COMMISSION ON A HIGH PERFORMANCE HEALTH SYSTEM

AN ANALYSIS OF LEADING CONGRESSIONAL HEALTH CARE BILLS, 2005–2007: PART I, INSURANCE COVERAGE

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ABSTRACT: The first of a two-part series, this report analyzes and compares leading congressional bills and Administration proposals to expand health insurance coverage introduced over 2005–2007. The Commonwealth Fund commissioned The Lewin Group to estimate the effect of the bills on stakeholder and health system costs and the projected number of people who would become newly insured through them. The proposals fall into three categories: those that propose fundamental reform of the health insurance system; those that would expand existing public insurance programs; and those that seek to strengthen employer-based health insurance. The report considers whether the proposals would improve access to care, increase health system efficiency, make the system more equitable, and improve quality of care.

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EXECUTIVE SUMMARY

The first of a two-part series, this report analyzes and compares leading congressional bills and Administration proposals to expand health insurance coverage introduced over 2005–2007.[1] The Commonwealth Fund commissioned The Lewin Group to estimate the effect of the bills on stakeholder and health system costs and the projected number of people who would become newly insured through them.

All coverage and cost estimates are for 2007 and are based on the assumption of full implementation of the proposals this year. The Lewin Group projects that, under current law, the number of uninsured in the United States will rise to 47.8 million people in 2007 out of a total estimated population of 295.1 million.

The proposals take different approaches to achieve near-universal coverage or more incremental expansions in health insurance. The approaches fall into three broad categories:

- fundamental reforms of the nation's health insurance system;
- expansions of existing public insurance programs; and
- strengthening employer-based health insurance.

FUNDAMENTAL REFORMS OF THE HEALTH INSURANCE SYSTEM

Proposals that would fundamentally reform the U.S. health insurance system include:

- health insurance tax deduction and tax on employer contribution to health insurance (President Bush);
- regional insurance exchanges (Senator Wyden);
- federal–state partnerships to expand health insurance (Senators Bingaman and Voinovich, Representatives Baldwin, Tierney, and Price); and
- Coverage through Medicare (Representative Stark, Senator Kennedy, Representative Dingell).

The proposals vary in design but contain common elements (Figure ES-1).

Figure ES-1. Major Features of Health Insurance Expansion Bills and Impact on Uninsured, National Expenditures

	President Bush's Tax Reform Plan	Healthy Americans Act[2]	Federal/State Partnership 15 States	AmeriCare
Aims to Cover All People		X		X
Individual Mandate or Auto Enrollment		X	X	X
Employer Shared Responsibility		X	X	X
Public Program Expansion			X	X
Subsidies for Lower Income Families		X	X	X
Risk Pooling		X	X	X
Comprehensive Benefit Package		X	X	X
Quality & Efficiency Measures	X	X	X	X
Uninsured Covered in 2007[1] (in millions)	9.0	45.3	20.3	47.8
Net Health System Cost in 2007 (in billions)	($11.7)	($4.5)	$22.7	($60.7)
Net Federal Budget Cost in 2007 (in billions)	$70.4	$24.3	$22.0	$154.5

[1]Out of an estimated total uninsured in 2007 of 47.8 million.
[2]Estimates reflect a mandatory cash-out of benefit on the part of employers that currently offer coverage.
Source: The Lewin Group for The Commonwealth Fund.

- With the exception of federal–state partnerships, all of the proposals would transform the traditional role of employers by eventually scaling back or eliminating the extent to which they contract directly with health plans for coverage. The president's and Senator Wyden's proposals would achieve this in part by eliminating the tax exemption for employer-provided benefits and replacing it with an income tax deduction. The proposals differ in the extent to which employers would continue to finance coverage.
- With the exception of President Bush's proposal, the plans would require individuals to have health insurance and require employers and individuals to share in the cost.
- All of the proposals except the president's would provide subsidies to people with lower incomes to help defray the costs of premiums.
- All of the proposals except the president's would pool health risks into large groups in order to equalize premium costs across families, regardless of health risk, and increase efficiency in insurance administration.

The proposals vary in the number of people covered, the source of coverage, and in the comprehensiveness and affordability of coverage (Figure ES-2).

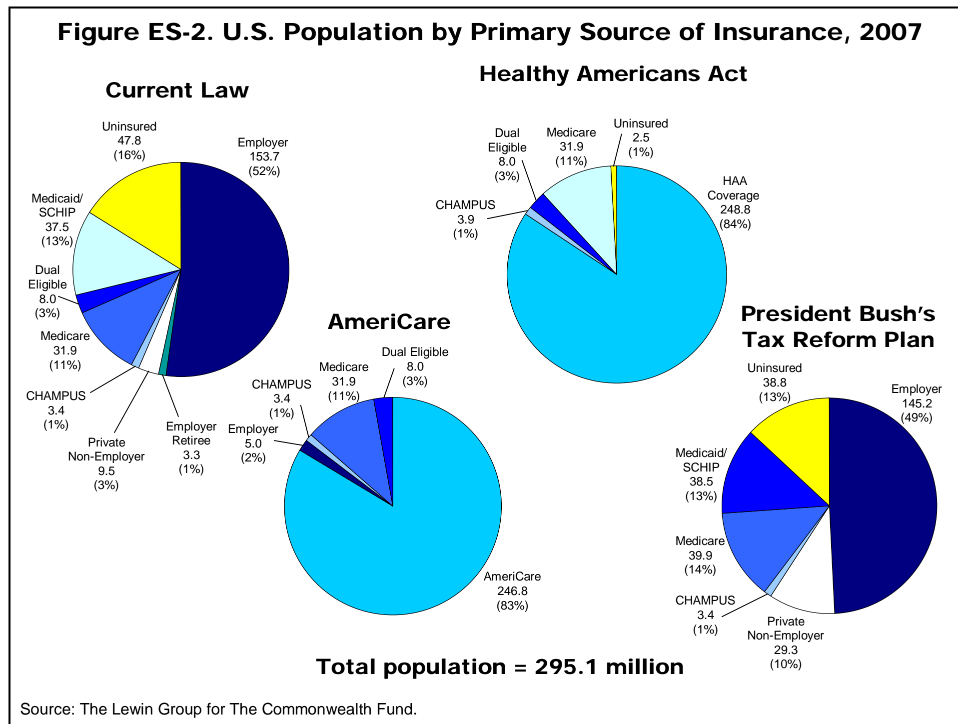


Figure ES-2. U.S. Population by Primary Source of Insurance, 2007

- Representative Stark's "AmeriCare" proposal would cover nearly all uninsured, as would Senator Wyden's "Healthy Americans Act."
- Medicare would become the primary source of coverage for all Americans under Representative Stark's bill and private Health Help Agency plans would become the major source under Senator Wyden's bill.
- The state–federal partnerships bills propose state demonstrations to expand health insurance and by definition do not provide sufficient details to permit cost estimates. For purposes of illustration of how such a partnership might work, The Lewin Group assumed a hypothetical model under which 15 states would implement a blended version of Massachusetts's Commonwealth Care and Governor Schwarzenegger's health proposal for California, with federal matching funds provided for Medicaid and State Children's Health Insurance Program (SCHIP) expansions.[2] About 20 million people are estimated to gain coverage out of 23.6 million currently uninsured in those states.
- President Bush's proposal to equalize the tax treatment of employer and individual coverage is estimated to cover 9 million previously uninsured people in 2007, mostly through the individual insurance market. The new income tax deduction would be for a fixed amount that would rise annually by the rate of consumer price inflation, which

is projected to rise more slowly than premiums. Therefore, the proposal is likely to cover more uninsured people in the first years of the proposal than in future years, when premiums are more likely to exceed the cap and thus be more expensive to taxpayers. Other families may buy increasingly less comprehensive coverage with higher out of pocket costs as the growth in the standard tax deduction lags that of premiums.

- By setting a floor on acceptable levels of health benefits, all of the proposals—with the exception of the president's—would improve coverage for millions of people who are currently underinsured. In addition, Representative Stark's bill, Senator Wyden's bill, and the state–federal partnership model would cap out-of-pocket costs as a share of income and/or subsidize premiums.

The cost of the proposals and how costs are shared depend on the source of coverage, the extent of premium subsidies, how broadly health risk is pooled, and inclusion of other efficiency measures (Figure ES-3).[3]

Figure ES-3. Health Insurance Expansion Bills Change in Health Spending by Stakeholder Group, Billions of Dollars, 2007

	President Bush's Tax Reform Plan	Healthy Americans Act[2]	Federal/State Partnership 15 States	AmeriCare
Total Uninsured Covered, Millions	9.0	45.3	20.3	47.8
Federal Government	$70.4	$24.3	$22.0	$154.5
State and Local Government	($0.3)	($10.2)	$13.4	($57.4)
Private Employers	($50.8)	$60.2	$5.7	($15.2)
Households	($31.0)	($78.8)	($18.4)	($142.6)
Net Health System Cost in 2007 (in billions)	($11.7)	($4.5)	$22.7	($60.7)
Total Uninsured Not Covered,[1] Millions	38.8	2.5	27.5	0

[1]Out of an estimated total uninsured in 2007 of 47.8 million.
[2]Estimates reflect a mandatory cash-out of benefits on the part of employers that currently offer coverage.
Source: The Lewin Group for The Commonwealth Fund.

- Representative Stark's AmeriCare bill would increase federal spending by $154.5 billion in 2007. President Bush's proposal would increase the budget deficit by $70.4 billion in 2007, but is expected to generate a surplus within the next ten years. Federal Medicaid and SCHIP matching funds for 15 states would increase federal spending by about $22 billion unless offset by savings measures. Senator Wyden's Healthy

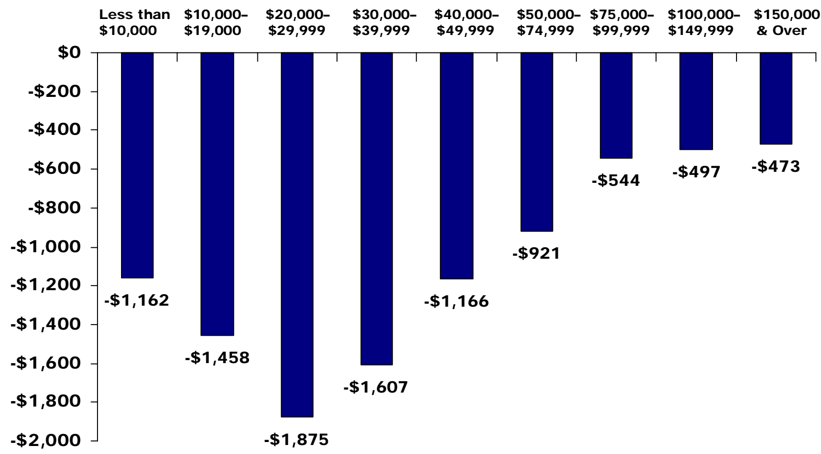
Americans Act would increase Federal spending by $165 billion but the tax revenue effect of the bill's requirement that employers cash-out their health benefits in the first two years of the program would dampen the increase significantly to $24.3 billion in 2007.

- Representative Stark's AmeriCare bill would result in substantial overall health system savings relative to the other approaches: the bill is estimated to reduce national health expenditures by $60.7 billion in 2007, compared with savings of $11.7 billion under the president's proposal and $4.5 billion under Senator Wyden's bill.
- This difference stems primarily from large savings in the cost of administering health insurance under Representative Stark's bill: the total costs of health insurance administration in the United States would decline by $74 billion in 2007. Insuring everyone under Medicare would spread risks across a large risk pool and bring Medicare's lower administrative costs per premium dollar to the full population.
- Senator Wyden's bill also substantially reduces insurance administrative costs by creating large regional groups in which people would buy private coverage. Insurance administration costs are estimated to decline by $57 billion in 2007, though the savings would be offset somewhat by the costs of administering the new program.
- Representative Stark's AmeriCare proposal is also estimated to achieve savings by requiring the federal government to negotiate prescription drug prices with pharmaceutical companies, thus reducing national spending on prescription drugs by $33.9 billion in 2007.
- The president's proposal achieves savings by reducing the comprehensiveness of coverage and inducing lower utilization of services.

Premium subsidies and new tax provisions in the bills greatly affect how family health spending changes.

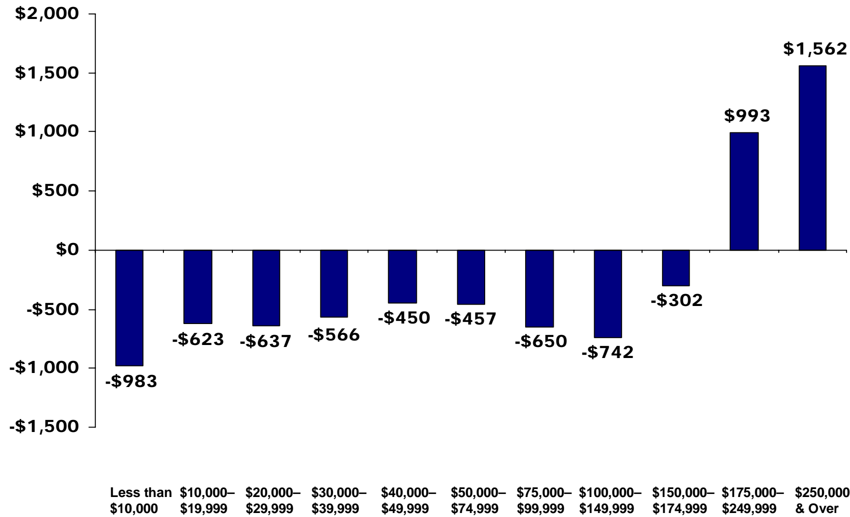
- Under Representative Stark's bill, households would see a dramatic drop in health care expenditures of $142.6 billion, with the largest savings falling to families with low and moderate incomes (Figure ES-4). However, these savings might be offset if taxes are increased to finance higher federal government spending.
- Under Senator Wyden's bill, household health spending would decline by $78 billion. Spending would decline the most for lower and moderate income households and rise for the highest income earners. Average health spending would fall by $983 per year among families earning less than $10,000 a year and increase by an average $1,562 among families earning $250,000 or more annually (Figure ES-5).

Figure ES-4. Change in Average Family Health Spending Under the AmeriCare Health Act in 2007, by Income Group



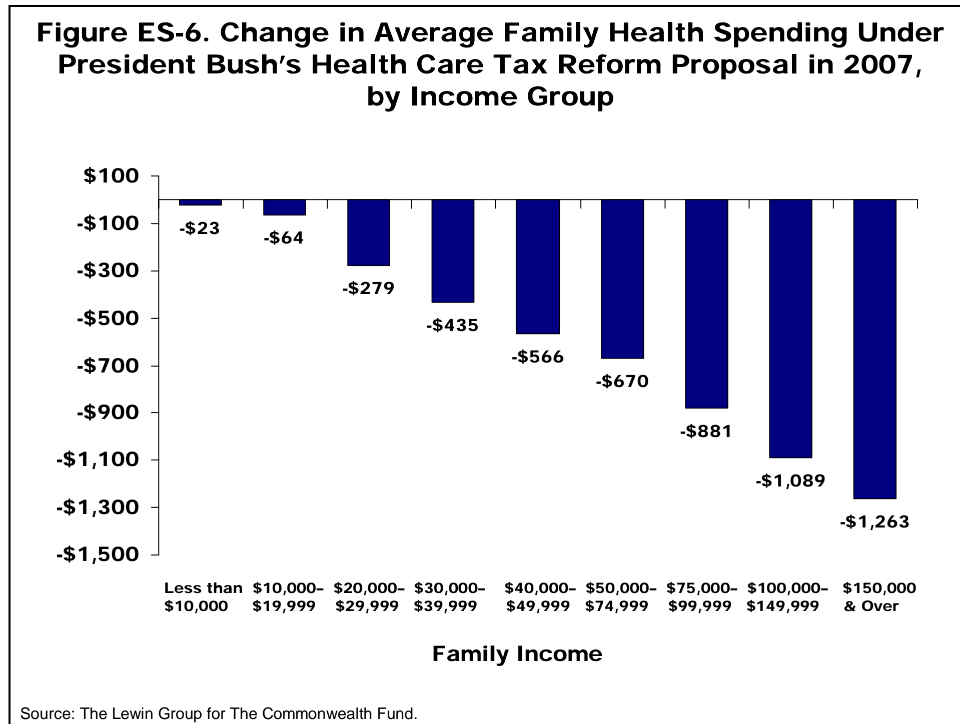
Source: The Lewin Group for The Commonwealth Fund.

Figure ES-5. Change in Average Family Health Spending Under the Healthy Americans Act in 2007, by Income Group



Note: Estimates reflect a mandatory cash-out of benefits on the part of employers that currently offer coverage.
Source: The Lewin Group for The Commonwealth Fund.

- Under President Bush's proposal, household spending on health care is estimated to fall by a net $31 billion in 2007 due to income tax savings. But tax savings disproportionately accrue to people in higher income brackets: average spending would decline by $23 in 2007 among families with annual incomes of less than $10,000 and by $1,263 a year among those earning $150,000 or more per year. (Figure ES-6). In future years, however, the differential indexing of the deduction and growth in employer premiums would lead to an increase in taxes for households now covered by employer plans.



EXPANSIONS OF EXISTING PUBLIC INSURANCE PROGRAMS

More modest proposals can be important first steps toward universal coverage. Several bills would expand health insurance coverage by building on Medicare, Medicaid, and SCHIP (Figure ES-7). These include:

- Medicare buy-in for older adults (Representative Stark);
- elimination of the Medicare two-year waiting period for people who are disabled (Senator Bingaman and Representative Green);
- universal coverage for children (Senator Kerry, Representative Waxman, Senator Rockefeller, Representative Stark); and
- Medicaid expansions (Representative Dingell).

Figure ES-7. Major Features of Health Insurance Expansion Bills and Impact on Uninsured, National Expenditures

	Medicare Buy-In	Eliminate Medicare 2-yr Waiting Period	Universal Coverage for Children	Medicaid/ SCHIP Children & Parents
Aims to Cover All People				
Individual Mandate or Auto Enrollment				
Employer Shared Responsibility	X			
Public Program Expansion	X	X	X	X
Subsidies for Lower Income Families	X		X	
Risk Pooling	X	X	X	X
Comprehensive Benefit Package	X	X	X	X
Quality & Efficiency Measures			X	X
Uninsured Covered in 2007[1] (in millions)	3.5	0.3	5.2	6.2
Net Health System Cost in 2007 (in billions)	$4.9	($0.1)	$3.0	$7.5
Net Federal Budget Cost in 2007 (in billions)	$26.9	$9.1	$19.9	$12.7

[1]Out of an estimated total uninsured in 2007 of 47.8 million.
Source: The Lewin Group for The Commonwealth Fund.

- Representative Stark would allow older adults ages 55 to 64 to buy in to Medicare, using tax credits to offset premium costs. This would insure an estimated 3.5 million out of 4.8 million uninsured older adults in 2007. The estimated cost to the federal budget is $26.9 billion, with spending on premiums and out-of-pocket costs reduced by $10.6 billion for people who enroll (Figure ES-8).

- People who become disabled and cannot work would eventually no longer have to wait 24 months before becoming eligible for Medicare under bills introduced by Senator Bingaman and Representative Green in June 2005. This would help 1.7 million disabled people currently in the waiting period, of whom 15 percent are uninsured. The estimated cost to the federal budget of immediately ending the waiting period in 2007 is $9.1 billion.

- Senator Kerry and Representative Waxman would provide states with incentives to expand coverage through Medicaid and SCHIP for children up to age 21 in families with incomes up to 300 percent of the federal poverty level, and would cap premium costs for children in families with incomes over 300 percent of poverty. The bill is estimated to cover 5.2 million out of 11.1 million uninsured children in 2007. It would increase federal spending by about $20 billion in that year, but reduce state and local government spending by $8.2 billion through increased federal matching funds for poor children.

