revenues, state revenues, and, possibly, individual contributions for plans or benefits beyond those in the standardized benefits package.

• Retain Medicare and Medicaid-financed long-term care.

• Monitor state implementation and make a substantial investment in measuring quality and outcomes, particularly for vulnerable groups.

Overview

University of California faculty members Richard Kronick and Thomas Rice propose that the United States adopt a health care financing system that would provide comprehensive health insurance to all non-elderly, legal residents and replace most major components of the current system, except for Medicare and Medicaid-financed long-term care. While employers and employees would continue to contribute to the health system, employers no longer would be involved with providing insurance. Instead, the federal government would oversee the new system, and states would administer it. All health insurance choices offered by the states would have to include services specified in a federally defined benefits package that states may choose to augment. Eligible residents would have at least one health insurance option that does not require premiums. The primary revenue source, a payroll tax levied on employers and employees, would be supplemented by general federal revenues, state revenues,and, possibly, individual contributions for certain plans or benefits beyond those included in the standard benefits package. States would receive an annual fixed-dollar contribution from the federal government to encourage them to contain costs.

Central Role for States

This new system would be predominantly financed and overseen by the federal government, but it would be administered by the states. To participate, states would be required to implement universal coverage (defined as at least 98 percent of non-elderly, legal residents enrolled), offer at least one health plan without premiums, monitor and ensure service quality, and collect and compile data to evaluate the system. If it chose not to participate,a state

would forfeit the federal money that otherwise would have been available but could continue to receive federal matching funds for Medicaid and S-CHIP. The authors assume that states would be eager to participate in order to access the new federal funds, and they believe that given the mandatory payroll tax on employers and employees described below, there likely would be tremendous political pressure on states to join the new system.

Under this proposal, Congress would establish a national, standard benefits package, to which all states and their health plans would have to conform. The package would roughly mirror benefits packages currently provided by most large employers. Dental care and long-term care would be provided only at state option. The federal government would oversee the quality of care delivered in each state, as well as whether medical necessity is being defined too narrowly by health plans. There would be low or no copayments for basic services such as inpatient, outpatient, and preventive care.

The federal government would pay participating state governments an amount equal to the estimated cost of providing the standard benefits package to all legal residents, minus the state government financial responsibility amount (90 percent of their current Medicaid and S-CHIP spending on those services that would be included in the standard benefits package). Most of the federal money raised would come from a payroll tax on employers and employees that would equal approximately 95 percent of that currently spent by employers and employees for today's employer-sponsored benefits packages. The tax would be uniform throughout the country and divided between employers and employees based on their current distribution of spending. However, the authors suggest a lower tax rate for employers with predominantly low-wage workers. The difference between the amount of money the federal government would be obligated to pay to the states and the amount raised by the payroll tax would be financed by general revenues, much of which would be a transfer from federal Medicaid funds currently used to support Medicaid and S-CHIP. Any needed additional funds could be drawn from anticipated budget surpluses.

The authors propose that a quasi-independent, bipartisan federal quality commission be established to monitor and measure health care quality and provide financial incentives to states to improve quality. A portion of the federal payments to states would be deducted and provided to the quality commission to distribute a "quality bonus" to states that improve their performance.

The Medicaid program for long-term care services would remain intact, including reimbursement for institutional, home, and community-based long-term care, with the current federal formula for matching payments. In addition,the federal government would administer directly Medicaid's payments to low-income Medicare recipients for prescription drugs, copayments, deductibles, and Part B premiums, rather than relying on the states to fill in the gaps of a federal program. Ninety percent of the financial burden lifted from the states by this federal assumption of responsibility would be added to states' financial responsibilities.

Outlook

Kronick and Rice indicate that two main features of the proposal are likely to create opposition: transforming current voluntary employer and employee payments into a mandatory payroll tax, and state government administration. Some employers with relatively young and highly paid employees might end up paying more in payroll taxes than they now pay for health insurance, as would employers who currently offer no health benefits. Some providers, insurers, and citizens would be nervous about giving state governments greater control over health care financing and delivery.

Nonetheless, the authors believe that a payroll tax would be superior to other options for financing universal coverage (such as a value-added tax or an increase in income taxes), since it would be more palatable politically and similar to the way in which the United States currently finances health care. They also assert that public sector-driven coverage would be better than the current arrangement, for two reasons: Employer-based financing combined

with means-tested public coverage for the poor inevitably leaves large gaps in coverage,and employers have not consistently succeeded in banding together to add greater value in purchasing health coverage. In addition, the authors believe that state, rather than federal, administration is necessary for the system to be flexible in responding to the needs of each state's residents and providers.