Figure ES-8. Health Insurance Expansion Bills Change in Health Spending by Stakeholder Group, Billions of Dollars, 2007

	Medicare Buy-In	Eliminate 2-yr Medicare Waiting Period	Universal Coverage for Children	Medicaid/ SCHIP Children & Parents
Total Uninsured Covered, Millions	3.5	0.3	5.2	6.2
Federal Government	$26.9	$9.1	$19.9	$12.7
State and Local Government	($2.0)	($3.0)	($8.2)	$3.2
Private Employers	($9.4)	($4.0)	($7.3)	($3.5)
Households	($10.6)	($2.2)	($1.5)	($4.9)
Net Health System Cost in 2007 (in billions)	$4.9	($0.1)	$3.0	$7.5
Total Uninsured Not Covered,[1] Millions	44.3	47.5	42.6	41.6

[1]Out of an estimated total uninsured in 2007 of 47.8 million.
Source: The Lewin Group for The Commonwealth Fund.

- Representative Dingell would insure parents of children in Medicaid and SCHIP, thus extending new coverage to an estimated 6.2 million children and adults. The bill would increase federal spending by $12.7 billion in 2007 and state and local government expenditures by $3.2 billion. Family spending on health care would decline by nearly $5 billion as more families gained more comprehensive insurance.

STRENGTHENING EMPLOYER-BASED HEALTH INSURANCE

Several proposals would expand health insurance by building on the employer-based system, which currently covers more than 160 million workers and their dependents, or about 63 percent of the population (Figure ES-9). They include:

Figure ES-9. Major Features of Health Insurance Expansion Bills and Impact on Uninsured, National Expenditures

	Employer Mandate	Association Health Plans	Small Business Expansion[2]
Aims to Cover All People			
Individual Mandate or Auto Enrollment			
Employer Shared Responsibility	X	X	X
Public Program Expansion			
Subsidies for Lower Income Families			X
Risk Pooling	X		X
Comprehensive Benefit Package	X		X
Quality & Efficiency Measures			X
Uninsured Covered in 2007[1] (in millions)	12.3	(0.3)	0.6
Net Health System Cost in 2007 (in billions)	$28.5	($0.4)	$2.1
Net Federal Budget Cost in 2007 (in billions)	($42.6)	$0.1	$12.0

[1]Out of an estimated total uninsured in 2007 of 47.8 million.
[2]Modeling assumed that firms with under 100 employees are eligible; reinsurance of 90% of costs over $50,000.
Source: The Lewin Group for The Commonwealth Fund.

- employer mandate for large employers (Representative Pallone); and
- improving the affordability of health insurance for small employers (President Bush, Representative Johnson, Senator Durbin, Representative Kind, Representative Allen).

  - Representative Pallone would require companies with 50 or more workers to offer and contribute to comprehensive health insurance for their employees and dependents. An estimated 12.3 million workers and their dependents would become newly insured under the proposal. Because workers and their dependents with coverage through public insurance programs are required to enroll in their employers' plans, 9.7 million workers and dependents would move from those programs into employer-based coverage, saving the federal government an estimated $42.6 billion in 2007 (Figure ES-10). Employers would face the largest net increase in costs under the bill, of $92.1 billion.

Figure ES-10. Health Insurance Expansion Bills Change in Health Spending by Stakeholder Group, Billions of Dollars, 2007

	Employer Mandate	Association Health Plans	Small Business Expansion[2]
Total Uninsured Covered, Millions	12.3	(0.3)	0.6
Federal Government	($42.6)	$0.1	$12.0
State and Local Government	$5.4	$0.6	($0.4)
Private Employers	$92.1	($1.3)	($6.9)
Households	($26.4)	$0.2	($2.6)
Net Health System Cost in 2007 (in billions)	$28.5	($0.4)	$2.1
Total Uninsured Not Covered,[1] Millions	35.5	48.1	47.2

[1]Out of an estimated total uninsured in 2007 of 47.8 million.
[2]Modeling assumed that firms with under 100 employees are eligible; reinsurance of 90% of costs over $50,000.
Source: The Lewin Group for The Commonwealth Fund.

- The Bush Administration and Representative Johnson would allow trade and other professional associations to create association health plans (AHPs) to provide health insurance to their member employers. The Johnson bill would in effect allow companies to bypass state insurance regulations such as community rating, which are aimed at increasing access to the small group market for small businesses with less healthy or older workers. The bill is estimated to make small group coverage more affordable for companies with a young and/or healthy workforce but to significantly increase premiums for companies with older and/or less healthy workforces that must continue to purchase coverage in the small group market. While 2.6 million workers and dependents are estimated to gain employment-based insurance through association health plans, 2.8 million would lose existing employer coverage because of a rise in premiums in the small group market. The number of uninsured is estimated to increase by a net 278,000 under the bill.
- Senator Durbin, Representative Kind, and Representative Allen propose bills that take an entirely different approach than AHPs by establishing pools for small businesses with premium protections and federal reinsurance. But in the absence of state-wide insurance market regulations, the proposals might ultimately have the unintended effect of increasing premiums within the pools, even with the reinsurance and tax credits, as those companies with less healthy and older workforces disproportionately enroll, attracted by the community-rated plans. About 600,000 people become newly insured.

CONCLUSION

To assess these proposals, the public might pose the following criteria: Will the proposals improve access to care, increase health system efficiency, make the system more equitable, and improve quality of care? Do they promise to set the nation on a path toward longer, healthier, and more productive lives?

Access to Care

- The proposals range in scope from targeted efforts that would cover a defined group of people to those that aim to expand coverage options for everyone. Bills that fundamentally reform the health system vary in their effectiveness (Figure ES-11). Representative Stark's AmeriCare proposal and Senator Wyden's Healthy Americans Act would cover nearly all of those currently uninsured. President Bush's proposal would cover less than one of five of those uninsured in 2007, and this number is likely to decline in future years.
- By setting a floor on acceptable levels of health benefits and providing premium assistance for low- and moderate-income families, several of the bills would improve coverage for the estimated 16 million people who are currently underinsured.

Figure ES-11. Major Features of Health Insurance Expansion Bills

	President Bush's Tax Reform Plan	Healthy Americans Act	Federal/State Partnership 15 States[2]	AmeriCare
Access *(% of uninsured covered[1] in 2007)*	19%	95%	42%	100%
Efficiency *(change in national health system spending in 2007)*	($11.7)	($4.5)	$22.7	($60.7)
Equity *(change in average family health spending by annual income in 2007)*	<$10,000: ($23) >$150,000: ($1,263)	<$10,000: ($983) >$250,000: $1,562	N/A	<$10,000: ($1,162) >$150,000: ($473)
Measures to Improve Quality		Medical home, hospital safety, reward healthy behavior, chronic disease management	State proposals to show improvements in quality, efficiency, and health IT	Uniform electronic claims forms and medical records; electronic national claims data set
Potential to Ensure Long, Healthy, Productive Lives		X	X	X

[1]Out of an estimated total uninsured in 2007 of 47.8 million.
[2]Estimated to cover 86% of the 23.6 million people projected to be uninsured in the 15 states in 2007.
Source: The Lewin Group for The Commonwealth Fund.

Efficiency

- The cost of the proposals and how those costs are distributed across stakeholders is affected by their scope and structure. In general, more targeted proposals are less expensive to the federal government than are more comprehensive coverage plans.
- Yet, the estimated savings to the overall health system from insuring everyone through Medicare or other near-universal mechanisms swamp those from incremental approaches. This results from the administrative savings from broadly pooling risk as well as other efficiency gains such as negotiating pharmaceutical prices on behalf of the full population.
- The proposals that would enroll people automatically through the tax system or at birth and mandate that people have coverage, such as the Representative Stark's bill and Senator Wyden's bill, are the most likely to ensure that people become enrolled and remain enrolled over their lifespan.

Equity

- The design of new premium subsidies, tax credits, or tax deductions for the purchase of health insurance has dramatic implications for how new costs or savings accrue across households. Representative Stark's AmeriCare proposal and Senator Wyden's Healthy Americans Act would distribute changes in health care expenses equitably, according to family income. Under President Bush's proposal, savings from the new tax deduction accrue disproportionately to those with higher incomes.
- Broad risk pooling; i.e., the sharing of health risks among many participants, also has implications for equity. The proposals that attempt to cover people through existing individual or small group insurance markets ultimately run up against the central dynamic governing those markets—the powerful incentive on the part of carriers to protect against health risk. To help ensure that everyone, regardless of health risk, has affordable insurance coverage and to prevent escalating premiums, risks should be spread among as large a group as possible, participation should be mandatory, community rating should be imposed for the full state market if one exists outside of the pool, and adequate federal reinsurance should be provided.

Quality

- The ways in which people are insured, the systems that evolve to achieve near-universal coverage, and the role of insurance carriers will be important determinants of whether significant and systematic improvements in quality can be achieved nationally. Proposals that would organize coverage through a central mechanism, such as the

Medicare program in Representative Stark's proposal and Health Help Agencies under Senator Wyden's bill, have the potential to improve quality in a number of ways. For example, they could enable development and use of common measures of health care quality, collection of outcome data for the full population, creation of uniform provider payment systems that reward high-quality care, and standardization and broad diffusion of health information technology.

- Most of the bills that would fundamentally reform the health system also include specific quality improvement measures. Senators Bingaman and Voinovich and Representatives Baldwin, Price, and Tierney would require or encourage states proposing coverage expansions to also include plans to improve health care quality and efficiency, and expand the use of health information technology. Senator Wyden would encourage people of all ages to have a "health home," establish an expert panel to ensure quality control in hospitals, reward healthy behavior, and establish a chronic care disease management program. Representative Stark would require uniform electronic claims reporting and electronic medical records and create a national electronic claims data set.

Longer, Healthier, and More Productive Lives

- The ultimate goal of health care reform should be improvements in the length, quality, and productivity of people's lives. The analysis of these proposals demonstrates that universal coverage is feasible and that many proposals and particular elements of the proposals have the potential to yield overall savings in national health expenditures and systematic, long-term improvements in the quality of care nationwide.
- The Institute of Medicine estimates that the millions of people who lack insurance coverage generate between $65 billion and $130 billion annually in costs associated with diminished health and shorter life spans. This provides a stark benchmark against which to compare inaction versus the estimated annual costs and savings in this report of investing in a more rational and equitable system of health care in the United States.

AN ANALYSIS OF LEADING CONGRESSIONAL HEALTH CARE BILLS, 2005–2007: PART I, INSURANCE COVERAGE

INTRODUCTION

American families and businesses are coping with rapidly rising health care costs and premiums, loss of comprehensive and affordable insurance coverage, and considerable variation in the quality and efficiency of health care. Members of Congress have tried to address many of these problems through the introduction of new bills during the 109th and beginning of the 110th Congresses. Neither government agencies nor the private sector, however, have systematically analyzed these proposals for their potential to improve health system performance through universal access to care, greater equity in terms of access to care and spending as a share of income, greater efficiency in the financing and delivery of care, and better quality of care. Would the proposals ultimately support longer, healthier, and more productive lives?

The first of a two-part series, this report analyzes and compares leading congressional bills to expand health insurance coverage.[4] Selected bills meet at least one of the following criteria: a) potential to significantly affect the problem addressed; b) reflective of ideas proposed in the Administration's budget; c) bipartisan support; d) unique or innovative. Where Congress has not introduced a bill reflective of the Administration's budget, the report analyzes the president's health care reform proposal. The Commonwealth Fund commissioned The Lewin Group to estimate the effect of the bills on stakeholder and health system costs and the projected number of people who would become newly insured through them. The Fund also commissioned Health Policy R&D to create detailed "side-by-side" comparative analyses of the bills, which appear in Tables A-1 through A-6.

Since 2005, members of Congress have introduced bills to expand health insurance coverage that take a variety of approaches to achieve incremental as well as more comprehensive expansions in coverage. The proposed approaches fall into three broad categories:

- fundamental reforms of the nation's health insurance system;
- expansions of existing public insurance programs; and
- strengthening employer-based health insurance.

To assess these bills, the public might pose the following criteria:

1. Will the bills improve access to care?
    - How many people would become newly insured under the proposal?
    - Do the proposals improve coverage for people who currently have inadequate insurance, with high costs or limited benefits?
2. Will the bills improve efficiency in the health care system?
    - How much do the proposals cost the health system and how are those costs shared by the federal government, state and local governments, employers, and families?
    - Do the proposals pool health care risks broadly?
    - Do the proposals make enrollment easy and reduce the potential that people will experience gaps in coverage?
3. Will the bills improve equity in the health system?
    - Do the proposals improve equity in access to health care?
    - How do the bills affect family health care spending across the income spectrum?
4. Will the bills improve the quality of care in the health system?
    - Is the insurance system organized to ensure the delivery of higher-quality care?
    - Are there specific provisions aimed at improving quality?

To help answer these questions, The Lewin Group used its Health Benefits Simulation Model to estimate the number of people who would gain coverage under the bills and what the bills' effects would be on national health care expenditures overall and on principal stakeholders, including federal and state governments, employers, and households. All estimates are for 2007 and are based on the assumption of full implementation in 2007. Lewin projects that, under current law, the number of uninsured in the United States will rise to 47.8 million people in 2007 out of a total estimated population of 295.1 million, so that 16.2 percent of the total population will be uninsured. This represents an increase from 46.6 million uninsured people in 2005, or 15.9 percent of the total population, the latest estimate from the Current Population Survey.

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

BILLS THAT WOULD FUNDAMENTALLY REFORM THE HEALTH INSURANCE SYSTEM

Members of Congress and President Bush have proposed fundamental reforms to the health insurance system (Figure 1). They include:

Figure 1. Major Features of Health Insurance Expansion Bills and Impact on Uninsured, National Expenditures

	President Bush's Tax Reform Plan	Healthy Americans Act[2]	Federal/State Partnership 15 States	AmeriCare
Aims to Cover All People		X		X
Individual Mandate or Auto Enrollment		X	X	X
Employer Shared Responsibility		X	X	X
Public Program Expansion			X	X
Subsidies for Lower Income Families		X	X	X
Risk Pooling		X	X	X
Comprehensive Benefit Package		X	X	X
Quality & Efficiency Measures	X	X	X	X
Uninsured Covered in 2007[1] (in millions)	9.0	45.3	20.3	47.8
Net Health System Cost in 2007 (in billions)	($11.7)	($4.5)	$22.7	($60.7)
Net Federal Budget Cost in 2007 (in billions)	$70.4	$24.3	$22.0	$154.5

[1]Out of an estimated total uninsured in 2007 of 47.8 million.
[2]Estimates reflect a mandatory cash-out of benefit on the part of employers that currently offer coverage.
Source: The Lewin Group for The Commonwealth Fund.

- health insurance tax deduction and tax on employer contribution to health insurance (President Bush);
- regional insurance exchanges (Senator Wyden);
- federal–state partnerships to expand health insurance (Senators Bingaman and Voinovich, Representatives Baldwin, Tierney, and Price);
- coverage through Medicare (Representative Stark, Senator Kennedy, Representative Dingell).

Health Insurance Tax Deduction and Tax on Employer Contribution to Insurance Premiums

In his fiscal year 2008 budget, President Bush proposes to end the current tax exemption for employer-provided health benefits, and instead provide personal income tax deductions for people who buy insurance coverage. People could continue to receive coverage through their employers or buy coverage on the individual insurance market. For the first time, health benefits offered through an employer would be counted as

taxable income and people purchasing coverage through the individual insurance market would receive a tax break on their insurance.

President Bush, Fiscal Year 2008 Federal Budget

Overall Approach: People with health insurance could deduct the first $7,500 of their income if they had a single policy and $15,000 if they had a family health plan, whether they obtained their coverage through an employer or purchased it through the individual insurance market. Health benefits offered through an employer would be counted as taxable income, but the first $7,500 or $15,000 would be tax deductible. The amount of premiums over the cap would be taxed as wage income.

Benefit Package: People with private health insurance would qualify for the deduction.

Eligibility: Anyone with health insurance and who paid taxes would be able to claim a tax deduction.

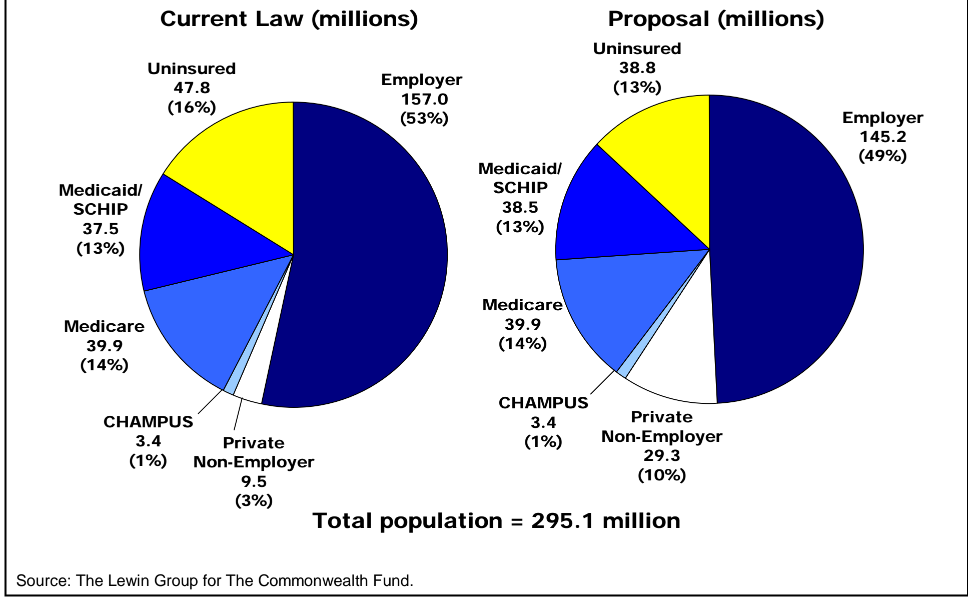
Affordability: The premium cap would rise annually by the rate of growth in consumer price inflation.

Lewin Group Estimates of Coverage and Costs in 2007
Under President Bush's FY 2008 Budget

Number of uninsured covered	9.0 million
Remaining uninsured	38.8 million
Net costs	
Total health spending	($11.7 billion)
Federal	$70.4 billion
State and local	($0.3 billion)
Employers	($50.8 billion)
Household	($31 billion)

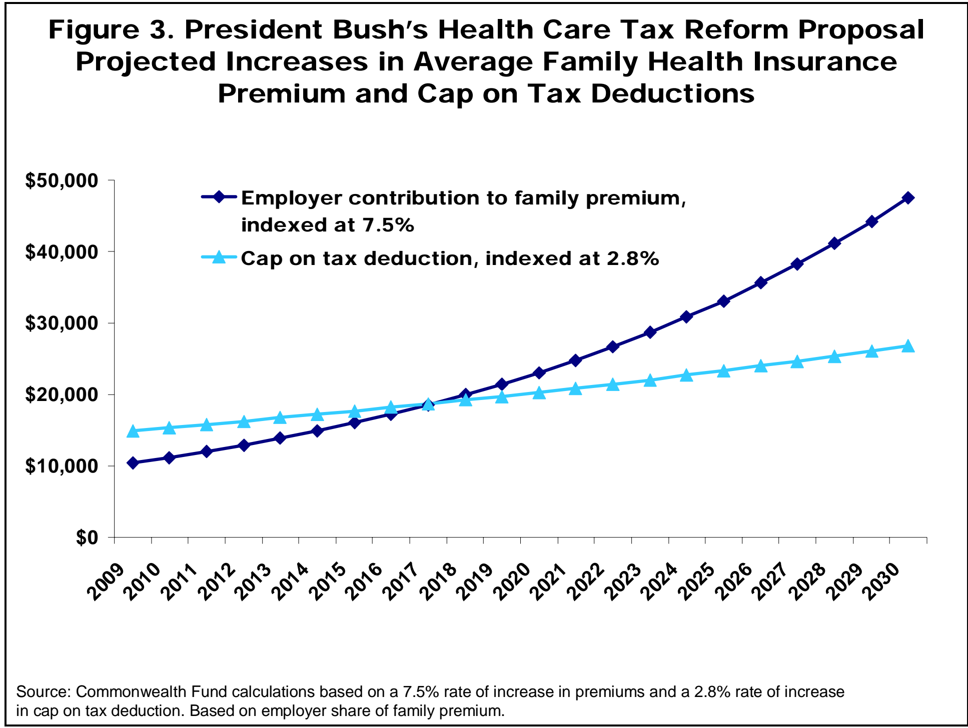
What the Estimates Mean

The Lewin Group estimates that about 9 million people would gain health insurance coverage under President Bush's proposal in 2007 (Figure 2). Because the income tax deduction does not vary by income, it is most valuable to those in higher income tax brackets. Consequently, although the largest concentration of uninsured people in the United States is in families with low incomes, the tax deduction would have the biggest impact on the uninsured among higher-income families. Lewin estimates that just 3.8 percent of uninsured people in families with incomes less than $10,000 would gain coverage, compared with 39 percent of those in families with annual incomes in excess of $100,000.[5]



In addition, since the tax deduction would be indexed to consumer price inflation, assumed to be about 2.8 percent per year, rather than the estimated growth in employer health insurance premiums of about 7.5 percent, the proposal might have a larger impact on reducing the number of uninsured people in the first years of the proposal than it would in future years, when premiums are more likely to exceed the deduction and thus be more expensive to families (Figure 3).[6] Households would pay more for their insurance in the future since the value of the deduction erodes. This effect might be exacerbated if more employers drop coverage in future years, leaving more people without an affordable coverage option.

Providing an equivalent capped income tax deduction for insurance gained through employers or through the individual market provides some employers—particularly small employers whose health care costs are higher on average—with an incentive to drop coverage since their employees would receive the same tax deduction for their benefits in the individual market. Lewin estimates that about 12.8 million workers and their dependents would lose coverage through their employers in the first year, but this number could grow over time if more employers dropped coverage. Of those losing employer coverage, 2.3 million would become uninsured, 1.0 million would enroll in Medicaid or SCHIP, and 9.5 million would purchase coverage on the individual insurance market. Altogether, the number of people covered in the individual market is estimated to increase by 19.8 million.



Household spending on health care is estimated to fall by a net $31 billion (Figure 4). Lewin estimates that families would spend more on health insurance premiums, since more people would purchase coverage in the non-group market, where premiums are higher on average. Because more people would also likely have higher-deductible health plans in order to keep premium costs down, family out-of-pocket spending is also estimated to increase. These higher expenditures would be offset by reduced use of health services and income tax savings because of the tax deduction. But those savings disproportionately accrue to people in higher income brackets and to people who have health insurance. The Lewin Group estimates that families earning less than $10,000 a year would see their average spending on health care decline by $23 in 2007, while those earning $150,000 or more would realize savings in average spending of $1,263 (Figure 5).

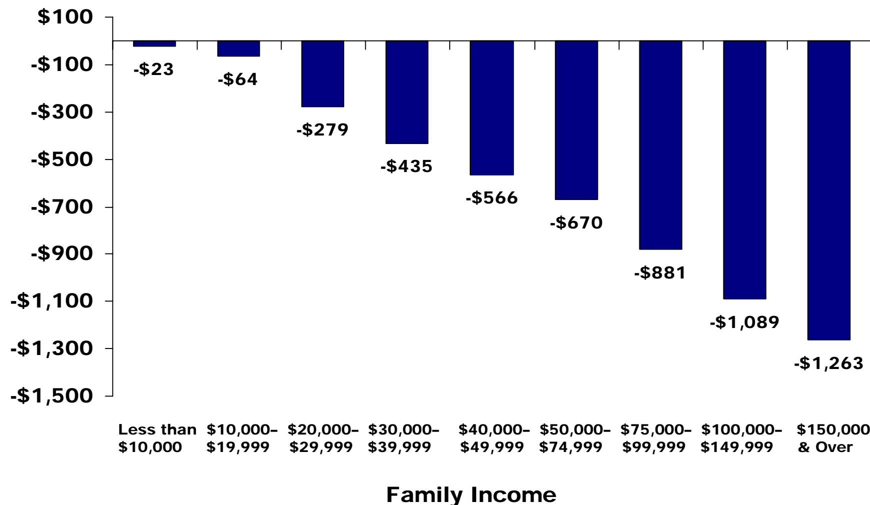
President Bush's proposal would increase the budget deficit by $70.4 billion in 2007 (Figure 4), but it would begin to generate a surplus in 2016.[7] This increase is driven primarily by tax revenue losses associated with the new tax deduction, which would be somewhat offset by new taxes on employer-provided benefits that exceeded the premium cap in 2007. However, since the premium cap would be indexed to consumer price inflation rather than the estimated growth in employer premiums, increasing numbers of families in the future would pay taxes on their employer health benefits. Thus, the revenue gain as a result of taxing employee benefits would grow more quickly than the losses associated with the tax deduction over time.[8]

Figure 4. Health Insurance Expansion Bills Change in Health Spending by Stakeholder Group, Billions of Dollars, 2007

	President Bush's Tax Reform Plan	Healthy Americans Act[2]	Federal/State Partnership 15 States	AmeriCare
Total Uninsured Covered, Millions	9.0	45.3	20.3	47.8
Federal Government	$70.4	$24.3	$22.0	$154.5
State and Local Government	($0.3)	($10.2)	$13.4	($57.4)
Private Employers	($50.8)	$60.2	$5.7	($15.2)
Households	($31.0)	($78.8)	($18.4)	($142.6)
Net Health System Cost in 2007 (in billions)	($11.7)	($4.5)	$22.7	($60.7)
Total Uninsured Not Covered,[1] Millions	38.8	2.5	27.5	0

[1]Out of an estimated total uninsured in 2007 of 47.8 million.
[2]Estimates reflect a mandatory cash-out of benefits on the part of employers that currently offer coverage.
Source: The Lewin Group for The Commonwealth Fund.

Figure 5. Change in Average Family Health Spending Under President Bush's Health Care Tax Reform Proposal in 2007, by Income Group



Source: The Lewin Group for The Commonwealth Fund.

Overall, The Lewin Group estimates that national health spending would decline by $11.7 billion. While there would be an increase in spending associated with more people gaining health insurance, this would be more than offset by the effect of higher

premium costs and out-of-pocket spending on health plan choices and use of services. Lewin assumes that, when people are faced with higher premiums, they would opt for lower-cost plans, including health maintenance organizations (HMOs), high-deductible health plans, or low-cost plans with limited benefits. Lewin assumes that HMO enrollment would lower costs by about 12 percent and high-deductible health plans would lower costs by about 4 percent. These savings would be somewhat mitigated by an increase in the costs of insurance administration, since so many more people would be insured in the individual market, where administrative costs as a share of premium are two to four times that of group coverage.[9] Insurance administration costs under the president's proposal are projected to increase by $5.5 billion dollars in 2007.

Regional Insurance Exchanges

Like President Bush's proposal, Senator Wyden's (D–Ore.) "Healthy Americans Act" (S.334) introduced in January 2007 would end the current tax exemption for employer-provided health benefits, and instead provide personal income tax deductions for people that buy insurance coverage. But Senator Wyden's proposal is different in that it would end employer-based coverage completely and create a large risk-pooling mechanism in the form of regional insurance exchanges, through which most people would purchase health insurance.

Senator Wyden's "Healthy Americans Act" (S.334)

Overall Approach: The full population, with the exception of people with Medicare or in the military, would choose from a set of health plans offered through regional insurance exchanges called "Health Help Agencies" (HHAs). The income tax exclusion for employer health benefits would be eliminated and employers that offer coverage would be required to pay the value of their health benefits as higher wages to workers in the first two years of the proposal; after that all employers would pay a share of worker's premiums. People would purchase their own health insurance through an HHA.

Benefit Package: A qualifying health plan would provide benefits at least equal in value to those of the Federal Employees Health Benefits Program (FEHBP) Blue Cross/Blue Shield Standard Plan; an actuarial equivalent HMO or health savings account (HSA)–qualified high-deductible health plan would be allowed.

Affordability: People with incomes at the federal poverty level or less would not pay a premium; those earning between 100 percent and 400 percent of poverty would pay premiums on a sliding scale. People can take a new standard deduction for health care costs, which will rise annually at the rate of consumer price inflation. The deduction is phased in for families with income between 100 percent and 400 percent of poverty and phased out for families with incomes between $125,000 and $250,000, with no deduction above $250,000. Cost-sharing is similar to that under FEBHP and would not apply to preventive services, screenings, chronic disease management, or chronic pain treatment. Carriers determine premiums based on adjusted or pure community rating.

Financing: For the first two years of the program, employers that offer coverage are required to pay wages to employees in lieu of premiums. Employers that don't offer coverage would pay an "Employer Shared Responsibility Payment" between 2 and 25 percent of the national average premium per employee, depending on firm size and revenues. After two years all companies would make this payment. The bill would also eliminate certain tax incentives for employers two years after enactment of the law.

Auto-Enrollment: People select the plan that meets their families' needs and their employer withholds the premium amount from their wages.

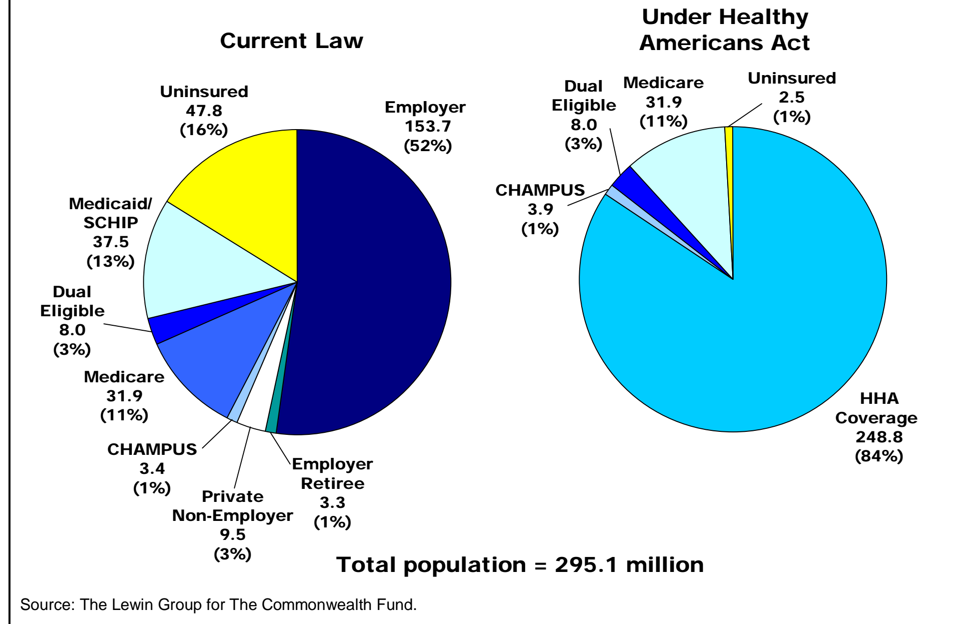
Efficiency and Quality Improvement: Each enrollee and Medicare beneficiary would have the opportunity to select a "health home" or a designated provider that monitors their health and health care. The plan would: establish a panel of experts to ensure that hospitals have state-of-the-art quality controls in place; help states make long-term care insurance simpler and more accessible; allow adjustment of Medicare Part B premiums to reward healthy behavior; establish a chronic care disease management program including payment of both primary and non–primary care physicians for management of chronic illness; and allow federal government to negotiate prescription drug prices with manufacturers under the Medicare Part D benefit, with savings going to close the coverage gap, or "doughnut hole," in the benefit.

Lewin Group Estimates of Coverage and Costs in 2007
Under the "Healthy Americans Act"

Number of uninsured covered	45.3 million
Remaining uninsured	2.5 million
Net costs	
Total health spending	($4.5 billion)
Federal	$24.3 billion
State and local	($10.2 billion)
Employers	$60.2 billion
Household	($78.8 billion)

What the Estimates Mean

The Lewin Group estimates that, under the Healthy Americans Act, 45.3 million people would become newly insured through Health Help Agencies (HHAs) in 2007 (Figure 6). In addition, everyone currently insured under their employer plans, Medicaid, SCHIP, or private non-group coverage also would become enrolled in the new program. People with coverage through Medicare and the military as well as those dually eligible for Medicare and Medicaid would retain their current coverage. Enrollment in HHAs would total 248.8 million in 2007.



Lewin estimates that under the Healthy Americans Act the federal government's expenditures on health care would climb by a net $24.3 billion in 2007 (Figure 4). Total federal costs (before offsets) for the program include those for benefits ($760 billion), the cost of the new income tax deduction for premiums ($148 billion), the costs of private insurance administration and profits ($26 billion), the administration of the HHAs ($25 billion), and the administration of premium collections and subsidies through the tax code ($2 billion). These costs would be offset by household premiums net of premium subsidies ($514 billion), premium payments from employers ($89 billion), savings from Medicaid, disproportionate share payments, state payments for savings realized by the elimination of Medicaid (state maintenance of effort payments) ($172 billion). Because the law requires that employers who offer coverage "cash-out" their employee premium contributions as wages in the first two years of the program, workers would have to pay new taxes on the value of those benefits that exceeded the deductible amount. This would have the effect of increasing income tax revenues for the federal government by $96 billion and Social Security and Medicare taxes by $65 billion.

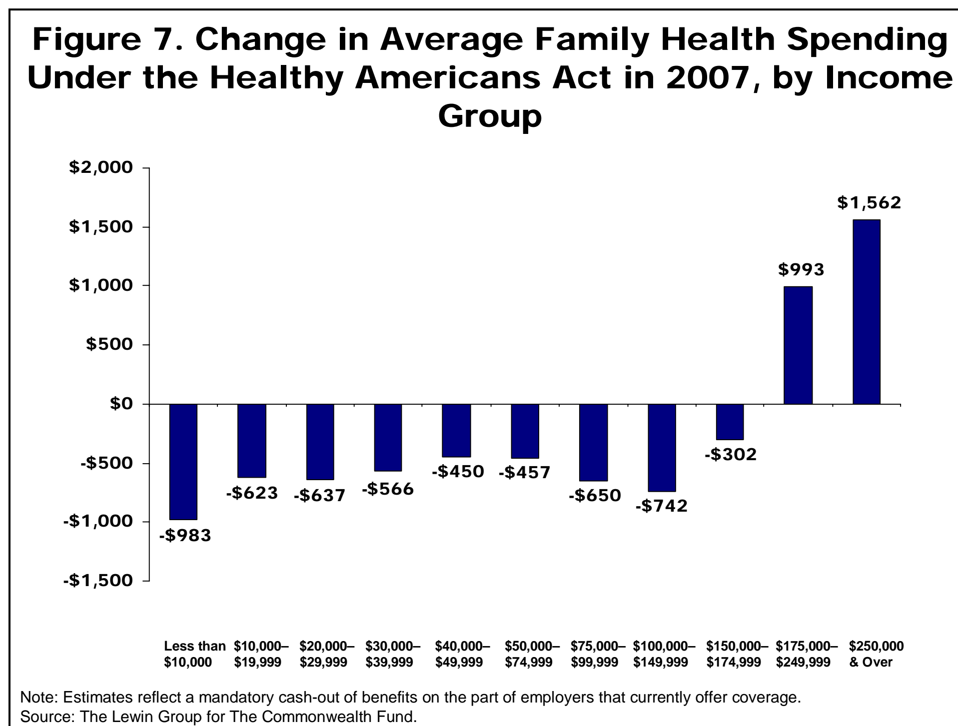
State and local spending on health care would decline by a net $10.2 billion. These savings are primarily the result of a decline in uncompensated care at safety-net institutions.

Even though they have a substantially reduced role in the provision of health benefits, employers would continue to share in the costs of covering their workers. Employer spending on health care would climb by $60.2 billion in 2007 because of the

requirement that employers that do not offer coverage pay a share of their employees' premiums. Lewin assumed that employers with fewer than 50 employees would pay a fee equal to 2 to 20 percent of the national average premium per full-time employee. Employers with 51–200 workers would pay an additional 0.1 percent for each additional employee. Companies with 200 or more employees would contribute 17 to 25 percent of the average premium. Nonprofits, state and local governments, and companies reporting no revenues in the prior year would pay between 2 and 17 percent, depending on size. The total premium bill for employers is estimated to be $74 billion in 2007, along with the continuing costs of retiree benefits.

Lewin estimates that households in the aggregate would see their health care bill decline by $78.8 billion. But because of the premium subsidies and structure of the new standard tax deduction, spending would rise with income. Families earning less than $10,000 a year would see their average spending on health care decline by $983 per year (Figure 7). At the other end of the income scale, families earning $250,000 or more would see their spending costs climb by about $1,562 on average.

Figure 7. Change in Average Family Health Spending Under the Healthy Americans Act in 2007, by Income Group



Note: Estimates reflect a mandatory cash-out of benefits on the part of employers that currently offer coverage.
Source: The Lewin Group for The Commonwealth Fund.

National health expenditures are estimated to fall by a net $4.5 billion. Lewin assumes that new health care expenditures among newly insured people would be offset by incentives to decrease health care utilization among both the currently insured and uninsured. Because people would face the full price of the premium, albeit with premium subsidies and tax deductions for most, people would choose lower-cost products. Lewin

thus assumes that most people would select HMOs and estimates a consequent reduction in spending of about $55 billion.

An additional source of savings in national health care expenditures is reductions in the cost of insurance administration. Like President Bush's proposal, Senator Wyden's bill would encourage non-employer-provided coverage, creating new group regional purchasing pools and imposing restrictions on individual underwriting. The regional pools, established and administered by the HHAs, would be expected to pool risks far more broadly than does the individual insurance market. Thus, while the insurance administration costs under the president's proposal are projected to increase by $5.5 billion dollars in 2007, the same costs in the Wyden plan would drop by $30 billion, even after accounting for the new administrative costs of the HHAs and the cost of administering subsidies.

Bills That Create Federal–State Partnerships to Expand Health Insurance

Several states have passed or are considering new laws to expand health insurance to their residents. Maine led the way with its Dirigo Health Plan in 2003. In April 2006, state leaders in Massachusetts marshaled bipartisan consensus to pass a landmark law that requires everyone to have health insurance and uses a public insurance expansion and a new "Connector" based on the small group and individual markets to expand health insurance opportunities for all. Vermont followed in May 2006 with its "Health Care Affordability Act," which targets those without access to work-based coverage and provides premium subsidies based on a sliding scale up to three times the federal poverty level. In early January, Governor Schwarzenegger announced a sweeping new initiative to cover California's 6.5 million uninsured residents in which costs would be shared by employers, individuals, government, and health care providers. The United Hospital Fund and The Commonwealth Fund recently released a blueprint with options for implementing universal health insurance in New York State.[10] And most recently Governor Blagojevich of Illinois announced a proposal that would build on his 2006 children's coverage initiative by expanding the Illinois FamilyCare program and creating a new, affordable private source of insurance for small businesses and families without employer-based health benefits called Illinois Covered Choice.

Several congressional bills seek to underscore the momentum building at the state level to expand health insurance through the provision of grants to states that propose promising plans (Figure 1). Senators Voinovich (R–Ohio) and Bingaman (D–N.M.) introduced the "Health Partnership Act" (S.2772) in May 2006. In July 2006, Representative Baldwin (D–Wis.) introduced a companion bill, "Health Partnership Through Creative Federalism Act" (H.R. 5864), cosponsored by Representative Tom Price (R–Ga.) and Representative John Tierney (D–Mass.). Senator Bingaman

reintroduced his bill, cosponsored by Senator Voinovich (S.325), and Representative Baldwin reintroduced her bill, cosponsored by Representatives Price and Tierney (H.R.506), in January 2007. Senators Feingold (D–Wis.) and Graham (R–S.C.) are planning to introduce the "State-Based Health Care Reform Act" this spring.