In the end, the authors claim that interests on both sides of the political spectrum will find things they like in the proposal. Many on the left should find mandated universal coverage (within participating states) with no required premiums attractive, and many on the right should like the opportunity states would be given to design systems that meet their needs. The authors believe that with growing numbers of uninsured Americans, rising health care costs, and increased patient dissatisfaction with providers and HMOs, the country may be ready to experiment with approaches that are "more revolutionary than evolutionary." ■

Richard Kronick, Ph.D., is Associate Professor in the Department of Family and Preventive Medicine at the University of California at San Diego.

Thomas Rice, Ph.D., is Professor in the Department of Health Services at the School of Public Health, University of California at Los Angeles.

An Adaptive Credit Plan for Covering the Uninsured

Mark V. Pauly has outlined a new proposal to reduce the number of uninsured that would:

- Implement a relatively straightforward intervention that could be easily modified in response to lessons learned from this new approach.
- Provide lower-middle-income households with flexible, refundable tax credits or "coupons," redeemable for insurance premiums or a reduction in taxes, for any licensed medical-surgical insurance policy with a premium at least as large as the credit.
- Make very low-income households eligible for publicly provided or contracted insurance, or for equivalent-cost private insurance, with no premium share required.
- Allow households with incomes above the median to retain the tax exclusion for group coverage, until mandated to participate in the new program at some point in the future.
- Guarantee that all health insurance policies are renewable.

Overview

Economist Mark V. Pauly, a professor at the Wharton School, proposes a tax-credit/coupon approach to expanding health coverage that, he says, emphasizes the advantage of beginning reform with a relatively straightforward,financially feasible, and easily modifiable intervention. He stresses that there is much uncertainty about the response of insurers and consumers to major changes, and thus it is desirable to adopt an approach that could be easily changed as experience shows what works and what does not. Thus, he proposes a two-phase plan that would initially provide refundable tax credits to lower middle-income families and individuals, who make up 40 percent of the uninsured. If private markets work well in the first phase, then credit options would be extended to the poor, and participation would be made mandatory for those uninsured with incomes above 300 percent of the federal poverty level.

A Two-Phase Plan

The first phase of Pauly's flexible tax credit plan divides the under-65 population into three groups, each treated differently. Lower-middle-income households (those with incomes between 125 percent and 300 percent of poverty, regardless of age, sex, or relationship of family members) would be eligible for a voucher or tax credit to purchase health insurance. Pauly recommends a flat amount of $1,500 for individuals and $3,500 for families. He estimates that such a credit would be large enough to cover about one-half to two-thirds of the premium for moderately comprehensive coverage. He believes that using coupons as a vehicle for the credits would improve take-up, solve cash flow problems, and permit easy administration. Minimal restrictions would be placed on the type or comprehensiveness of insurance that could be purchased, or on the pricing of the insurance. A publicly provided or contracted fallback insurance plan would offer policies on the same terms as and with the same subsidy available for privately purchased plans. Participants would be permitted to use the voucher to buy a wide range of different insurance polices of their choice, including a low-cost policy whose premium approximately equals the subsidy.

Very low-income households (those with incomes below 125 percent of poverty) would be eli-

gible for publicly provided or contracted comprehensive insurance, with no premium share required. Households with incomes above 300 percent of poverty (with a few exceptions for people with high health risks and, possibly, those with incomes near the threshold) would not be eligible for the new program initially but would retain the tax exclusion for group coverage.

Under the program,all insurance policies would carry a provision for guaranteed renewability. Plans whose premiums approximately equal the tax credit would use adjusted community rating, while coverage beyond that level could be risk-rated. The public alternative plans would be regulated, rated,and subsidized on the same basis as private insurance, so that the public and private plans are competing.

The second phase of this plan would proceed directly from the results of Phase I. If private markets work well and coverage rates increase, very-low-income households would be permitted to use tax credit coupons to purchase private insurance equal in value to the cost of public coverage. In addition, households with incomes above 300 percent of poverty would be required to buy coverage. Additional regulations for low-cost coverage plans could be added at this point if needed, but only if they did not discourage take-up.

Financing

Pauly contends that the new credits or vouchers can be logically viewed as reductions in taxes. As credits are used, federal tax revenues decline, so the financing comes from general revenues. Participants who purchase more expensive coverage would use their own resources to pay the additional premium amount. Full coverage for the very poor would be financed by a combination of state and federal revenues.

How Would Markets Respond?

The key to the plan's success is how the new credits would affect the private insurance market. Pauly is optimistic that insurers would develop products that would make good use of the tax credits. But he acknowledges that this is an open question that can be answered only by actual experience.

By offering tax subsidies for families and individuals to purchase their own coverage, Pauly's plan would enable people to more easily afford either employer-based or individual coverage. Furthermore, it would promote more equity between uninsured workers and lower-wage workers who sacrifice wages to afford employer-sponsored coverage. Some 10 million people under age 65 buy coverage in the costly individual market, and an additional 18 million people would be eligible for insurance credits under the first phase of his plan. Pauly believes that if the credits were sufficiently generous,many of these people would be eager to obtain comprehensive insurance.