Health Partnership Act/Health Partnership Through Creative Federalism Act/ State-Based Health Care Reform Act (for more detail see Table A-1)

Overall approach: Establishes a State Health Innovation Commission, or Task Force in the Feingold-Graham bill, to oversee demonstration grants to regions, states, or local governments to expand health insurance coverage and improve health care quality and efficiency. The commission would provide states with reform options, which might include a range of coverage strategies including expansion of public programs, tax credits, purchasing pools, buy-ins to state and federal employee benefit programs, risk pools, single payer systems, health savings accounts, or other alternatives. The House bill would not require states to propose the listed options, but the list of recommendations sent to Congress would have to reflect a range of approaches. The Feingold-Graham bill would leave it to the states to propose approaches to expand coverage. States are prevented from changing eligibility criteria for state public insurance programs and must maintain the same level of expenditures for health care coverage prior to the grant. States must provide a five-year target for reducing the number of uninsured and estimates of the percentage of uninsured that would receive coverage. The commission or task force would review state applications and determine grant amounts and submit to Congress a list of recommended applications and requests for grant funding.

Benefits package: States must submit a minimum benefits package, which cannot exclude preexisting conditions. The House bill suggests that minimum benefits package be equivalent to a benchmark package specified under SCHIP. The Feingold-Graham bill specifies SCHIP as the minimum standard.

Affordability: The Feingold-Graham bill specifies protections for lower-income families including no premiums for families in poverty and cost-sharing not to exceed 0.5% of income; families 100%–200% of poverty would pay no more than 3% of their income on premiums and no more than 5% on premiums plus cost-sharing; families 200%–300% of poverty would pay no more than 5% of income on premiums and no more than 7% on premiums plus cost-sharing.

Financing: States whose proposals receive congressional approval would receive federal grants, the size of which would be determined and requested from Congress by the commission or task force. The House bill requires that a slate of proposals approved in a given year not increase the federal budget collectively at the end of the five-year period. The Feingold-Graham bill allocates $32 billion in funding for grants over 10 years, with a set of suggested spending offsets.

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

How Federal–State Partnerships Might Expand Coverage: An Example

The state–federal partnership bills introduced to date would request proposals from States for demonstrations to expand health insurance. By definition, the bills do not provide sufficient details to permit cost and coverage estimates like those performed for other bills in this report. In order to illustrate how a state–federal partnership might work and what the federal and state cost might be if the federal government helped finance expansions of coverage to lower income families, The Lewin Group assumed a hypothetical model for this set of bills. Lewin assumed that 15 states would propose coverage plans based on a blended version of Massachusetts's Commonwealth Care and Governor Schwarzenegger's proposal for California. In addition to California and Massachusetts, states were selected to provide regional and population diversity, variation in numbers of uninsured residents, and a range of income eligibility limits in Medicaid and SCHIP. The 15 states are: Arizona, California, Georgia, Illinois, Iowa, Kansas, Louisiana, Massachusetts, Montana, New Mexico, New York, North Carolina, Ohio, Texas, and Wisconsin. Lewin assumed that each state would expand SCHIP for children in families with incomes up to 300 percent of poverty and Medicaid to adults to 100 percent of poverty and allow adults with incomes between 100 and 300 percent of poverty to buy in to a blended small group and individual market "connector," based on premium contributions that increase with income. People with incomes above that would pay the full premium, but their costs in excess of 10 percent of income would be subsidized. Small employers with fewer than 50 employees could also buy coverage through the connector. All state residents would be required to have insurance and employers with more than 10 workers would be required to offer comprehensive coverage and contribute at least 65 percent of the premium, or pay 4 percent of payroll into a state fund.

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

It is important to note that Representative Baldwin's bill would require that a set of approved applications in a given year be budget-neutral at the end of their five-year demonstration period—i.e., they would not collectively increase federal expenditures at the end of five years. Under the bill, states would be selected by a commission from among competing applicants, and successful states would need to develop supplementary measures that improve efficiency. New budget costs would be offset with new revenues or offsetting savings from other provisions. Senators Feingold and Graham would allocate $32 billion over 10 years for state demonstrations to expand coverage, in combination

with a set of proposed offsets to federal spending. The bill would also require that states provide matching funds.

Lewin Group Estimates of Coverage and Costs in 2007
Under a Federal–State Partnership to Expand Health Insurance

Number of uninsured covered in the 15 states (out of 23.6 million currently uninsured)	20.3 million
Remaining uninsured in the 15 states	3.3 million
Remaining uninsured nationally	27.5 million
Net change in costs in 2007	
Total health system	$22.7 billion
Federal	$22.0 billion
State and local	$13.4 billion
Employers	$5.7 billion
Household	($18.4 billion)

What the Estimates Mean

For the hypothetical, blended California-Massachusetts approach that The Lewin Group modeled in the 15 states, 23.6 million people are estimated to be uninsured in 2007, about half of the total number of people without coverage nationally. Lewin estimates that, under the hypothetical program, 20.3 million of those would become newly insured (Figure 8). Of those gaining coverage, nearly 10 million would buy plans through the newly established insurance connectors in each state, 3.7 million would gain employer coverage, and 6.7 million would enroll in Medicaid and SCHIP (data not shown). Overall, 11.7 million people in the 15 states are estimated to buy coverage through connectors, Medicaid and SCHIP enrollment would grow by 7.3 million, employer-based coverage would grow by more than 4 million people, and the number of people enrolled in the individual non-group market would decline by 2.7 million (Figure 8).

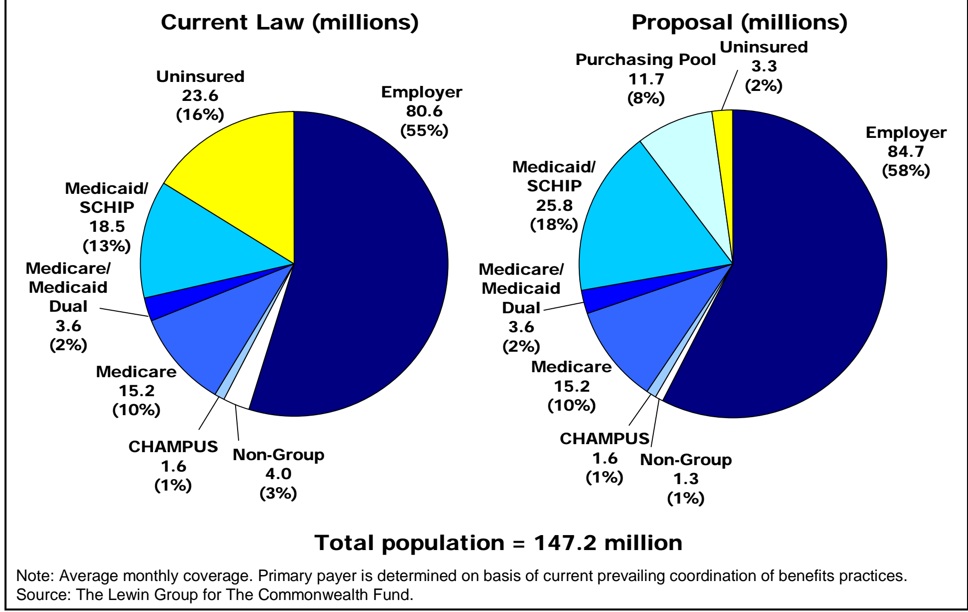


Figure 8. U.S. Population by Primary Source of Coverage Under Current Law and the 15-State Scenario in 2007: For Affected States Only (millions)

Note: Average monthly coverage. Primary payer is determined on basis of current prevailing coordination of benefits practices.
Source: The Lewin Group for The Commonwealth Fund.

The net costs to the federal government under the hypothetical program in the 15 states are estimated to be $22 billion in 2007, unless offset by identified savings (Figure 4). This is mainly the result of the matching funds provided to states for the expansions to Medicaid and SCHIP, subsidized premiums for people who buy coverage through the connectors with incomes of less than 300 percent of poverty, and the cap on premiums that exceed 10 percent of income.

The 15 state governments are estimated to see a net increase in spending of $13.4 billion in 2007 under the program. This increase is driven by the increase in Medicaid and SCHIP enrollment (offset by the federal share of those costs) and the state share of the premium subsidies and cap in the connectors. State costs would also be offset by tax revenues from those employers that do not offer coverage and savings to safety-net institutions.

Lewin estimates that employers in the 15 states would incur a net increase in costs of $5.7 billion. Among previously insuring firms, new costs would be associated with covering workers who previously had declined coverage or had not been eligible for employer plans, such as part-time workers. A few mainly lower-wage firms would drop coverage so their employees could take full advantage of the new subsidies available through the connectors. Non-insuring firms would see their costs increase by the amount of the new payroll tax.

Health spending by families in the 15 states is estimated to decline in the aggregate by $18.4 billion. Premium expenditures decline in the aggregate as a result of the premium subsidies and cap. Further, with more people covered under more comprehensive plans, overall out-of-pocket spending declines.

The Lewin Group estimates national health expenditures would increase by a net $22.7 billion in 2007. This is primarily driven by new health care use by previously uninsured and underinsured families. Because many people receive coverage through the connector, a blend of small group and individual insurance markets, the costs of insurance administration are projected to rise by $1.9 billion. The provision of premium subsidies is estimated to increase administrative costs by an additional $1.4 billion.

Coverage Through Medicare

People of all ages would be eligible to enroll in the Medicare program under three bills introduced in 2006. Senator Kennedy (D–Mass.) and Representative Dingell (D–Mich.) introduced the "Medicare for All Act" in January and February 2006 (S. 2229 and HR 4683) and Representative Stark (D–Calif.) introduced the "AmeriCare Health Act of 2006" (HR 5886) in July 2006. The Lewin Group estimated the coverage and cost impact of Representative Stark's bill (Figure 1).

AmeriCare Health Act of 2006/Medicare for All Act
(for more detail see Table A-2)

Overall Approach: Open Medicare to everyone with choice of health plan. Under the Stark bill, employers with 100 or more employees would either offer their employees coverage or pay into a fund to cover their employees through the program. Under the Kennedy and Dingell bills, employers and their employees would help finance the expansion through new payroll taxes.

Benefits Package: Enrollees could have two choices: 1) Fee-for-service option under Medicare Parts A and B, enhanced with additional benefits such as pregnancy-related services and well-child care and the drug benefits package similar to that in the most popular Federal Employees Health Benefits Program (FEHBP) plan; and 2) a choice of private plans that contract with the federal government as in FEHBP with a minimum benefit package equivalent to FEHBP plans or Medicare Part C.

Cost-Sharing: Under Stark bill, deductibles would be $350 for individuals and $500 for families; 20 percent coinsurance; out-of-pocket cap of $2,500 for individuals and $4,000 for families; premiums determined by HHS.

Affordability: Under the Stark bill, no cost-sharing for children and young adults under age 24, pregnant women, and people with income under 200 percent of poverty. People with income of less than 200 percent of poverty do not pay premiums. Families with incomes between 200–300 percent of poverty would receive a premium subsidy (modeling assumes 50%) and pay no more than 5 percent of income on total out-of-pocket spending, including premiums; families with incomes between 300 percent–500 percent

of poverty would pay no more than 7.5 percent of income on total out-of-pocket costs, including premiums.

Financing: Establishes new Trust Fund modeled on Medicare Trust Fund. Under the Stark bill, employers of 100 or more employees would either offer their employees coverage and pay 80 percent of their premiums or pay 80 percent of the AmeriCare premium into the Trust Fund, with employees paying remaining 20 percent. States would contribute what they would have contributed to Medicaid and SCHIP into the Trust Fund. Under the Kennedy and Dingell bills, employers would pay a 7 percent payroll tax and employees pay 1.7 percent wage tax, both of which go to the Trust Fund.

Automatic Enrollment: People are automatically enrolled at birth. Under Stark bill, people with employer coverage with equivalent benefits can opt out of AmeriCare.

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

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

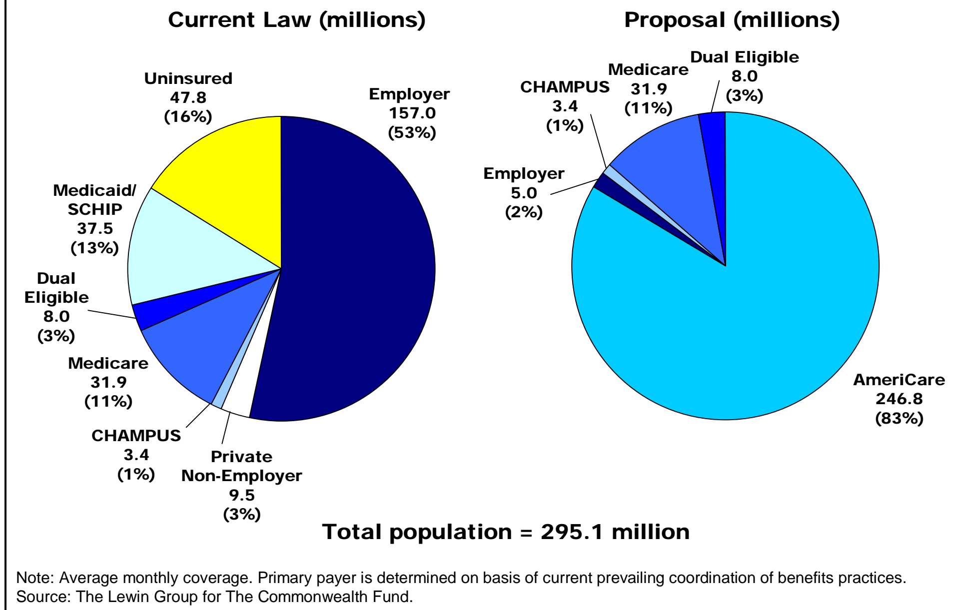
Lewin Group Estimates of Coverage and Costs in 2007
Under the "AmeriCare Health Act"

Number of uninsured covered in 2007 (Stark bill)	47.8 million
Remaining uninsured (Stark bill)	0
Net change in costs in 2007	
Total health spending	($60.7 billion)
Federal	$154.5 billion
State and local	($57.4 billion)
Employers	($15.2 billion)
Household	($142.6 billion)

What the Estimates Mean

The Lewin Group assumed that all people currently uninsured and with individual health insurance would become enrolled in AmeriCare and would not be able to opt out. Under these assumptions, the bill would achieve universal coverage (Figure 9). Lewin also assumed that all employers would ultimately stop offering health insurance such that most people under age 65 become insured through AmeriCare: 246.8 million people eventually become enrolled in the program (Figure 9).

Figure 9. Distribution of People by Primary Source of Coverage Under Current Law and the AmeriCare Health Act in 2007



Note: Average monthly coverage. Primary payer is determined on basis of current prevailing coordination of benefits practices.
Source: The Lewin Group for The Commonwealth Fund.

The costs to the federal government from the expansion and enhanced benefits to existing Medicare beneficiaries would be $154.5 billion in 2007 (Figure 4). Lewin assumed that the benefits and effect of drug price negotiation would also extend to current Medicare beneficiaries.

There are potentially large estimated savings to the overall health system from insuring everyone through Medicare. The Lewin Group estimates that overall national health care spending would decline by nearly $61 billion in 2007 (Figure 10). This is driven in part by a substantial savings in the costs of administering health insurance by enrolling everyone in a single risk pool: the total costs of health insurance administration in the United States would decline by $73.9 billion in 2007. Even now, Medicare has significantly lower administrative costs per premium dollar than employer or individual market insurance—2 percent compared with approximately 10 percent for employer group coverage and 25 percent to 40 percent for the individual insurance market.[11]

Figure 10. Changes in National Health Spending Under the AmeriCare Health Act in 2007 (in Billions)

Change in health services expenditures		**($4.2)**
Change in utilization for newly insured	$51.0	
Change in utilization due to improved coverage	$3.1	
HHS negotiated Rx discounts	($33.9)	
Reimbursement Effects	($24.4)	
Payments for uncompensated care	$21.8	
Medicare Payment Rates	($62.4)	
Increased cost shifting[1]	$16.2	
Change in administrative costs		**($56.5)**
Insurance administration	($73.9)	
Administration of subsidies[2]	$17.4	
Total Change in Health Spending		**($60.7)**

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

Additional declines in spending arise from allowing the federal government to negotiate discounted prescription drug prices for enrollees. The Lewin Group estimates that this provision would amount to a decline in national spending on prescription drugs of $33.9 billion in 2007 (Figure 10). This is based on the assumption that the government would negotiate prices for AmeriCare and Medicare and that those prices would ultimately fall midway between current average Medicaid prescription drug prices and those currently negotiated on behalf of federal programs.

In addition, paying all providers Medicare rates would lower national spending by an additional $62.4 billion in 2007. This is based on estimated differences in provider payment levels that existed in 2006 between Medicaid, Medicare, and private payers: Medicaid hospital payment rates are approximately 98 percent of Medicare rates and Medicaid physician rates are 69 percent of Medicare rates. In contrast, private payers reimburse hospitals on average 135 percent of Medicare rates and physicians 120 percent of Medicare rates.[12]

Households would see a dramatic drop in health care expenditures of $142.6 billion, with the largest savings falling to families with low and moderate incomes (Figure 11). This results both from people becoming insured as well as the new protection from out-of-pocket costs and premiums that would benefit families who are currently insured but who have high out-of-pocket costs and premiums relative to their incomes. If the

federal government were to finance the program in part through higher taxes, household savings might be less. Because the Medicaid and SCHIP programs are rolled into AmeriCare, states would see a decline in costs of $57.4 billion per year.

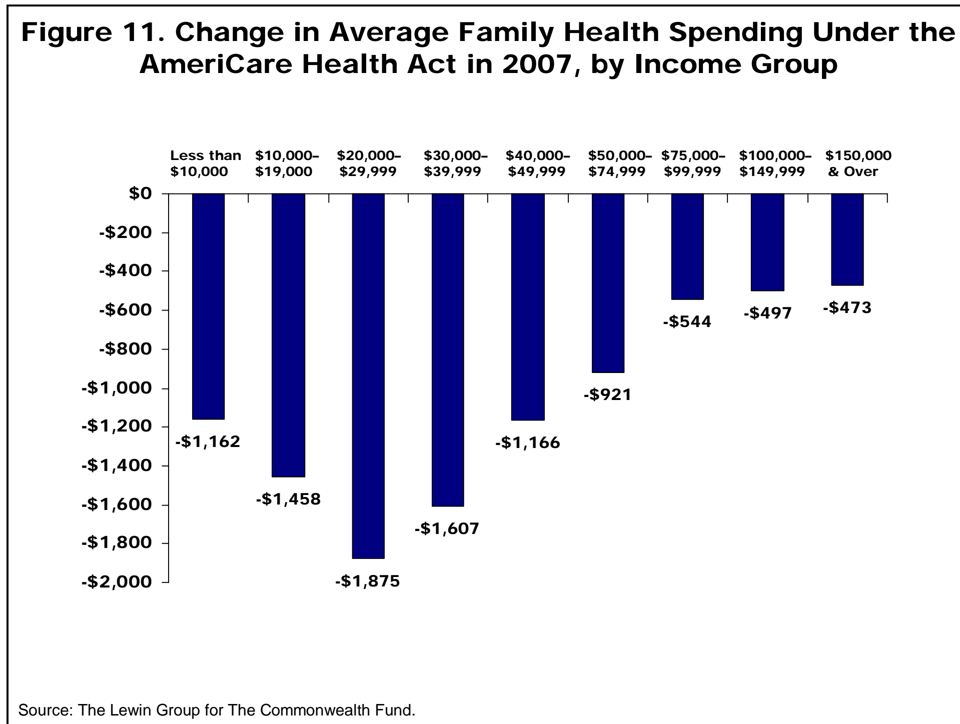


Figure 11. Change in Average Family Health Spending Under the AmeriCare Health Act in 2007, by Income Group

BILLS THAT EXPAND EXISTING PUBLIC INSURANCE PROGRAMS

Several members of Congress introduced bills that seek to expand health insurance coverage by building on Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP) (Figure 12). They include:

- Medicare buy-in for older adults (Representative Stark);
- elimination of the Medicare two-year waiting period for people who are disabled (Senator Bingaman and Representative Green);
- universal coverage for children (Senator Kerry, Representative Waxman, Senator Rockefeller, Representative Stark); and
- Medicaid expansions (Representative Dingell, Senator Lincoln, Representative Snyder).

Figure 12. Major Features of Health Insurance Expansion Bills and Impact on Uninsured, National Expenditures

	Medicare Buy-In	Eliminate Medicare 2-yr Waiting Period	Universal Coverage for Children	Medicaid/ SCHIP Children & Parents
Aims to Cover All People				
Individual Mandate or Auto Enrollment				
Employer Shared Responsibility	X			
Public Program Expansion	X	X	X	X
Subsidies for Lower Income Families	X		X	
Risk Pooling	X	X	X	X
Comprehensive Benefit Package	X	X	X	X
Quality & Efficiency Measures			X	X
Uninsured Covered in 2007[1] (in millions)	3.5	0.3	5.2	6.2
Net Health System Cost in 2007 (in billions)	$4.9	($0.1)	$3.0	$7.5
Net Federal Budget Cost in 2007 (in billions)	$26.9	$9.1	$19.9	$12.7

[1]Out of an estimated total uninsured in 2007 of 47.8 million.
Source: The Lewin Group for The Commonwealth Fund.

Medicare Buy-In for Older Adults

Older adults ages 55–64 without coverage through an employer would be allowed to buy in to Medicare under the "Medicare Early Access Act of 2005" (HR2072) introduced in May 2005 by Representative Stark (D–Calif.) (Figure 12).

Medicare Early Access Act of 2005 (for more detail see Table A-3)

Overall Approach: Older adults who do not currently have coverage through an employer (other than COBRA or retiree health benefits), a public insurance program, or a public employee's health insurance program would be allowed to enroll in Medicare.

Benefits Package: Same as that available to Medicare beneficiaries. Employers providing retiree health benefits could provide wraparound benefits.

Cost-Sharing: Premiums based on national per-capita cost of services to older adults 55–64, with premiums varying by age; cost-sharing is same as in Medicare.

Affordability: Advanceable, refundable tax credits for up to 75 percent of premium cost. Employers that offer retiree benefits could pay the remaining 25 percent.

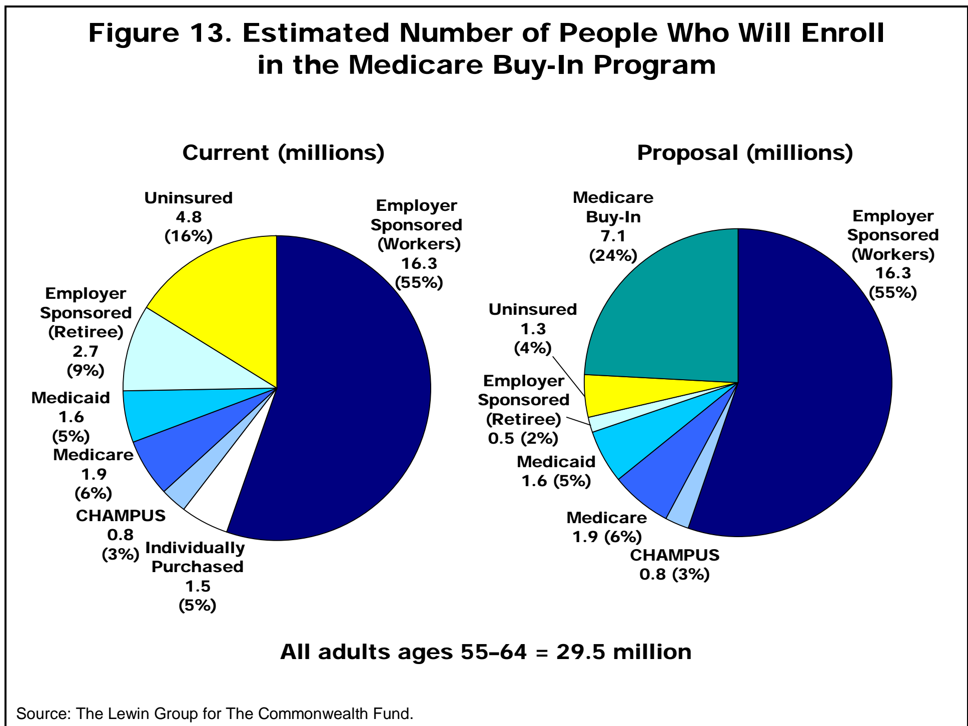
Financing: Medicare program would finance the coverage of those who become newly eligible.

Lewin Group Estimates of Coverage and Costs in 2007 Under the "Medicare Early Access Act"

Number of uninsured covered ages 55–64	3.5 million
Remaining uninsured	
Ages 55–64	1.3 million
All uninsured	44.3 million
Net change in costs in 2007	
Total health spending	$4.9 billion
Federal	$26.9 billion
State and local	($2 billion)
Employers	($9.4 billion)
Household	($10.6 billion)

What the Estimates Mean

There are an estimated 29.5 million people ages 55–64 in 2007. Of those, an estimated 4.8 million are uninsured, 1.5 million purchase insurance through the individual market, and 2.7 million are early retirees and receive retiree health benefits through their employer (Figure 13). Under a Medicare buy-in, The Lewin Group estimates that 3.5 million currently uninsured older adults would buy in to Medicare, all of the 1.5 million who are currently buying coverage in the individual market would buy in, and 2.1 million early retirees with employer health benefits would buy in, with wraparound coverage from their employer.



The cost to the federal government of the 75 percent premium subsidy for those who buy in to Medicare is estimated at $26.9 billion in 2007 (Figure 14). State and local governments might see savings of approximately $2 billion in that year because of a decline in uncompensated care at government-funded safety-net institutions. Employers who provide retiree health benefits would save $9.4 billion as a result of retirees buying into the program. And savings on premiums and out-of-pocket costs would reduce family spending on health care by $10.6 billion.

Figure 14. Health Insurance Expansion Bills Change in Health Spending by Stakeholder Group, Billions of Dollars, 2007

	Medicare Buy-In	Eliminate 2-yr Medicare Waiting Period	Universal Coverage for Children	Medicaid/ SCHIP Children & Parents
Total Uninsured Covered, Millions	3.5	0.3	5.2	6.2
Federal Government	$26.9	$9.1	$19.9	$12.7
State and Local Government	($2.0)	($3.0)	($8.2)	$3.2
Private Employers	($9.4)	($4.0)	($7.3)	($3.5)
Households	($10.6)	($2.2)	($1.5)	($4.9)
Net Health System Cost in 2007 (in billions)	$4.9	($0.1)	$3.0	$7.5
Total Uninsured Not Covered,[1] Millions	44.3	47.5	42.6	41.6

[1]Out of an estimated total uninsured in 2007 of 47.8 million.
Source: The Lewin Group for The Commonwealth Fund.

National spending on health care overall is estimated to increase by a net $4.9 billion in 2007 as a result of the program. Health care use would rise, increasing spending by $6.4 billion (data not shown). But the costs of insurance administration, because of Medicare's lower administrative costs relative to the individual and employer markets, are estimated to decline by $2 billion.

Elimination of the Medicare Two-Year Waiting Period for People Who Are Disabled

People who are unable to work because of a disability would eventually no longer have to wait 24 months before becoming eligible for Medicare under a bill introduced by Senator Bingaman (D–N.M.) and Representative Green (D–Texas) in June 2005 (Figure 12). "Ending the Medicare Disability Waiting Period Act of 2005" (S.1217 and H.R.2869) would phase out the waiting period by approximately two months per year by 2015 and

immediately eliminate it for people with life-threatening diseases (for more detail see Table A-3). For modeling purposes, The Lewin Group assumed that the bill would immediately eliminate the waiting period for everyone.

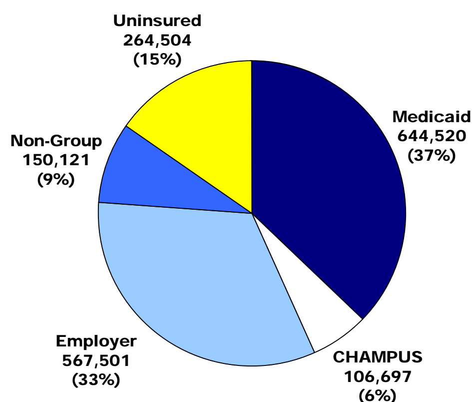
Lewin Group Estimates of Coverage and Costs in 2007
Under "Ending the Medicare Disability Waiting Period Act of 2005"

Number of uninsured covered	264,500 currently in waiting period
Remaining uninsured	47.5 million
Net change in costs in 2007	
Total health spending	($0.1 billion)
Federal	$9.1 billion
State and local	($3 billion)
Employers	($4.0 billion)
Household	($2.2 billion)

What the Estimates Mean

There are an estimated 1.7 million people who are disabled and currently in the waiting period for Medicare (Figure 15). Of those, about one-third have coverage through a former employer under COBRA or through a spouse's employer, just over a third are covered by Medicaid, 9 percent purchase coverage through the individual market, and 15 percent, or nearly 265,000 people, are without health insurance. The Lewin Group assumes that all of those in the waiting period would enroll in Medicare if the waiting period were eliminated. The cost to the federal government of those newly enrolled in Medicare would be about $9.1 billion in 2007 (Figure 13). This annual number might be expected to decline over time since there would be fewer people enrolling all at once and there would be less pent-up demand for health services as a result of being uninsured or underinsured during the waiting period. States are estimated to save about $3 billion in 2007. This is because Medicare would become the first payer for those currently enrolled in Medicaid, with Medicaid providing wraparound benefits. States also would save money from uncompensated care provided to those currently without insurance coverage. Employers currently providing benefits to early retirees in the waiting period would save about $4 billion as they move to Medicare. Households would see premiums and out-of-pocket spending decline by $2.2 billion. The overall effect of the change would be a decline in national health care spending of $100 million in 2007.

Figure 15. Disabled People in the Waiting Period for Medicare in 2007, by Source of Coverage



Total people currently in waiting period = 1,733,343

Note: Number of people in the waiting period was estimated using the number of SSDI awards to disabled workers, widowers and adult children in 2004 and 2005 from the Social Security Administration Annual Statistical Supplement (2005 and 2006).
Source: The Lewin Group for The Commonwealth Fund.

Universal Coverage of Children

All children under age 21 would have access to affordable health insurance coverage under four bills introduced in 2005, two of which were reintroduced in 2007. Senator Kerry (D–Mass.) and Representative Waxman (D–Calif.) introduced bills that would offer states incentives to expand Medicaid and SCHIP and require employers and carriers to offer dependent coverage, the "Kids Come First Act of 2005" (S. 114 and H.R. 1668). Both Senator Kerry and Representative Waxman reintroduced their bills in early 2007 (S. 95, H.R. 1111 "Kids Come First Act of 2007"). Senator Rockefeller (D–W.Va.) and Representative Stark (D–Calif.) introduced bills in 2005 that would create a program modeled after Medicare for all children: "MediKids Health Insurance Act of 2005" (S.1303 and H.R. 3055). The Lewin Group modeled Senator Kerry's and Representative Waxman's bills (Figure 12).

Kids Come First Act of 2007 (for more detail see Table A-4)

Overall Approach: Provides states with incentives to expand coverage for children up to age 21 in families with incomes up to 300 percent of poverty through Medicaid and SCHIP and to simplify enrollment procedures. The act would require group health plans and carriers providing group coverage to offer coverage for dependents up to age 21 and create a new refundable tax credit for coverage of dependent children. Any taxpayer, except those in the lowest tax brackets, whose children are uninsured would forfeit their personal tax exemption.

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

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

Benefits Package: Current Medicaid and SCHIP benefits.

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

Financing: Partial rollback of the tax cuts instituted since 2000 in the highest federal income tax bracket.

Auto Enrollment: People would have to demonstrate at tax filing coverage of dependent children.

Efficiency and Quality Improvement: To qualify for increased federal matching rates, states would have to agree to several measures that would remove enrollment and reenrollment barriers, including: adoption of 12-month continuous eligibility rules (i.e., eligibility for assistance under Medicaid and SCHIP could not be re-determined more than once every year for children); presumptive eligibility; allowing families to self-declare income; acceptance of eligibility determinations for other assistance programs such as Food Stamps and the School Lunch Program; not to require face-to-face interviews at enrollment or reenrollment; not to impose a waiting period prior to enrollment.

Lewin Group Estimates of Coverage and Costs in 2007 Under "Kids Come First Act"

Number of uninsured covered—Children under age 21	5.2 million
Remaining uninsured	
Children under age 21	5.9 million
All uninsured	42.6 million
Net change in costs in 2007	
Total health spending	$3 billion
Federal	$19.9 billion[13]
State and local	($8.2 billion)
Employers	($7.3 billion)
Household	($1.5 billion)[14]

What the Estimates Mean

The Lewin Group projects that there will be 11.1 million uninsured children under age 21 in 2007 (Figure 16). Of those, 68 percent are in families with incomes under 300 percent of poverty. Under the Kids Come First Act, Lewin estimates that 5.2 million, or 47 percent, of those uninsured children will gain coverage: 4.3 million will become enrolled

through Medicaid or SCHIP and 900,000 will enroll in private health plans (Figure 17). About 5.9 million children are estimated to remain uninsured.

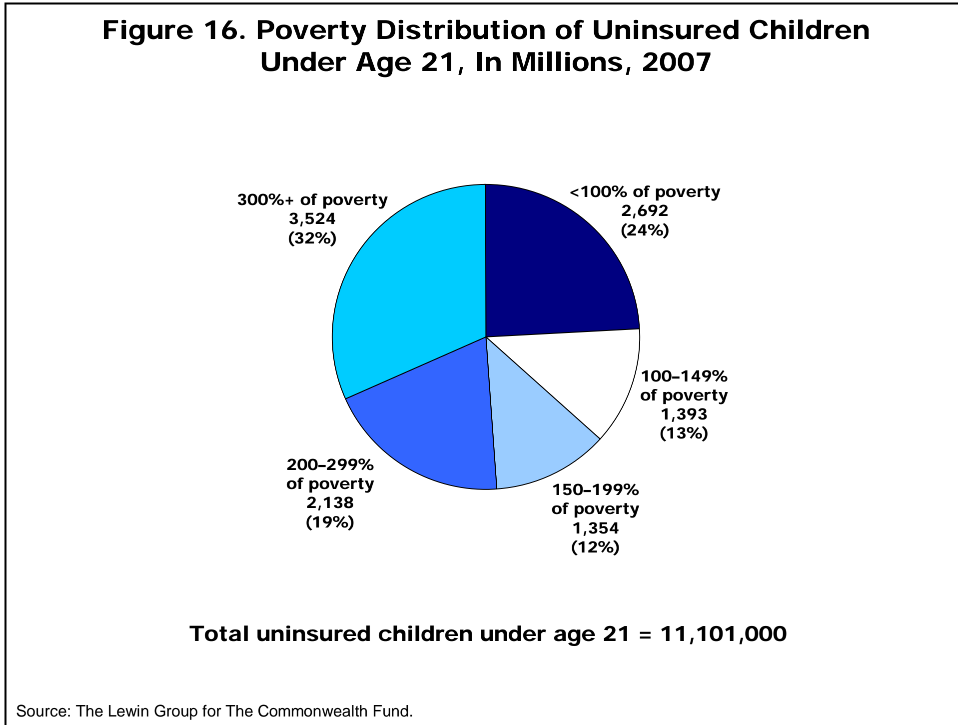


Figure 16. Poverty Distribution of Uninsured Children Under Age 21, In Millions, 2007

Source: The Lewin Group for The Commonwealth Fund.

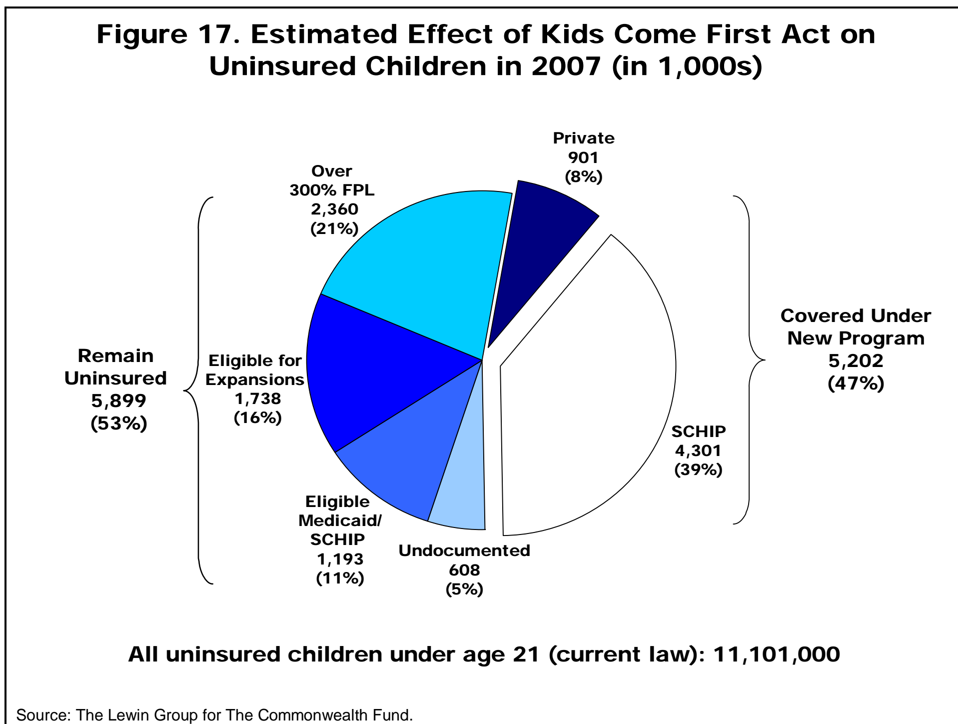


Figure 17. Estimated Effect of Kids Come First Act on Uninsured Children in 2007 (in 1,000s)

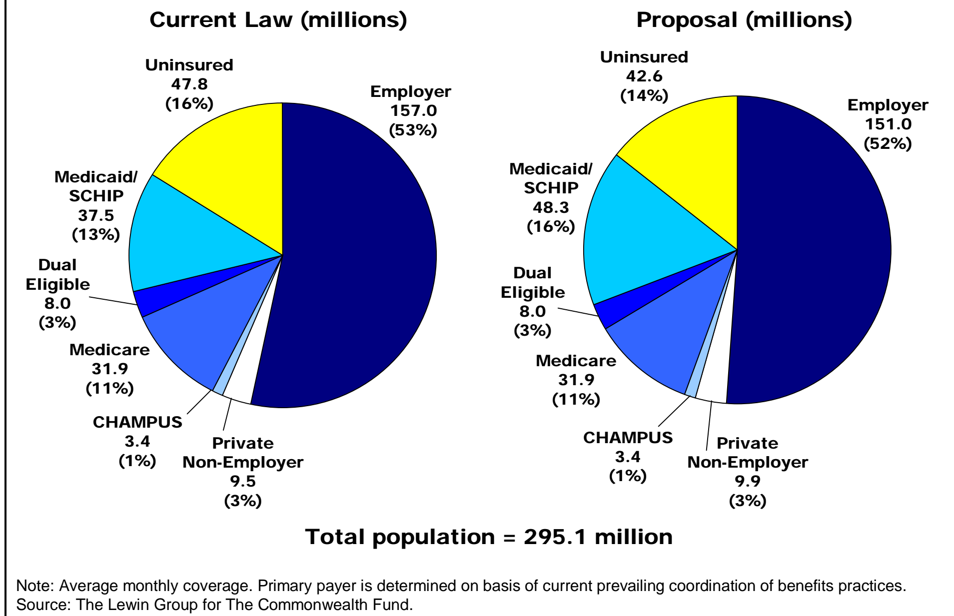
Source: The Lewin Group for The Commonwealth Fund.