Pauly notes that the influx of new consumers could help individual markets function better by substantially lowering administrative costs and reducing problems with risk variation.Generally, the lower-middle-income uninsured are reasonably good risks. If enough new buyers who are good risks entered the market, the proportion of high risks in the pool would diminish. Insurers would expend less effort to identify proportionately fewer high risks, which would lead to lower underwriting costs. With guaranteed renewability, people who maintained their insurance would be protected against high premiums even if they eventually became high risks.

Problems may emerge, but Pauly believes that they could be addressed. High-risk pools or community rating rules, or a combination of the two, could be used to deal with risk segmentation, if that remains an issue in some markets.

Outlook

Pauly seeks to rely as much as possible on private markets because of their ability to satisfy consumers with varying desires—how much insurance they want, what they expect from their insurer, and how they value different aspects of plan performance.

Pauly's hope is that a combination of tax credits and market forces with relatively little new regulation would substantially reduce the number of uninsured. His two-phase plan is intended to be

easy to administer, financially feasible, and permissive rather than restrictive. In addition, he claims that it would be easily modifiable if the proposals' goals were not met.

The proposal would leave intact the current system of employer-sponsored group health coverage while neutralizing incentives so that some workers might move out of poorly managed or expensive small-group markets and into the individual market. Pauly contends that this shifting could help improve individual markets without hurting efficient group markets.

Pauly frankly admits that the outcomes of his plan would depend on variables that are difficult to predict. But he believes that if the plan works well, large numbers of people who are currently uninsured would benefit, and if the plan fails, policy makers would gain a better understanding of which kinds of markets private insurers could be expected to serve and the role private insurers could play in helping to cover the uninsured. ■

Mark V. Pauly, Ph.D., is Bendheim Professor and Chair of the Department of Health Care Systems, Professor of Health Care Systems, Insurance and Risk Management and Public Policy and Management at the Wharton School, and Professor of Economics in the School of Arts and Sciences at the University of Pennsylvania.

Near-Universal Coverage Through Health-Plan Competition: An Insurance Exchange Approach

Sara J. Singer, Alan M. Garber, and **Alain C. Enthoven** have designed a comprehensive, new approach for expanding access to health insurance. The proposal is built on the following key elements:

• The plan would provide near-universal coverage by making private plans more affordable and helping low- and middle-income people buy coverage. This would be accomplished through tax credits and by creating "insurance exchanges" that would provide health insurance choices and promote competition among health plans.

• Insurance exchanges would be operated by public or private entities or employers (for their own employees). Exchanges would offer individuals a choice of at least two health plans in every geographic region at community-rated premiums. The "U.S. Insurance Exchange" would be established to serve individuals and companies with fewer than 50 employees in areas where private exchanges do not emerge. Coverage purchased through exchanges would be exempt from state small-group reform laws and insurance mandates.

• Low- and middle-income Americans who purchase insurance through an exchange would receive refundable tax credits valued at 70 percent of the median-cost plan. The credits would apply only for coverage purchased through the exchanges. Eligible low-income individuals who did not enroll in a health plan would be automatically enrolled in a federally funded default plan organized by the state. Other individuals would continue to exclude from taxable income their individual or employer-paid health insurance contributions, but a phased-in cap would limit this exclusion.

• A new "Insurance Exchange Commission" would be created. It would be similar to the Securities and Exchange Commission—having authority to distribute tax credits and default payments, accredit insurance exchanges, risk-adjust premiums across insurance exchanges, and serve as an information clearinghouse for consumers.

Overview

Stanford University researchers Sara J. Singer, Alan M. Garber, and Alain C. Enthoven, in consultation with Mark B. McClellan, have developed a plan for near-universal coverage that they believe would make private health care plans more affordable for low- and middle-income people while promoting competition to increase the value of insurance offerings. The authors say that their plan preserves the best features of the existing health insurance system while closing gaps in coverage and providing more choices for consumers. Tax credits and the creation of new mechanisms for purchasing private health insurance are the key features. Viable reform, the authors contend, must include incentives for health plans to control medical costs and to offer "high-value" coverage to all who seek it, regardless of income or medical history. The authors believe that an approach that combines new "insurance exchanges" with targeted subsidies will achieve this end while giving consumers a wide choice of plans at a reasonable cost.

Insurance Exchanges

One of the two key components of this proposal is the creation of insurance exchanges designed to

help individuals buy reasonably priced coverage. Exchanges, at least one of which would serve every geographic region, could be private or public entities, for-profit or nonprofit organizations, electronic insurance purchasing programs, or employers (certified as exchanges for their own employees). Employers or individuals would have the guaranteed right to purchase coverage from any plan in the exchange at a uniform "community rate." Offering choice among multiple plans, with incentives for individuals to select high-value plans, these exchanges would have a role comparable to that of the Federal Employees Health Benefits Program or CalPERS (which serves public employees in California). Ideally, nearly everyone would be covered through the exchanges.

The authors recognize that the new insurance exchanges could not succeed unless they captured a large share of the health insurance market. Without a large share, they would be unable to attract health plans or negotiate effectively. The major drawing point for exchanges is that the new tax credit subsidies could be used only for coverage purchased through a qualified exchange. In addition, exchanges would be exempt from state benefit mandates, which would make them a competitive option for employers who now self-insure, as well as allow them to form and operate across state lines. A risk-adjustment mechanism would be established among exchanges to financially protect exchanges that might attract a disproportionate share of high-risk enrollees.

A new federal Insurance Exchange Commission (IEC), analogous to the Securities and Exchange Commission, would be established to distribute new tax credits and default plan payments and to oversee the new insurance exchanges. The IEC would have the authority to deny or withdraw certification for exchanges that failed to meet standards. Requirements would include accepting all individuals and groups in their service area at a flat premium rate, offering "meaningful choices" of plans, standardizing some basic features of benefit packages, performing minimal risk adjustment, creating incentives for plans to enroll and care for high-cost patients, and helping consumers to compare the value of health plan offerings.

Tax Credits

The second key component of this proposal is a subsidy in the form of tax credits for low- and middle-income households. The authors propose a new refundable tax credit set at 70 percent of the cost of the median-price plan premium sold in the geographic area the previous year. The credit would be available only to those who buy coverage through the insurance exchanges. Those now eligible for Medicaid or the State Children's Health Insurance Program (S-CHIP) could choose the tax credit subsidy, but many would stay with the current subsidized programs because the subsidies are substantially greater (100 percent of Medicaid benefits rather than 70 percent of the median plan). The tax credits would be available not just to low-income households but to a large portion of the population; the credit would be phased out starting at an annual income of $31,000 for an individual and $51,000 for a couple or family, and would be fully phased out at $41,000 for an individual and $61,000 for a couple or family. A federal payment system would prepay premiums to the insurance exchange so that individuals would pay only the portion above the tax credit. A credit available only at tax time would not help people who cannot afford to pay premiums during the year.

The new system of tax credit subsidies would be implemented in conjunction with a change in the current tax treatment of employer-paid health insurance premiums. Presently, the amount that employers contribute for the workers' health insurance does not count as taxable income to employees. The authors argue that this way of subsidizing health coverage is neither equitable nor efficient: the tax savings benefit high-income people more than low-income people, and the system makes employees insensitive to the cost of coverage. The authors would not eliminate the tax exclusion, but they would cap it at the price of the median plan. This cap would be phased in over 10 years and would be geographically adjusted. The plan also makes the tax exclusion available to people who do not get it now, such as individuals whose employers do not offer insurance.

State Responsibilities

States would develop "default plans" to serve as a backup for the exchange-based system. Any person eligible for the tax credits, Medicaid, or S-CHIP who declined or neglected to purchase insurance through an exchange would automatically be enrolled in a default plan designated by the state. The providers of services for default plans would generally be "safety net" institutions, such as county hospitals and clinics. The federal government would subsidize states to help them pay for services provided by default plans. The subsidy would be 50 percent of the value of the tax credit. In addition, states would be financially rewarded for moving people from the default plans to the tax-credit subsidy program and for demonstrating improvements in preventive services and the effectiveness of health care.

Financing

The authors note that the proposal would impose a substantial cost on the federal government. New costs include the tax credits for lower-income Americans, default payments to states for enrollees in their default plans, additional payments to the Internal Revenue Service to administer the tax aspects of the plan, and an operating budget for the IEC. These costs would be financed from three sources—a cap on the current unlimited exclusion of employer-paid health insurance, savings that would accrue over time from changed consumer behavior and increased health plan competition, and general revenues.

Outlook

The authors note that by building on the current system and preserving its best features,their plan would not trigger a major disruption of health insurance coverage. The approach would retain the employer-based system and give lower-income Americans the option of staying in Medicaid or S-CHIP. The cap on the tax exemption for employer-paid health coverage would be phased in over a 10-year period. All of these factors,the authors argue, bode well for building bipartisan support for this plan.

But the authors acknowledge that the proposal faces hurdles. The plan comes with a high price. Further, many of the low-income families who would receive new subsidies are already enrolled in insurance plans. Although some would argue that this is an inefficient use of tax funds, the authors believe that offering the subsidy only to those who lack insurance is inequitable, and it would encourage employers to drop coverage.