Historically, complex application processes and onerous reenrollment rules in state public insurance programs have contributed to millions of children going without health insurance, or experiencing gaps in their health insurance, even though their families' incomes make them eligible for public coverage. The Kids Come First bill would institute several provisions aimed at simplifying enrollment and reenrollment processes in the programs (see Box and Table A-4). The Lewin Group estimates that these provisions would help enroll about 1.1 million children eligible for coverage (data not shown). Still, about 3 million children up to age 21 who would be eligible for Medicaid and SCHIP under the bill remain uninsured, accounting for about half of the remaining uninsured children (Figure 17). This finding points to the potential limits to expanding coverage by targeted approaches, in the absence of a more comprehensive system of health insurance coverage nationally. Under a system which provided options for the full population, enrollment into particular forms of coverage might be achieved more systematically.[15]

Among the 3.5 million uninsured children under age 21 in families with incomes over 300 percent of poverty, about 2.4 million would remain uninsured (Figure 17). The subsidy for dependent children in families above 300 percent of poverty is a refundable tax credit equal to the amount paid for qualified private health insurance that exceeds 5 percent of adjusted gross income. For many families with incomes close to 300 percent of poverty, the credit might be too small to substantially affect their decision to take up coverage. The Lewin Group estimates that about 30 percent of families would enroll their uninsured children in order to keep their personal tax exemptions.

Overall, enrollment in Medicaid and SCHIP would increase by 10.8 million children under age 21 (Figure 18). The Lewin Group estimates that about 6 million children with dependent coverage under employer plans would become enrolled in the expanded program.

Figure 18. Distribution of People by Primary Source of Coverage Under Current Law and the Kids Come First Act, 2007



Note: Average monthly coverage. Primary payer is determined on basis of current prevailing coordination of benefits practices.
Source: The Lewin Group for The Commonwealth Fund.

The Lewin Group estimates that the costs to the federal government in 2007 would be $20 billion (Figure 14). Senator Kerry would fund his proposal by partially or fully eliminating the Bush Administration's tax cuts of the last few years to income earners in the top tax bracket. This could have the effect of offsetting the estimated federal costs of the expansion by $18 billion in 2007 (data not shown).

Households would save about $1.5 billion in spending, mostly through reduced out-of-pocket costs for health care as their children gain coverage (Figure 14). The Lewin Group estimates that rolling back the tax cuts would offset such savings for those families in higher income tax brackets.

State and local governments could experience a drop in spending of about $8.2 billion in 2007 (Figure 14). This is primarily because the federal government would fully fund children in the Medicaid program in families with incomes of less than 100 percent of poverty, in exchange for expanding SCHIP and streamlining enrollment. The Lewin Group assumes that all states would do this and receive the new matching funds.

Employer costs could potentially decline as well, falling by an estimated $7.3 billion in 2007, reflecting the shift to the expanded program of children currently enrolled in employer plans.

National spending overall would increase by $3 billion in 2007 (Figure 14). This is driven by an increase in health care utilization from newly insured children as well as the costs of administering the subsidies for the program. But these new expenditures would be offset somewhat by savings from children receiving care from providers who are paid Medicaid rates, which are on average lower than private payment rates.

Expanding Medicaid and SCHIP Coverage to Families

Parents of children in Medicaid and SCHIP would become eligible for health insurance through Medicaid and a newly named FamilyCare program that would replace SCHIP under the "Family Care Act of 2005" introduced by Representative Dingell (D–Mich.) (HR2071) (Figure 12).

Family Care Act of 2005 (for more detail see Table A-4)

Overall Approach: Provides states with incentives to expand coverage for parents of children eligible for Medicaid and SCHIP as well as pregnant women. The federal government would fully finance the expansions for two years so long as states cover children in SCHIP up to 200 percent of poverty, simplify enrollment procedures, and set the income limit for parents at least as high as that for children. States would be eligible for enhanced federal financing for the expansions after the first two years.

State Options: States would have the option to provide coverage to children up to age 21 and legal immigrants who meet the expanded eligibility criteria.

Benefits Package: Current Medicaid and SCHIP benefits.

Affordability: No cost-sharing for pregnancy-related health care. Cost-sharing in FamilyCare is not to exceed 5 percent of income for the full family or pregnant women.

Financing: The federal government would appropriate $50 billion in new allotments for the Medicaid and SCHIP expansions over 2006–2013, though they would not apply to the expansion for parents. After that the annual amount allotted would rise by the increase in the medical care component of the Consumer Price Index. Costs exceeding the allotments would not be paid by the federal government.

Auto Enrollment: Children born to parents enrolled in FamilyCare would be automatically eligible for the program.

Efficiency and Quality Improvement: States would be required to adopt 12-month continuous eligibility rules for children and have the option to adopt these rules for adults (i.e., eligibility for assistance under Medicaid and SCHIP would not be re-determined more than once every year for children); apply presumptive eligibility to all those eligible; extend eligibility for families for up to 12 additional months (instead of the current six) for transitional medical assistance; provide information about Medicaid and FamilyCare and how to apply on applications distributed to families for the School Lunch Program.

Lewin Group Estimates of Coverage and Costs in 2007 Under the "Family Care Act"

Number of uninsured covered	6.2 million
Remaining uninsured	41.6 million
Net change in costs in 2007	
Total health spending	$7.5 billion
Federal	$12.7 billion
State and local	$3.2 billion
Employers	($3.5 billion)
Household	($4.9 billion)

What the Estimates Mean

Lewin estimates that about 7.7 million children, parents, and legal immigrants would enroll in the program, including 6.2 million who were previously uninsured (Figure 19). The number of uninsured parents would decline by 3.7 million and 2.4 million children would become newly insured (data not shown). Those newly insured children would include an estimated 550,000 children previously eligible for SCHIP but not enrolled, who would be enrolled as a result of their parents signing up as a family. About 1.2 million adults and children who currently have employer group coverage or private non-group insurance would enroll in FamilyCare.

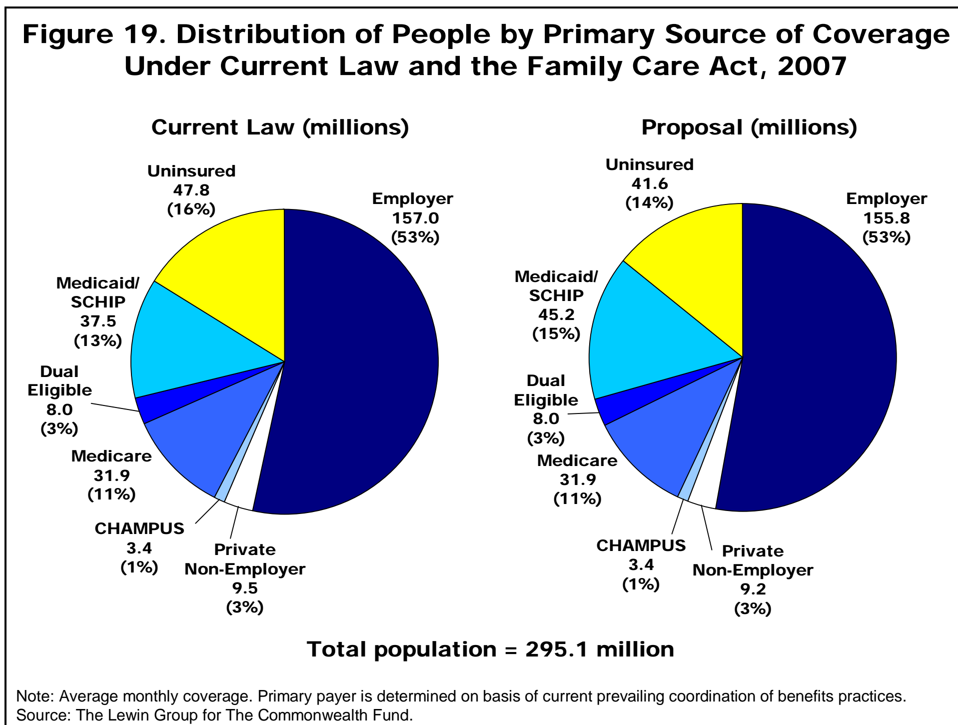


Figure 19. Distribution of People by Primary Source of Coverage Under Current Law and the Family Care Act, 2007

Note: Average monthly coverage. Primary payer is determined on basis of current prevailing coordination of benefits practices.
Source: The Lewin Group for The Commonwealth Fund.

Net federal spending under the new program is estimated to increase by $12.7 billion in 2007 as a result of the expansions (Figure 14). State and local government spending as a result of FamilyCare would rise by $5.2 billion, but would be offset by nearly $2 billion in savings to safety-net institutions and some savings from families covered in state employee benefit programs shifting to the new program where their costs are shared with the federal government. Similarly, employers would see a decline in spending of $3.5 billion as some families with employer coverage enroll in the new program. Savings in premiums and out-of-pocket costs for currently uninsured or underinsured parents and children would amount to a net decline in household spending on health care of $4.9 billion.

National health care spending would increase by a net $7.5 billion in 2007. This is primarily the result of an increase in health care use by newly insured families and new payments for care that was previously uncompensated. New national spending is somewhat offset by payments to providers for FamilyCare enrollees that would be less than private payments, assuming they are paid at Medicaid rates.

BILLS THAT AIM TO STRENGTHEN EMPLOYER-BASED HEALTH INSURANCE

Several proposals would expand health insurance by building on the employer-based system, which currently covers more than 160 million workers and their dependents. They include:

- employer mandate for large employers (Representative Pallone); and
- improving the affordability of health insurance for small employers (President Bush, Representative Johnson, Senator Durbin, Representative Kind, Representative Allen).

Employer Mandate for Large Employers

The "Health Care for Working Families Act of 2005" (H.R.2197) introduced by Representative Pallone (D–N.J.) would expand health insurance by requiring that companies of 50 or more workers offer and contribute to health insurance for their employees and dependents (Figure 20).

Figure 20. Major Features of Health Insurance Expansion Bills and Impact on Uninsured, National Expenditures

	Employer Mandate	Association Health Plans	Small Business Expansion[2]
Aims to Cover All People			
Individual Mandate or Auto Enrollment			
Employer Shared Responsibility	x	x	x
Public Program Expansion			
Subsidies for Lower Income Families			x
Risk Pooling	x		x
Comprehensive Benefit Package	x		x
Quality & Efficiency Measures			x
Uninsured Covered in 2007[1] (in millions)	12.3	(0.3)	0.6
Net Health System Cost in 2007 (in billions)	$28.5	($0.4)	$2.1
Net Federal Budget Cost in 2007 (in billions)	($42.6)	$0.1	$12.0

[1]Out of an estimated total uninsured in 2007 of 47.8 million.
[2]Modeling assumed that firms with under 100 employees are eligible; reinsurance of 90% of costs over $50,000.
Source: The Lewin Group for The Commonwealth Fund.

Health Care for Working Families Act of 2005 (for more detail see Table A-5)

Overall Approach: Requires employers with 50 or more employees to offer and contribute to health insurance coverage for their workers and dependents through a qualifying health plan. Contract workers are considered employees under the legislation. Employees or their dependents with coverage through a public insurance program would be required to take up coverage, but other employees could decline coverage.

Benefits Package: A qualifying health plan would provide benefits at least equal in value to those of the Federal Employees Health Benefits Program (FEHBP) Blue Cross/Blue Shield Standard Plan. For those enrolled in public insurance programs, the employer plan would be the primary payer and the public program would be the secondary payer for services not covered under the employer plan.

Cost-Sharing and Affordability: The employer premium contribution must be at least that made by the federal government to the FEHBP Blue Cross/Blue Shield Standard Plan. Employers could reduce their contribution for employees working less than 30 hours per week and eliminate it for those working less than 10 hours. Employers would withhold the employee premium share from wages.

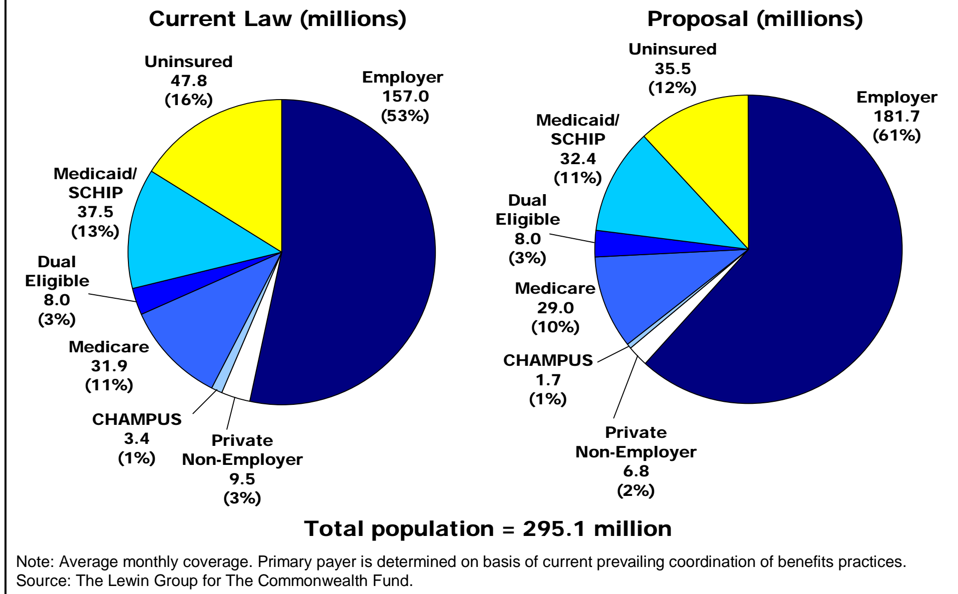
Lewin Group Estimates of Coverage and Costs in 2007 Under the "Health Care For Working Families Act"

Number of uninsured covered	12.3 million
Remaining uninsured	35.5 million
Net change in costs in 2007	
Total health system	$28.5 billion
Federal	($42.6 billion)
State and local	$5.4 billion
Employers	$92.1 billion
Household	($26.4 billion)

What the Estimates Mean

The Lewin Group assumes that all employers with 50 or more employees would offer their workers the equivalent of the FEHBP Blue Cross/Blue Shield Standard Plan and contribute 70 percent of the premium, pro-rated on a sliding scale for employees working between 10 and 30 hours per week. Lewin also assumes that 95 percent of workers offered such coverage would enroll, which is the current enrollment rate of those workers without an offer of coverage from another source, such as a spouse.

Lewin finds that an estimated 12.3 million workers and their dependents would be newly insured as a result of the employer mandate (Figure 21). The primary reason that such a large number of people remain uninsured (35.5 million) under the bill is that there are so many uninsured workers and/or dependents employed in small firms. An estimated 17 million uninsured people in 2007 are workers, or dependents of workers, employed in firms of fewer than 50 employees.[16]



Because of the requirement in the bill that workers and their dependents with coverage through public insurance programs such as Medicaid and SCHIP take up employer-based coverage, 9.7 million workers and dependents would move from those programs into employer-based coverage (Figure 21). In addition, there would be a shift of 2.7 million workers and dependents currently purchasing coverage in the individual insurance market to employer-sponsored coverage. In total, over 12 million currently insured workers and dependents would become insured under their employers' plans. Overall, enrollment in employer-based coverage would increase by about 25 million people to cover 62 percent of the population in 2007, up from just over half that Lewin projects would be covered by employer plans in 2007 under current law.

Reflecting the shift of many workers from public insurance programs to their own employers, The Lewin Group estimates that net federal health expenditures under the Working Families Act would decline by $42.6 billion (Figure 22). States also would realize savings from workers and their dependents moving from public insurance programs, but these savings would be more than offset by the requirement that state and federal workers accept coverage offered by their employers: state and local governments would thus incur a net increase in spending of $5.4 billion.

Figure 22. Health Insurance Expansion Bills Change in Health Spending by Stakeholder Group, Billions of Dollars, 2007

	Employer Mandate	Association Health Plans	Small Business Expansion[2]
Total Uninsured Covered, Millions	12.3	(0.3)	0.6
Federal Government	($42.6)	$0.1	$12.0
State and Local Government	$5.4	$0.6	($0.4)
Private Employers	$92.1	($1.3)	($6.9)
Households	($26.4)	$0.2	($2.6)
Net Health System Cost in 2007 (in billions)	$28.5	($0.4)	$2.1
Total Uninsured Not Covered,[1] Millions	35.5	48.1	47.2

[1]Out of an estimated total uninsured in 2007 of 47.8 million.
[2]Modeling assumed that firms with under 100 employees are eligible; reinsurance of 90% of costs over $50,000.
Source: The Lewin Group for The Commonwealth Fund.

Employers would face the largest net increase in costs under the bill, at $92.1 billion. The cost increase stems from more employers offering coverage to a larger number of workers, and from more employers offering more comprehensive health benefits with a significant premium contribution.

With more families covered with more comprehensive benefits, household health care spending would decline by a net $26.4 billion. This is driven primarily by a substantial decline in out-of-pocket spending.

Overall, national health care spending would increase by a net $28.5 billion as newly insured, and more comprehensively insured, people increase their use of health care services. In addition, the shift out of public insurance programs, which have lower insurance administrative costs than private employer-based coverage, would increase the costs of insurance administration nationally by an estimated $4.9 billion.

Improving the Affordability of Coverage for Small Businesses

Among employers, small businesses face the greatest challenges in offering affordable and comprehensive health insurance coverage to their employees. A recent study by Jon Gabel and colleagues found that, when premiums were adjusted for the amount of medical bills for which a health plan would pay, companies with fewer than 10 workers pay about 18 percent more for employee health insurance than do companies with 1,000 or more

employees.[17] It isn't surprising, therefore, that the greatest erosion in employer health insurance coverage is occurring among the smallest firms. Less than half (48 percent) of companies with fewer than 10 employees offered coverage in 2006—down from 57 percent in 2000.[18]

To help reduce the costs of coverage for small business, the Bush Administration and Representative Sam Johnson (R–Texas) have proposed allowing trade, industry, or professional associations to create association health plans (AHPs) to provide health insurance to their member employers (Figure 20). The "Small Business Health Fairness Act of 2005" (H.R.525), which was introduced by Rep. Johnson, passed the house in July 2005, but was never voted on in the Senate. President Bush has proposed AHPs as part of his fiscal year 2008 budget.

Using another approach, Senator Richard Durbin (D–Ill.) and Representative Ron Kind (D–Wis.) introduced the "Small Employers Health Benefits Program Act of 2006" (S.2510, H.R. 1955), which would provide a new group health program for small businesses based on the Federal Employees Health Benefits Program (Figure 20). Representative Thomas Allen (D–Maine) introduced a similar bill, the "Small Business Health Plans Act of 2006" (H.R.5288) which would allow states to set up group pooling arrangements for small business through grants provided by the federal government.

The Small Business Health Fairness Act of 2005

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

State Insurance Regulations: AHPs could offer fully insured plans (those issued by a state-licensed insurance carrier) or self-insured plans. AHPs would not have to comply with state insurance benefit requirements, though they would have to open the plan to all association members. An AHP could offer the same fully insured plan to members in other states as long as the plan were approved in the original state. All other states would have to accept the approved plan. Self-insured AHPs would be certified under the Employee Retirement Income Security Act of 1974 (ERISA), which means they would not be subject to state insurance regulations. Self-insured AHPs would be required to maintain certain reserves and comply with other solvency requirements.

Benefits Package: AHPs do not have to follow benefits requirements under state insurance laws, but states are allowed to require AHPs to cover some diseases and conditions. Fully insured AHPs would be subject to state laws regulating premiums but the premiums offered would be based on the average expected costs per enrollee of the association's member companies, not on the broader market that other carriers offering coverage in the small group market must serve under availability regulations. Self-insured AHPs would not be subject to state insurance regulations but they would be restricted

from varying premiums by health status or industry unless allowed by the state. They could charge member employers different premiums based on other factors, however.