The other major hurdle, according to the authors, will be convincing the public of the merits of limiting the tax exclusion for employer-paid health premiums. Today's exclusion benefits high-income people and families who buy high-cost plans. But the authors hope that the gradual phase-in of the cap and pegging the cap to the cost of a reasonably representative and generous private plan would temper some criticism.

The authors suggest that critics may reject the proposal for an independent federal agency to oversee health insurance as yet another intrusive bureaucracy. The authors counter that the IEC's role would be limited mostly to setting minimum standards rather than playing a hands-on regulatory role.

Finally, because the plan does not feature a mandate to cover every American, it is unlikely to achieve full universal coverage, which may make it fall short in the eyes of some.

The authors conclude that overall their plan poses little threat to existing interests or institutions. It preserves private health insurance, makes it easier for individuals to buy coverage, and protects safety net providers—all features that have heretofore engendered bipartisan support. ■

Sara J. Singer, M.B.A., is Executive Director of Stanford University's Center for Health Policy and a Senior Research Scholar at Stanford's Institute for International Studies.

Alan M. Garber, M.D., Ph.D., is the Henry J. Kaiser, Jr., Professor and Professor of Medicine at Stanford University, where he is also Professor of Economics,

Professor of Health Research and Policy, and Professor of Economics in the Graduate School of Business (courtesy).

Alain C. Enthoven, Ph.D., is a Senior Fellow, Center for Health Policy, Institute for International Studies, and the Marriner S. Eccles Professor of Public and Private Management, Emeritus, in the Graduate School of Business at Stanford University.

This paper was prepared in consultation with Mark B. McClellan, M.D., Ph.D., of the Department of Economics and the Center for Health Policy, Stanford University.

The Medical Security System: A Proposal to Ensure Health Insurance Coverage for All Americans

Alan R. Weil proposes creating a Medical Security System (MSS) to provide health insurance coverage to every legal resident under age 65. His plan would:

• Guarantee all non-elderly Americans access to a basic health coverage package at no cost to them, by requiring employers either to provide coverage or pay a payroll tax to finance coverage purchased through insurance exchanges.

• License health insurance exchanges designed to organize the insurance market. The exchanges would operate in defined geographic areas and contract with health plans that would offer all their products on a guaranteed-issue, community-rated basis.

• Enable individuals to obtain insurance through a health insurance exchange or their employer. At their option, employers could opt out of the MSS financing system by providing part- and full-time employees with a health plan equal to or greater in value than one of the standard benefits packages.

• Eliminate the State Children's Health Insurance Program (S-CHIP) and the low-income and adult components of Medicaid, folding those beneficiaries into the MSS, while waiving copayments and providing wraparound coverage for services not included in the basic package.

• Rely on a payroll tax, existing government funding sources, individual premium payments, and additional appropriations for financing.

Overview

Urban Institute analyst Alan R. Weil proposes a plan for universal coverage that combines three key elements: making access to a standard free health insurance plan a "right," requiring employers to "play or pay," and allowing everyone not covered by an employer plan to buy coverage through large purchasing pools called "insurance exchanges." Unless an employer offers one of the federally defined standard benefit packages, automatically enrolls all employees, and pays for 85 percent of the employer premium and 75 percent of dependent coverage,the employer and the firm's employees pay a payroll tax equal to approximately what the average employer and employee premium is today. People not covered by employer plans receive coverage through insurance exchanges that operate in all geographic regions and can be private or public entities licensed by the federal government.

Health Insurance Exchanges

Weil sees the insurance exchange—which he compares in function to a stock exchange—as the key to organizing insurance markets to ensure that affordable coverage is available to all and to promote competition among health plans. The federal government would license health insurance exchanges to provide coverage to individuals not receiving coverage through an employer. Exchanges would contract with multiple health plans, allow enrolled individuals to select any plan,and pay plans for each enrollee in the exchange who selects that plan. The exchanges could take any ownership or governance form (private, public, corporate, non-profit). They

would operate in defined geographic areas that approximate health care markets. An exchange choosing to operate within a geographic area would have to serve the entire area. Multiple, competing exchanges could operate in any given area.

Exchanges would combine the funds they receive from the payroll tax and other government funding sources with the premium contributions made by individuals and pass them along to health plans.

At a minimum, exchanges would have to offer all standard benefits packages (as defined by a national board), a "no-cost" plan, and a medical savings account (MSA) option. They also would be required to offer all of their products on a guaranteed-issue, community-rated basis. They would not bear risk or have any regulatory power.

Weil believes that exchanges that perform their functions well would obtain a sufficient enrollment base to be financially self-sustaining. However, since the MSS cannot function without the exchanges, states would be required to create an exchange if none developed in some area of the state.

Benefit Options

A national board would create a series of standard benefits plans reflecting a range of options with respect to cost sharing and delivery system (tightly managed, loosely managed, unmanaged). As noted above, all exchanges would offer all standard plans, as well as a no-cost plan, which may or may not correspond to one of the standard plans. As a practical matter, an exchange, knowing the funds it would receive per member, would ask health plans to specify what benefits they could offer for that per-member amount. The benefit design of the received bids would determine what an exchange could offer at no cost. Given this method, it is important to note that the specifics of the no-cost plan would vary among exchanges.

Every exchange would offer an MSA option. However, an individual who elects this option would be required to remain in the MSA for renewable periods of five years at a time.

To significantly reduce opportunities for risk selection, exchanges also would not be permitted to offer below-cost plans and then refund excess funds to enrollees of such plans.

Employer Plans

Employers could opt out of the payroll tax by providing part- and full-time employees with a health plan equal to or greater in value than one of the standard benefits packages. Employers choosing this option would be required to contribute at least 85 percent of the cost of individual coverage (75 percent for dependents). Employers providing their own coverage would need to make employee participation in the company's health plan automatic and mandatory. Employer exemptions would be granted for renewable three-year periods.

Other Subsidies

The proposal would eliminate the State Children's Health Insurance Program (S-CHIP) and the low-income child and adult components of Medicaid, folding those beneficiaries into the MSS. The portion of Medicaid that serves people with disabilities would be reconfigured as wraparound coverage beyond the basic benefits available through the MSS.

In the MSS, states would administer a system that permits individuals in low-income families to obtain copayment and deductible waivers. (The "no-cost" plans would likely have copayments and/or deductibles, but not premiums.) Waiver eligibility would be guaranteed for everyone with income below poverty and all other current mandatory Medicaid eligible populations, but states could adopt broader eligibility standards. Eligibility would be for one year and would have to be renewed annually.

All children in families that receive the cost-sharing waiver also would receive state-administered fee-for-service coverage for the additional services that Medicaid currently provides beyond those included in the "no-cost" plan. Additionally, the portion of Medicaid that serves people with disabilities would be reconfigured as wraparound coverage beyond the basic benefits available through the MSS.

The MSS also would include a refundable tax

credit for exempt employers' low-income employees who otherwise would not be able to afford the cost of their required contributions.

Financing

The MSS would rely on three sources of financing: (1) a payroll tax approximating current private insurance spending; (2) new general revenues combined with a portion of existing state and federal Medicaid and S-CHIP funds for poverty-related eligible populations; and (3) individual premium contributions to pay for higher-cost plans offered by health insurance exchanges. The payroll tax rates would be set to approximate current private insurance spending. Financing for the public subsidy programs discussed above would retain the existing Medicaid matching structure between the federal government and the states.

Outlook

Weil notes that his proposal would differ fundamentally from the current system and would require a substantial transition. He acknowledges that this plan would have difficulty passing muster in today's political climate. Since the last major health reform attempt in the early 1990s, it has become clear that mandates are a lightning rod in the context of expanding health coverage. Weil admits that, if history is a guide, employers are likely to balk at the idea of any mandate, particularly one involving expansion of payroll taxes for purposes outside of their control. Still, he argues that the universality, individual choice, and market orientation components of his plan could mute criticisms since they are values that dominate public policy discussions today. In the end,he claims that his plan could make a significant difference in generating a more equitable distribution of health care resources. In addition, he believes that by structuring market competition around health plans, his plan does more to promote quality than reforms that rely on market forces at the point of service. ■

Alan R. Weil, J.D., M.P.P., is Director of the Assessing the New Federalism project at the Urban Institute.

A Plan for Achieving Universal Health Coverage: Combining the New with the Best of the Past

Elliot K. Wicks, Jack A. Meyer, and **Sharon Silow-Carroll** have outlined a proposal to achieve universal health coverage while maintaining a market-based system and simplifying administration. Key elements of the proposal include the following:

• Refundable tax credits, payable in advance, for all households, with the credit varying by income, sufficient for those below the federal poverty level to cover the full cost of coverage comparable to Medicaid and gradually reduced for higher-income people.

• A requirement that everyone buy coverage at least as comprehensive as Medicare plus drugs and well-child care. Those not meeting the requirement would be automatically covered by Medicare as a backup but would have to pay a premium plus a penalty (at tax time) for every month without private coverage.

• A requirement that all employers offer (but not necessarily pay for) a minimum benefits plan no less comprehensive than Medicare.

• Elimination of the federal tax provision that permits employees to exclude from their taxable income the amount that their employer pays for health coverage.

• Establishment of purchasing pools, or aggregate purchasing arrangements, to serve as a source of health coverage for individuals and small employers. Insurers are required to participate and offer a standard benefits plan comparable to Medicare.