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

Lewin Group Estimates of Coverage and Costs in 2007 Under the Small Business Health Fairness Act of 2005

Number of uninsured covered	(278,000)
Remaining uninsured	48.1 million
Net change in costs in 2007	
Total health spending	($0.4 billion)
Federal	$0.1 billion
State and local	$0.6 billion
Employers	($1.3 billion)
Household	$0.2 million

What the Estimates Mean

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

The most important implication of the Small Business Health Fairness Act is that it would enable AHPs to avoid state insurance regulations by selling policies across state lines.[19] For example, if an AHP organized in Delaware, which allows carriers to vary premiums by health status, age, and other factors, it could sell policies to small groups in New York, which has full community rating, meaning that premiums cannot vary by health status or age. This means that, in New York, companies with healthier employees could go outside of the small group market in New York and buy a cheaper policy from

the Delaware-based AHP. The consequence over time for New York would be that an increasing share of companies in the small group market would have less healthy or older workers, causing premiums to climb. Thus, while AHPs might encourage small companies that do not currently offer coverage to buy health plans from the AHP, the adverse effect on premiums in the small group market might cause small firms that currently offer coverage to drop it.

The Lewin Group estimates that the lower premiums of AHPs will cause 2.6 million workers and dependents in firms that do not currently offer coverage to gain employment-based insurance through their companies. Of those, 1.9 million are currently uninsured, 300,000 have coverage in the individual market, and 392,000 have enrolled in Medicaid or SCHIP. But the adverse effect of AHPs on premiums in the small group market is estimated to cause 2.8 million workers and dependents that currently have employer benefits to lose their coverage. Of those, 2.1 million would become uninsured, 400,000 would buy coverage in the individual market, and 292,000 would be covered by Medicaid. The number of uninsured under the Small Business Health Fairness Act is therefore estimated to increase by a net 278,000.

The bill is estimated to have only a minor effect on national health spending and on spending among most stakeholders (Figure 22). The overall net change in spending across targeted small employers would be a decline of $1.3 billion, since more firms would drop coverage because of higher premiums than would take up coverage, and their premiums would be higher on average than those firms that take up coverage under the bill. There would be little net change in household spending on premiums, since about equal numbers of people would lose employer coverage as would gain. Out-of-pocket spending among affected workers and their families would rise by a net $600 million (data not shown).

The Small Employers Health Benefits Program Act of 2006 and The Small Business Health Plans Act of 2006

(For more detail, see Table A-6)

Overall Approach: Provides new group options for small employers to purchase coverage for their employees. Durbin and Kind would establish a national program based on the Federal Employees Health Benefits Program (FEHBP), though the new program would be separate. Allen would allow states to establish their own small pools, based on FEHBP, but employers in states without pools could buy coverage through a national FEHBP-like program. Carriers that contract with the programs would be required to either comply with existing state insurance regulations or those established for the program.

Eligibility: Employers with fewer than 100 workers could participate in the program proposed by Durbin and Kind and those with fewer than 50 workers could participate in the Allen program. Participating companies that grow in size could continue to buy coverage through the program. Each bill would allow for eligibility waivers on a case-by-case basis, such as the employment of temporary or seasonal workers.

State Insurance Regulations: Under the Durbin and Kind proposals, participating employers would pay an adjusted community-rated premium that could vary only according to the geographic area, family size, and age of enrollees. This rule would apply to the FEHBP-like program except in states that required less premium variation such as full community rating. States would still set rating rules for their small group market. The Allen bill would require participating carriers to comply with all state insurance regulations but would not allow exclusions or premium variation based on health status.

Benefits Package: Equivalent to the minimum standard for health benefits required under FEHBP (Durbin/Kind) or the four largest FEHBP plans in a state (Allen). Benefits would have to comply with all state benefit requirements. Participating plans observe state insurance market regulations.

Affordability: Small employers, including nonprofits, under the Durbin and Kind bills would be eligible for a refundable tax credit (25% self only, 30% two adults or single with child, 35% for family coverage) for employees with incomes of less than $25,000 (wage limit rises each year with inflation) if they contribute at least 60 percent of premiums for singles and 50 percent for families. They would receive reduced credits for employees with incomes up to $30,000. Employers that cover more of the premium would receive bonus tax credits of 5 percent per additional 10 percent of the premium covered. Employers that enroll in the first year receive a 10 percent bonus refundable that year. The Allen bill would provide tax credits to be determined by HHS for employers paying 50 percent of employee premiums and would not require employers to contribute to dependent coverage.

Reinsurance: The Durbin and Kind bills would establish a reinsurance fund for the first two years of the program that would pay up to 80 percent of covered claims to carriers that experience catastrophic claims over $50,000 for benefits to an employee. Once the risk pool stabilized, the reinsurance fund would switch to the “service charge” system currently in place under FEHBP. The reinsurance fund established under the Allen bill would cover 75 percent of covered claims in excess of $100,000 for an employee and would not terminate after two years.

Efficiency and Quality Improvement: Under the Allen bill, HHS would promote participation by carriers with established health insurance technology tools to improve quality, chronic disease management programs, coverage of preventive health services, and the use of evidence-based medicine criteria in treatment decisions.

Lewin Group Estimates of Coverage and Costs in 2007 Under a Blended Version of the "Small Employers Health Benefits Program Act of 2006" and the "Small Business Health Plans Act of 2006"

(assuming firms with fewer than 100 workers are eligible with federal reinsurance to cover 90 percent of catastrophic events of $50,000 or more)

Number of uninsured covered	600,000
Remaining uninsured	47.2 million
Net change in costs in 2007	
Total health system	$2.1 billion
Federal	$12.0 billion
State and local	($0.4 billion)
Employers	($6.9 billion)
Household	($2.6 billion)

What the Estimates Mean

The Lewin Group assumed that states would operate the new pooling arrangements for small businesses and that benefit plans offered would be equivalent to the Blue Cross/Blue Shield standard option under FEHBP. In addition, participating health plans would have to abide by state insurance market regulations, but the program would set the floor for consumer protections requiring at least adjusted community rating (i.e., premium variation by age but within an established range and no variation by gender or health status). Lewin modeled the proposals with four blended options: 1) firms with fewer than 50 employees and federal reinsurance of 75 percent of costs for an individual catastrophic event costing more than $100,000; 2) firms with fewer than 100 employees with the same level of federal reinsurance; 3) firms with fewer than 50 employees and federal reinsurance of 90 percent of costs for an individual catastrophic event costing more than $50,000; 4) firms with fewer than 100 employees with the same level of federal reinsurance.

Lewin estimates that the adjusted community rating of the pools would result in significant adverse selection, disproportionately drawing small firms with older and less healthy workforces into the pool. While the federal reinsurance would lower premiums somewhat, carriers are estimated to increase premiums by an estimated 50 percent. This would significantly limit enrollment in the program.

Under a blended approach, Lewin assumed that companies of fewer than 100 employees can participate in the program and that federal reinsurance would cover 90 percent of costs for an event in excess of $50,000. Lewin estimates that, of the 59 million

workers and dependents in companies of fewer than 100, about 6.7 million would enroll. The number of uninsured people would decline by 600,000 (Figure 22). The cost to the federal government in 2007 would be an estimated $12 billion. Employers of fewer than 100 workers would experience a net decline in their health care bills of $6.9 billion. Households are estimated to save $2.6 billion through lower premiums and out-of-pocket costs.

In order to maintain more affordable premiums for the pools and increase enrollment, states and the federal government might finance the pools by paying for the difference between the estimated cost of benefits for those enrolled and the adjusted community-rated premium. Lewin estimates that this would have the effect of drawing 33 million eligible workers in companies of 100 or fewer employees into the pools, and reducing the number of people without coverage by up to 2.8 million. However, the estimated cost to federal and state governments would be high relative to the number of people gaining coverage: $42 billion in 2007.

The pools might also be stabilized and enrollment increased by requiring adjusted community rating for the full state insurance market, not just for premiums in the small group pools.

DISCUSSION

How do the proposals compare under the broad set of criteria posed in this report: Will they improve access to care, increase efficiency, make the system more equitable, and improve quality of care? Do they promise to set the nation on a path toward supporting longer, healthier and more productive lives?

Access to Care

How many people would the proposals cover? The proposals to expand health insurance analyzed in this report range dramatically in scope from targeted efforts that would cover a defined group of people, such as children, older adults, people with work-ending disabilities, and small businesses, to those that aim to expand coverage options for everyone. The number of uninsured people estimated to be covered under the bills thus ranges from fewer than 1 million to 47.8 million, or the estimated number of people who will be without health insurance under current law in 2007. Bills that aim to cover nearly everyone vary in their effectiveness and which previously uninsured people would gain coverage, and what their source of coverage would be (Figure 23). Representative Stark's AmeriCare proposal would cover nearly all of those currently uninsured, as would Senator Wyden's bill to cover people through private insurance via regional insurance exchanges. Medicare would become the primary source of coverage under Representative Stark's bill

and Health Help Agency plans would become the major source under Senator Wyden's bill. President Bush's proposal to equalize the tax treatment of employer and individual coverage is estimated to cover 9 million previously uninsured people, leaving 38.8 million uninsured. But because the new income tax deduction in the president's proposal would be for a capped amount that would rise annually by the rate of consumer price inflation, which is projected to rise more slowly than premiums, the proposal is likely to cover more uninsured people in the first years of the proposal than in future years, when premiums are more likely to exceed the cap and thus be more expensive to taxpayers.

Figure 23. Major Features of Health Insurance Expansion Bills

	President Bush's Tax Reform Plan	Healthy Americans Act	Federal/State Partnership 15 States[2]	AmeriCare
Access *(% of uninsured covered[1] in 2007)*	19%	95%	42%	100%
Efficiency *(change in national health system spending in 2007)*	($11.7)	($4.5)	$22.7	($60.7)
Equity *(change in average family health spending by annual income in 2007)*	<$10,000: -$23 >$150,000: -$1,263	<$10,000: -$983 >$250,000: +$1,562	N/A	<$10,000: -$1,162 >$150,000: -$473
Measures to Improve Quality		Medical home, hospital safety, reward healthy behavior, chronic disease management	State proposals required to show improvements in quality, efficiency, and health IT	Uniform electronic claims forms and medical records; electronic national claims data set
Potential to Ensure Long, Healthy, Productive Lives		X	X	X

[1]Out of an estimated total uninsured in 2007 of 47.8 million.
[2]Estimated to cover 86% of the 23.6 million people projected to be uninsured in the 15 states in 2007.
Source: The Lewin Group for The Commonwealth Fund.

Do the proposals improve coverage for people who currently have inadequate coverage, entailing high costs or limited benefits? By setting a floor on acceptable levels of health benefits, several of the bills would improve coverage for millions of people who are currently underinsured. In most bills that specify a minimum level of benefits, qualifying health plans would have to be equivalent in value to the Blue Cross/Blue Shield Standard Plan offered to federal employees and members of Congress under the Federal Employees Health Benefits Program. In addition some bills, such as Representative Stark's AmeriCare bill and Senator Wyden's Healthy Americans Act, would also cap out-of-pocket costs as a share of income and/or subsidize premiums. In addition, bills such as Senator Kerry's Kids Come First Act and Representative Dingell's FamilyCare Act would improve existing benefits and lower premiums and out-of-pocket costs for many currently underinsured children and adults with low to moderate incomes by expanding access to Medicaid and

SCHIP. In the case of Representative Stark's AmeriCare bill, requiring a comprehensive set of benefits and lower cost-sharing in the new program would improve coverage for existing Medicare beneficiaries who currently face substantial cost-sharing. President Bush's proposal would move some people into plans with more limited benefits or higher deductibles.

Efficiency

How much do the proposals cost the health system and how are those costs shared by the federal government, state and local governments, employers, and families? The cost of the bills and how the cost is distributed across stakeholders is affected by their scope, structure, and whether a financing mechanism or revenue source is identified. Not surprisingly, the more targeted proposals in general are less expensive to the federal government than are more comprehensive coverage plans. For example, allowing older adults who lose coverage as they near retirement to buy in to the Medicare program is estimated to cost the federal government $27 billion in 2007. Allowing everyone to gain coverage through the Medicare program could cost the government $154.5 billion in that year.

But the estimated savings to the overall health system from insuring everyone through Medicare or other near-universal mechanisms swamp the savings from incremental approaches. For example, the savings to the health system under Representative Stark's AmeriCare proposal are estimated at nearly $61 billion in 2007, compared with an increase in national health spending of $4.9 billion when just older adults ages 55–64 are allowed to buy in to Medicare. This difference stems primarily from a substantial savings in the costs of administering health insurance under the AmeriCare proposal: the total costs of health insurance administration in the United States would decline by $74 billion in 2007. This savings reflects a reduction in the administrative complexity that characterizes the current system, in which people receive coverage through multiple, competing insurance carriers. Both proposals would benefit from the fact that Medicare has significantly lower administrative costs per premium dollar than employer or individual market insurance.

Representative Stark would also require the federal government to negotiate prescription drug prices with pharmaceutical companies. This provision is estimated to reduce national spending on prescription drugs by $33.9 billion in 2007.

Many of the proposals would profoundly change the role of the employer in the health system, though in fundamentally different ways. Representative Pallone's proposal would change the current voluntary nature of the employer role to a requirement that

employers of a certain size offer and pay for coverage to their employees. Because the Pallone bill would require workers and their dependents with coverage through public insurance programs to enroll in their employers' plans, 9.7 million workers and dependents would move from those programs into employer-based coverage, saving the federal government an estimated $42.6 billion in 2007. Representative Stark, Senator Kennedy, and Senator Wyden would remove employer's direct responsibility for offering insurance but require a financial commitment to support the overall system, though the proposals vary in the level of that commitment. President Bush would relieve employers of the responsibility to provide or finance health insurance. From the employer's perspective, the implications of these different roles are the following: Under the employer mandate, employer spending on health insurance would climb by $92.1 billion. Under Representative Stark's AmeriCare proposal, employers would pay 80 percent of worker premiums, but their aggregate costs would decline by $15.2 billion. Among employers that are already providing coverage, costs would decline by $122 billion. Under Senator Wyden's proposal, employers' health spending would increase by $60 billion, as all employers are required to contribute to their employees' premiums for private coverage, which would be relatively more expensive than the AmeriCare premiums. Under President Bush's proposal, employers would save $50.8 billion in 2007 as employers discontinued coverage for an estimated 12.8 million people.

Do proposals pool health care risks broadly? How a proposal is structured and how broadly risks are pooled has a fundamental impact on costs. Under President Bush's proposal, for example, providing an equivalent capped income tax deduction for insurance gained through employers or through the individual market would have the effect of moving more people into the individual market. Consequently, the number of people covered in the individual market is estimated to increase by 19.8 million. Senator Wyden's proposal would also encourage non-employer coverage, but would create new group regional insurance exchanges called Health Help Agencies and impose restrictions on individual underwriting. While the national spending on insurance administration costs under the president's proposal are estimated to increase by a net $5.5 billion dollars in 2007, the same costs in the Wyden plan would drop by $30 billion, even after accounting for the new administrative costs of the Health Help Agencies and the cost of administering subsidies. This is primarily the result of broadly pooling risk through regional insurance exchanges and limiting underwriting in the Wyden proposal as compared with an increase in individually underwritten risk in the president's proposal.

The difficulty in attempting to address the ongoing affordability crisis plaguing small companies that buy coverage through the small group market by regulating or

deregulating the market is highlighted by the small business proposals. The Johnson bill would in effect allow companies to bypass state insurance regulations, such as community rating, which are aimed at increasing access to the small group and individual markets among small businesses and older consumers or those with health problems. The bill is estimated to make small group coverage more affordable for companies with a young and healthy workforce, but to significantly increase premiums for less healthy consumers or companies with older workers that must continue to purchase coverage in the small group market. The Durbin/Kind and Allen bills would take an entirely different approach—establishing pools for small businesses with premium protections, federal reinsurance, and tax credits. But their proposals are estimated to ultimately have the unintended effect of increasing premiums within the pools, as those companies with less healthy and older workforces disproportionately enroll, attracted by the community-rated plans.

Do the proposals make enrollment easy and reduce the potential that people will experience gaps in coverage? The bills that would enroll people automatically through the tax system or at birth, such as the Representative Stark's AmeriCare bill and Senator Wyden's bill, are the most likely to ensure that people become enrolled and remain enrolled. The fact that most people would be covered under one system under both bills would also help ensure that people remain enrolled, regardless of changes in income, age, health status, or employment status.

Some of the more targeted bills also attempt to make enrollment easier and to prevent people from spending time without coverage. Senator Bingaman's bill to eliminate the two-year waiting period for the disabled in Medicare, for example, would eventually eliminate the precarious period of time that people who are too disabled to work must endure before becoming eligible for Medicare. Senator Kerry's bill would cover all children under age 21 and Representative Dingell's FamilyCare bill would expand access to Medicaid and SCHIP and at the same time make it easier to enroll and stay enrolled in both programs. Both bills would increase the age at which children are no longer eligible for coverage under the programs, thus addressing the fact that a large and growing number of young adults (ages 19 to 29) lack coverage.[20] The bills would institute several provisions to increase enrollment and retention in the programs, including adoption of 12-month continuous eligibility rules (i.e., eligibility for assistance under Medicaid and SCHIP could not be re-determined more than once every year for children), allowing families to self-declare income, and allowing state programs to accept eligibility determinations for other assistance programs such as Food Stamps and the School Lunch Program. These provisions seek to raise the rates of enrollment of eligible individuals in public health insurance programs. Research shows that more than three of

five uninsured children are eligible for Medicaid or SCHIP but not enrolled.[21] The Lewin estimates show that, although these features do increase enrollment, millions of children and adults eligible for the programs would remain uninsured. This analysis reveals the limited ability of targeted expansions to cover all of those eligible when eligibility is determined by income in the absence of a more comprehensive system nationally to ensure that people get the coverage for which they are eligible.

Equity

How do the bills affect family health care spending across the income spectrum? The way in which new premium subsidies, tax credits, or tax deductions for the purchase of health insurance are designed has significant implications for how costs or savings accrue across households. Under Representative Stark's AmeriCare bill, households would see a dramatic drop in health care expenditures of $142.6 billion, with the largest savings falling to families with low and moderate incomes. However, these savings might be offset if taxes are increased to finance the higher federal government spending under the bill. Families earning less than $10,000 a year would see their average annual costs decline by $1,162, those earning between $20,000 and $30,000 would realize savings on average of $1,875, and those earning $150,000 or more would save $473 per year. This is because of substantial premium and cost protections for consumers that gradually phase out for families with incomes up to 500 percent of poverty. Cost savings arise from people becoming insured, as well as from the new protection from out-of-pocket costs and premiums that benefit currently insured families who have high out-of-pocket costs and premiums relative to their incomes.

The Wyden bill is also structured progressively. Family health spending overall would decline by $78.8 billion, but spending would climb with income. Average health spending would fall by $983 per year among families earning less than $10,000 a year and increase by an average $1,562 among families earning $250,000 or more annually. This is because families with incomes under 100 percent of poverty would pay no premiums and those earning between 100 and 400 percent of poverty would pay premiums on a sliding scale relative to their incomes. In addition, a new standard income tax deduction for health care would be phased in for families with income between 100 and 400 percent of poverty and phased out for families with incomes between $125,000 and $250,000 with no deduction above $250,000.

Under President Bush's proposal, household spending on health care is estimated to fall by a net $31 billion in 2007. Families are estimated to spend more on health insurance premiums since more people would purchase coverage in the non-group

market, where premiums are higher on average. In order to keep premium costs down, people will also be likely to purchase higher-deductible health plans and/or lower benefit plans, potentially increasing family out-of-pocket spending. These higher expenditures would be offset by reduced use of health care services and income tax savings because of the tax deduction. But those savings disproportionately accrue to people in higher income brackets and to people who have health insurance. The Lewin Group estimates that families earning less than $10,000 a year would see their average spending on health care decline by $23 in 2007, while those earning $150,000 or more would realize savings in average spending of $1,263. In out-years, however, the differential indexing of the deduction and growth in employer premiums would lead to an increase in taxes for households now covered by employer plans.