• Centralized administration of all claims, coordination of benefits, etc., to reduce administrative duplication and inefficiency.

Overview

Elliot K. Wicks, Jack A. Meyer, and Sharon Silow-Carroll, health policy analysts at the Economic and Social Research Institute, have crafted a proposal that would provide health coverage for all Americans. The authors contend that the plan would achieve universal coverage while reducing the fragmentation and inequities of the present financing system, simplifying administration of health coverage, and maintaining the role of market-based decision-making and employer-sponsored private health insurance. Three elements are the keys to ensuring that coverage is universal: Generous tax credit subsidies would ensure that everyone had the means to buy coverage, federal law would require everyone to purchase coverage, and a fallback coverage system would be in place to guarantee temporary coverage for anyone who would otherwise fall through the cracks.

Subsidy Structure

Most of the uninsured lack coverage because they cannot afford it, according to the authors. So they propose to establish a tax credit system that would provide every American with a “refundable” tax credit, varying by income but sufficient to make coverage affordable for everyone. Those at or below the poverty level would have a credit sufficient to

buy coverage comparable to that provided by Medicaid today. Households above the median income would have a credit approximately equal to the average value of the tax break received by people whose employers pay for health insurance. (These premiums are a non-taxable form of compensation that produces annual tax savings averaging about $700 for an individual and $1,500 for a family.) Households between the poverty level and the median income would be eligible for tax credits that are gradually scaled back from the full Medicaid-equivalent level to the standard tax credit.

The problems with tax credits are that typically they do not produce any benefit until tax time, and the benefit is limited to the amount of a household's tax liability. Wicks and his colleagues would deal with these problems by making the credit payable during the year and not limited by tax liability. In other words, people could "get money back" even if they owe no federal taxes.

The new tax credit system would make Medicaid and the State Children's Health Insurance Program (S-CHIP) unnecessary, so these programs would be eliminated. (Medicaid would still cover long-term care—at states' expense. And for special-needs populations, states would provide non-medical but health-related services now provided through the Medicaid program.)

The new tax credit system also would replace the current federal tax subsidy provision that excludes employer premium contributions from employees' taxable income. The authors criticize the tax exclusion as being inequitable and inefficient because it fails to provide assistance to people whose employers do not provide coverage, and it more heavily subsidizes higher-income people, who typically have generous employer-paid coverage and do not need help anyway.

The authors contend that universal coverage cannot be achieved in a system that depends entirely on the voluntary purchase of coverage. To ensure that everyone has coverage requires one of two conditions: either everyone must be required to buy coverage, or a public system must be in place that automatically covers everyone. The authors choose elements of both: they mandate the purchase of private coverage that is at least as comprehensive as Medicare benefits plus prescription drugs and well-child care coverage. But recognizing that some people will not heed the mandate for a variety of reasons, the authors also structure Medicare as a fallback system to automatically cover anyone who lacks private coverage. The medical bills of people who lack coverage but show up in a doctor's office or a hospital for treatment will have their expenses paid by Medicare. But the authors want to preserve the private coverage system and avoid having Medicare become the default coverage system of choice for large numbers of people. Therefore, not only would they require people to pay a premium for every month they are without private coverage (in the form of a tax liability due as part of their income tax); they also would impose a penalty on top of the premium to make private coverage a more attractive alternative than Medicare.

Organizing the Purchase of Private Coverage

Though they support private coverage, the authors acknowledge that the system has not worked well for everybody. To make sure that everyone has a ready way to buy coverage, the authors would require all employers to offer coverage, though they would not necessarily have to pay anything toward the premium. In addition, each state would establish a purchasing pool, or aggregate purchasing arrangement (APA), specially designed to serve as a convenient and efficient way for individuals and small employers (those with up to 100 employees) to purchase coverage. The smallest employers (those with 10 or fewer workers) would be required to offer coverage through the APA, and even large employers could opt to do so.

Any insurer offering coverage in a state would be required to participate in the purchasing pool by offering at least two plans—one with coverage equal to Medicaid (to ensure ready availability of such a plan for people at or below the poverty level) and one equivalent to Medicare plus prescription drugs and well-child care. Coverage would be guar-

anteed to all applicants, whether individuals or groups. There would be no exclusions or waiting periods for prior medical conditions. And premiums would be community-rated—that is, everybody buying coverage as individuals or employees of small groups would be in the same insurance pool and pay the same rates for the standard coverage plans. Individual employees could choose from any plan available through the APA. Insurers would participate in a risk-adjustment system to compensate insurers that might end up with more than their fair share of higher-risk enrollees.

One of the features of the current system that particularly bothers the authors is its administrative inefficiencies. The analysts charge that the processes for submitting claims, determining eligibility, calculating copayment obligations, coordinating benefits, and so forth are woefully duplicative, burdensome, and inefficient. They would replace them with a centralized mechanism that would function much as the credit card reconciliation system does, with a single centralized system that handles everything electronically.

Financing

The authors would have the federal government finance the tax credits in the new system, with the money coming from general revenues. But not all spending would be new. Large savings would be realized by eliminating the tax exclusion of employer-paid insurance premiums and by terminating Medicaid and S-CHIP. As they do now, employers and individuals would continue to pay premiums (above and beyond the tax credits).

Outlook

The authors acknowledge that this is a far-reaching proposal that departs appreciably from the status quo. They know it will not be easy to sell. Like any plan that seriously addresses the problem of the uninsured, it is expensive. And it involves compulsory elements that some will find objectionable. But the authors argue that these are prices that have to be paid to achieve universal coverage.

They also believe that many features of the plan will have broad appeal. Besides being simpler and more equitable than the current system,the new tax credit approach would give everyone the capacity to buy "mainstream" care. Nobody would be stigmatized by being in a special public program that may have connotations of welfare. The plan would preserve, even strengthen, the private market for insurance and employer-based coverage. No services would go unpaid; there would be no charity care and no uncompensated care. But, most important, because coverage would be universal, financial constraints would no longer prevent anyone from getting needed care. ■

Elliot K. Wicks, Ph.D., is Senior Fellow at the Economic and Social Research Institute and Senior Consultant with Health Management Associates.

Jack A. Meyer, Ph.D., is the founder and President of the Economic and Social Research Institute.

Sharon Silow-Carroll, M.S.W., M.B.A., is Senior Research Manager at the Economic and Social Research Institute.

A Comparison of Reform Plan Features

The following table provides a side-by-side comparison of the features of the reform plans that are described in detail in the preceding narrative. The plans are identified by the names of the authors.

A Comparison of Reform Plan Features

	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
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.	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.	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.	A new Medical Security System would be created to provide universal coverage, making coverage a "right."	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.
All non-elderly legal residents.	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.	Low and moderate-income people who are not eligible for Medicare.	All legal U.S. residents under age 65.	All of the uninsured.
Federal subsidies to states to finance availability of no-cost coverage to all legal residents.	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.	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.	Payroll tax, Medicaid, and S-CHIP funds.	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.
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.	None.	None.	All employers and employees would pay a new payroll tax. All people would have to enroll or be enrolled by default.	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.
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.	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.	Phased-in cap on current federal tax exclusion; general revenues; and savings over time from changing consumer behavior and increasing health plan competition.	Payroll tax, premiums, and federal subsidies.	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.

	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
Payroll tax substitutes for employer and employee premiums, which has implications for tax exclusion provision of employer premium contributions.	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.	Phased-in cap on current federal tax exclusion for employer-paid premiums.	New payroll tax would be established for employers and employees.	The tax exclusion for employer-paid health premiums would be eliminated.
A federally-defined standard benefit package. Benefits would include prescription drug coverage; dental and long-term care would not be required.	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.	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.	Guarantee is for basic coverage, but individual may supplement with own funds to buy more comprehensive.	A package of benefits comparable to Medicare's plus a prescription drug benefit and well-child care coverage.
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.	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.	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.	Would set up and regulate insurance exchanges, forward tax revenues, and determine size of payroll tax.	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.
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.	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.	Continue to provide Medicaid and S-CHIP; use new federal funds to pay for care under default plans by reimbursing safety-net providers.	States would continue to pay some Medicaid costs to keep coverage at current levels; would subsidize copayments under basic plan for low-income residents.	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.

	Butler	Feder / Levitt / O'Brien / Rowland	Gruber	Hacker	Holahan / Nichols / Blumberg
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 clearinghouse, 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.

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Would vary by state, but new state program could replace S-CHIP and portions of Medicaid.	Medicaid and S-CHIP would continue, and more low-income people would be subsidized to enroll in these programs or some other public program.	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.	S-CHIP would be subsumed; Medicaid would be mostly subsumed.	S-CHIP and Medicaid largely replaced, except for disabled and elderly.
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.	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.	Would compete to provide low-cost, high-quality care; collect and report quality of care and health outcomes data.	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.	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.
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.	Similar to current role.	May become their own insurance exchange; continue to offer benefits to employees; or purchase coverage from exchanges.	Employers would collect payroll tax but could opt out by offering own generous plans to employees.	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.
Since coverage in no-cost plan is automatic, everyone is pooled together, though states would have latitude to decide specifics.	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.	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.	Insurers selling through insurance exchanges would be required to offer guaranteed-issue, community rated standard benefit packages.	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.

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Economic and Social Research Institute
1015 18th Street, N.W., Suite 210
Washington, D.C. 20036
Phone: (202) 833-8877
Website: www.esresearch.org