Do the proposals improve equity in access to health care? Proposals such as Representative Stark's AmeriCare bill and Senator Wyden's bill that aim to achieve near-universal coverage with comprehensive benefits and cost protections for families with low and moderate incomes will go the farthest in providing equal financial access to the health care system. More targeted proposals, including bills to expand coverage for children and lower-income families, the Medicare buy-in for older adults, and ending the two-year waiting period for people who are disabled, would make small but necessary improvements in providing equal access to the health system for millions of children and adults who face financial barriers to care.

Broad risk pooling is also crucial on equity grounds. The proposals that attempt to cover people through existing small or non-group markets ultimately confront the central dynamic governing those markets—the powerful incentive on the part of carriers to protect against health risk. The president's proposal fails to address the significant variation in premiums and in the value of benefits that characterizes the individual insurance market. Beyond the varying value of the tax deduction by income, its value would likely vary for people living in different parts of the country, of different ages, health status, and gender—not to mention people with severe health problems for whom no insurer will write a policy. Similarly, the bills that attempt to make coverage more affordable for small businesses, with measures aimed at the small group market, ultimately might help healthier and younger people at the expense of less healthy or older people, or vice versa, with only small changes in people covered. The Stark AmeriCare bill would avoid these problems by ultimately pooling the population into one large pool. The Wyden bill would organize large regional pools with community rating for the region. Participation by the full population would be mandatory and the Health Help Agencies would organize people into large regions, and solicit and approve carrier bids to offer insurance. The private

insurance connectors established in each state under the hypothetical federal–state partnership analysis might be more at risk for adverse selection and premium escalation. Protections for these private purchasing mechanisms might include mandatory participation, community rating for the full state market as well as for the insurance connectors, and adequate federal reinsurance.

Quality

Is the insurance system organized in a way that would facilitate the delivery of higher- quality care? A significant barrier to improving the quality of health care nationally is the large number of people who lack meaningful health insurance coverage and are therefore largely outside the system. Those proposals that would cover the most people would help ensure that the population as a whole has access to preventive care and timely essential medical care across the lifespan.

But the ways in which people are insured, the systems that evolve to achieve near-universal coverage, and the role of insurance carriers will be important determinants of whether significant and systematic improvements in quality can be achieved across the country. For example, the central organization of Representative Stark's AmeriCare bill would enable the nation to develop and utilize common quality metrics, gather data on the health care outcomes of the full population, and to evaluate and improve the performance of providers based on a large pool of patients that is not fragmented by insurance type, as is the case today. It also would enable the creation of uniform provider payment systems that reward high-quality care, standardization in health information technology, and the creation of universal processes to improve safety systematically across health care institutions. Senator Wyden's Health Help Agencies would be less centralized and would not include the over-65 population, but if the agencies were provided with the requisite authority they might be able to coordinate similar, system-wide quality improvement activities.

Are there specific provisions aimed at improving quality? Most of the bills that would fundamentally reform the health system include specific quality improvement measures. Senators Bingaman and Voinovich and Representatives Baldwin, Price, and Tierney would require or encourage state proposals to expand coverage to also include plans to improve health care quality and efficiency, and expand the use of health information technology. Senator Wyden's bill would provide the opportunity for each enrollee and Medicare beneficiary to have a "health home," or a designated provider who monitors their health and health care, establish an expert panel to ensure that hospitals have state-of-the-art quality controls in place, allow the adjustment of Medicare Part B premiums to

reward healthy behavior, and establish a chronic care disease management program, including payment of both primary care and specialist physicians for management of chronic illness. Representative Stark's AmeriCare bill would establish uniform electronic claims forms to facilitate the creation of a national electronic claims data set and require all participating providers to adhere to the standard format. AmeriCare would also establish uniform standards and data elements for electronic medical records, consistent with the claims reporting forms, and require participating providers to maintain electronic medical records on all patients.

Longer, Healthier, and More Productive Lives

The ultimate goal of health care reform should be improvements in the length, quality, and productivity of people's lives. The Institute of Medicine (IOM) estimates that the millions of people who lack insurance coverage generate between $65 billion and $130 billion annually in costs associated with diminished health and shorter life spans.[22] According to the IOM, an estimated 18,000 avoidable deaths occur each year in the United States as a result of leaving so many people without coverage. The Commonwealth Fund Commission on a High Performance Health System's National Scorecard on U.S. Health System Performance reveals how far the nation lags behind in achievable benchmarks in access, quality, equity, and efficiency.[23] This analysis of health coverage proposals demonstrates that universal coverage is feasible and that many proposals and particular elements of the proposals could yield savings in national health expenditures and systematic, long-term improvements in the quality of care nationwide. The IOM estimates of the annual costs associated with uninsurance are a stark benchmark against which to compare the cost of inaction with the estimated annual costs and savings of investing in a more rational and equitable system of health care in the United States. Moreover, the IOM estimates are nearly five years old, dating from a time when the number of uninsured people stood at 41 million. At 47 million uninsured and counting in 2007, the costs of inaction are mounting with each passing year. With nearly two-thirds of the American public calling for universal health insurance and the higher taxes it would take to achieve it in a recent *New York Times*/CBS News Poll, it is clear that a majority of families have already made this calculus in their own lives.[24]

APPENDIX. TABLES

Table A-1. Analysis of the Health Partnership Act/ Health Partnership Through Creative Federalism Act

Bill name	**Health Partnership Act/ Health Partnership Through Creative Federalism Act**
Bill number	S. 325/H.R. 506[25]
Bill sponsor(s)	S. 325 is sponsored by Senator Bingaman and has 1 cosponsor. H.R. 506 is sponsored by Representative Baldwin and has 28 cosponsors.
Latest Congressional action	S. 325 was referred to the Senate Committee on Health, Education, Labor, and Pensions on January 17, 2007. H.R. 506 was referred to the House Committee on Energy and Commerce and the Committee on Rules on January 17, 2007.
Basic structure of coverage expansion	Establishes a State Health Innovation Commission (the "Commission") that would oversee demonstration grants to regions, states, or local governments for expanding health coverage and improving health care quality and efficiency.
Description of target population	No single population would be targeted. States seeking to receive federal grants would submit plans to expand access to health care coverage and reduce the number of uninsured individuals.
Eligibility criteria for states	States and regions (i.e., more than one state), could apply to establish a health care expansion and improvement program. If a state declines to submit an application, a unit of local government could submit an application. The application would include a health care plan that complies with the following requirements: • Describes the manner in which access to coverage would be ensured and provides a five-year target for reducing the number of uninsured; • Describes the number of uninsured who would be covered under the program; • Describes the minimum benefit package; • Identifies programs which could be coordinated with the program; • Provides for increased access for medically underserved populations; • Provides a plan to improve health care quality; • Contains results-based quality indicators; • Provides for the development of systems to improve the efficiency of health care; • Describes private and public sector financing; • Estimates the amount of federal, state, and local expenditures; • Describes how the applicant would ensure the financial solvency of the program; • Provides that the applicant would submit required reports; and • Provides a methodology for the appropriate use of health information technology (HIT) to improve infrastructure. **Note:** H.R. 506 would not require the HIT element (it would be permissive but not mandatory) and applicants would be required to describe exceptions to otherwise applicable federal statutes, regulations, and policies. If awarded a grant, the state or region would be required to maintain expenditures for the support of direct health care delivery at or above the same level of expenditures of the fiscal year preceding the grant year.

Bill name	Health Partnership Act/ Health Partnership Through Creative Federalism Act
Benefits	None specified. **Note:** Under H.R. 506, coverage under the state plan could be: • Actuarially equivalent to a benchmark benefit package (including FEHBP, state employee coverage, or coverage offered through the largest non-Medicaid HMO in the state); • Access that is, on average, not less than coverage provided through a benchmark benefit package; or • A combination of coverage and a consumer-directed health care spending account, provided the actuarial value of the coverage plus deposits for the spending account are equivalent to the value of a benchmark benefit package.
Premium and cost-sharing requirements	None specified.
Incentives and federal subsidies	Approved applicants would receive a federal grant to carry out the health care program. The amount of each grant would be determined based on recommendations of the Commission.
Changes to public program(s)	No direct changes would be made to public programs. Prohibits any entity from affecting any Medicaid provisions in the course of implementing this bill.
Requirements for private insurers or health plans	Not applicable.
Administration and oversight of the coverage expansion	The Commission would be charged with responsibility for monitoring the status and progress achieved under approved projects and would be required to hold an annual meeting with participating states to have the states report progress toward the goals of the program. The Commission's responsibilities would include: • Providing states with reform options for state health care expansion and improvement programs; • Establishing minimum performance measures and goals regarding coverage, quality, and cost of state programs; • Reviewing applications from states; • Submitting recommendations to Congress with respect to state applications that the Commission recommends for approval; • Monitoring the status and progress of the program; • Promoting information exchange between states and the federal government; and • Making recommendations to Congress for minimizing any adverse impacts of approved programs on national employer groups, provider organizations, and insurers. The Commission would submit annual reports to Congress on the effects of the reforms undertaken, the effectiveness of such reforms, and recommendations regarding increasing federal financial assistance. At the end of the five-year period (beginning on the date on which the first grant is awarded), the Commission would prepare and submit to Congress a report on the progress made by states receiving grants in meeting programmatic goals. **Note:** H.R. 506 would require this report to be submitted one year prior to the end of the five-year period.
Changes to federal or state oversight of health coverage	Not applicable.

Bill name	Health Partnership Act/ Health Partnership Through Creative Federalism Act
Financing	For FY 2007 (and each year thereafter), $3 million to carry out the provisions regarding the creation and responsibilities of the Commission. **Note:** H.R. 506 would stipulate that such funding would be for FY 2008 and thereafter. With regard to the funding of grants to states and other entities, such sums as may be necessary in each fiscal year. The Commission would be directed to make recommendations to Congress.
Key implementation dates	The Secretary of Health and Human Services (HHS) would be required to establish the Commission, with specified membership from the legislative branch, within 90 days of the enactment. The Commission would hold its first meeting within 30 days after all members had been appointed. **Note:** S. 325 would provide for a 21-member Commission while H.R. 506 would provide for a 19-member Commission. With respect to an application for a grant, HHS and the Commission would complete an initial review within 60 days of receipt of the application. Within 90 days of the initial review, the Commission would determine whether to submit the proposal to Congress for approval; a determination to submit a proposal would require the approval of two-thirds of the Commission's members. No later than 90 days prior to October 1, the Commission would submit a list (in the form of a joint resolution) of state applications that the Commission recommends for approval to Congress. The consideration of the joint resolution by Congress would follow procedures described in the bill. A program could be approved for a period of five years and extended for subsequent five-year periods by HHS and the Commission.
Other key elements of the bill	A proposal that had been recommended and submitted to Congress for approval would be deemed approved and federal funds would be provided to such program unless a joint resolution by Congress is enacted disapproving the proposal. **Note:** H.R. 506 would not allow for deemed approval in the absence of a joint resolution. However, the process for introduction and Congressional consideration of the resolution would be identical to that in S. 325 (described above). In awarding grants, HHS would be required to: • Fund a diversity of approaches; • Give priority to programs determined to have the greatest opportunity to succeed in expanding coverage and improving access for vulnerable populations; and • Link allocations to the meeting of goals and performance measures. **Note:** H.R. 506 would only require funding of a diversity of approaches and linking the funding to the achievement of goals and performance measures. HHS could, for good cause and in consultation with the Commission, revoke any program granted under the Act. Grantees could not impose preexisting condition exclusions for covered benefits under a program approved by the Act. No payment would be made for expenditures for assistance provided to an individual where a private insurer would have been obligated to provide the assistance but for a contractual provision limiting such obligation because the individual is provided assistance under the plan. Similarly, no payment would be provided if payment would be made under any other federally operated or financed health care insurance program.

Table A-2. Side-by-Side Analysis of the AmeriCare Health Act of 2006 and the Medicare for All Act

Bill name	AmeriCare Health Act of 2006	Medicare for All Act
Bill number(s)	H.R. 5886	S. 2229/H.R. 4683
Bill sponsor(s)	H.R. 5886 is sponsored by Representative Stark and has 33 cosponsors.	S. 2229 is sponsored by Senator Kennedy and has no cosponsors. H.R. 4683 is sponsored by Representative Dingell and has 18 cosponsors.
Latest Congressional action	H.R. 5886 was referred to the House Energy and Commerce, Ways and Means, and Education and Workforce Committees on July 25, 2006.	S. 2229 was referred to the Senate Finance Committee on January 31, 2006. H.R. 4683 was referred to the House Energy and Commerce Subcommittee on Health on February 17, 2006, and to the Ways and Means and Government Reform Committees on February 1, 2006.
Basic structure of coverage expansion	Creates a new public health insurance program, AmeriCare, that would be administered by the federal government and financed using a combination of general tax revenues, enrollee premiums, mandatory employer contributions, and "maintenance of effort" payments by states (to cover payments that would have been made under Medicaid and SCHIP). Enrollees would have two choices for coverage: an option equivalent to fee-for-service coverage under Medicare Parts A and B, plus an additional package of benefits; or an option modeled after Federal Employees Health Benefits Program (FEHBP) coverage using private plans that contract with the federal government.	Creates a new public health program, Medicare for All, administered by the federal government and financed through new payroll taxes on employees and employers. Establishes a new Medicare for All trust fund. Enrollees would have two choices for coverage. The first option would be the equivalent to fee-for-service coverage under Medicare Parts A and B, plus an additional package of benefits. The second option would be Federal Employees Health Benefits Program (FEHBP)–style coverage under a private plan that would contract with the federal government.
Description of eligible participants	All U.S. residents and certain non-residents.	All U.S. citizens and legal immigrants not otherwise eligible for health care coverage under the Medicare program would be covered.
Eligibility criteria	Individuals would be required to be U.S. residents. Coverage for non-residents would be available to the extent that the Secretary of Health and Human Services (HHS) determines that such benefits would be available to U.S. nationals in other countries. Persons under age 24, pregnant women, and low-income individuals under 300 percent of the federal poverty level (FPL) would be designated "special eligibility categories."	Individuals would be required to be: • U.S. citizens or immigrants lawfully present in the U.S.; and • Not eligible for Medicare Part A or B. Eligibility would be phased in by age group according to the following schedule: • During the first five years of the program, eligibility would be limited to individuals under 20 or over 55 years old; • During years six to 10 of the program, eligibility would be expanded further to include individuals under 30 or over 45 years old; and • Beginning in year 11, eligibility would be expanded to include all age groups.

Bill name	AmeriCare Health Act of 2006	Medicare for All Act
Benefits	Eligible individuals could enroll in one of two types of coverage. Enrollees under Choice 1, a supplemented Medicare fee-for-service plan, would receive: • Medicare Parts A and B benefits; • Preventive services recommended by the U.S. Preventive Services Task Force; • Coverage for treatment of substance abuse; • Newborn and well-baby care, including normal newborn care and pediatrician services for high-risk deliveries; • Well-child care, including routine office visits, routine immunizations, routine laboratory tests, and preventive dental care; • Pregnancy-related services including prenatal care (including care for all complications of pregnancy), inpatient labor and delivery services, postnatal care, and family planning services; • Mental health treatment parity (i.e., mental health benefits must be comparable to other medical benefits); • The Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT) provided to individuals under age 21 in the Medicaid program; and • Prescription drug coverage equivalent to the Blue Cross/Blue Shield Standard Plan provided under FEHBP. Current Medicare benefits would be modified to conform with the new AmeriCare benefit package. Under enrollees' prescription drug coverage, the use of more affordable therapeutic equivalents would be encouraged except in cases where substitutions would conflict with medically necessary care. Benefit exclusions under Medicare Part A and Part B also would apply to AmeriCare, unless benefits are expressly guaranteed (see list above). In addition, payment could not be denied for services for pregnant women, or for eyeglasses and hearing aids/examinations for children and low-income individuals. Under Choice 2, private health plans would be required to comply with minimum benefit levels required of private plans participating in Medicare Part C.	Eligible individuals could enroll in one of two types of coverage. Under Choice 1, a supplemented Medicare fee-for-service plan, enrollees would be entitled to the following benefits: • The full range and scope of benefits provided to Medicare beneficiaries under Parts A and B; • Prescription drug coverage at least as comprehensive as that offered under the Blue Cross/Blue Shield Standard Plan provided under FEHBP; • The Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT) provided to individuals under age 21 in the Medicaid program; • Parity in coverage of mental health benefits (i.e., mental health benefits must be comparable to other medical benefits); • Preventive services; • Home- and community-based services; and • Any additional benefits deemed appropriate by the Secretary of Health and Human Services (HHS). Enrollees in Choice 1 would be guaranteed the same free choice of providers that is available to current Medicare beneficiaries. Under Choice 2, eligible individuals could enroll in an FEHBP-style private health plan. To qualify for participation, private plans would be required to guarantee a level of benefits at least as generous as those offered to members of Congress and federal employees under FEHBP.

Bill name	AmeriCare Health Act of 2006	Medicare for All Act
Premium and cost-sharing requirements	Enrollees in Choice 1 would be subject to the following cost-sharing requirements: • Deductibles of $350 for individuals and $500 for families; • 20 percent coinsurance; • Out-of-pocket cap of $2,500 for individuals and $4,000 for families; • Premiums established by HHS based on the cost of coverage (determined on a state-by-state basis and taking into account administrative expenses) and enrollment class (e.g., individual, couple, or family). Premiums would be reduced for employed enrollees because employers would be required to make a contribution on behalf of their enrolled employees. Individuals receiving equivalent coverage through their employers would not be required to enroll in AmeriCare and would not be required to pay any premiums. Premiums would be collected using a mechanism similar to payroll tax withholding and would be reconciled through annual income tax filing. Special cost-sharing provisions for low-income individuals would be as follows: • Special eligibility categories would pay no cost-sharing; • Total out-of-pocket spending (premiums, deductibles, and coinsurance) would be capped at 5 percent of annual income for individuals and families between 200–300 percent FPL; • Total spending would be capped at 7.5 percent for individuals and families with income between 300–500 percent FPL; • Premium subsidies would be provided to families with annual income less than 300 percent FPL and for individuals who receive Temporary Assistance for Needy Families (TANF) or Social Security Insurance (SSI) (i.e., individuals receiving welfare or disability payments); and • Pregnant women presenting for prenatal care during their first trimester would receive a 5 percent additional reduction in the fees for such services. Cost-sharing and out-of-pocket spending limits would be indexed to the consumer price index (CPI) after 2006.	Enrollees in Choice 1 would be subject to the following cost-sharing requirements: • Enrollees would pay cost-sharing—including deductibles, coinsurance, and copayments—for all Medicare Part A and Part B services; • For prescription drug benefits, enrollees would pay cost-sharing—including deductibles, coinsurance, and copayments—applicable under the Blue Cross/Blue Shield Standard FEHBP plan; • For preventive services, enrollees would pay cost-sharing—including deductibles, coinsurance, and copayments—consistent with the cost-sharing levels under Medicare Part A or Part B; • For EPSDT and home- and community-based services, enrollees would pay nominal cost-sharing—including deductibles, coinsurance, and copayments—that is consistent with cost-sharing levels for these services under the Medicaid program; and • Low-income individuals would pay reduced cost-sharing amounts at least as protective as the cost-sharing levels for Qualified Medicare Beneficiaries (QMBs) under Medicaid.[26] Enrollees in private plans under Choice 2 would be subject to cost-sharing requirements established by the individual plans. Plans would be restricted, however, in the cost-sharing and premium amounts that could be charged according to the beneficiary protections under FEHBP and Medicare Advantage (Medicare Part C).

Bill name	AmeriCare Health Act of 2006	Medicare for All Act
Incentives and federal subsidies	None specified.	Health care providers participating under Choice 1 would be eligible for additional payments for meeting certain quality standards established by HHS.
Changes to public program(s)	AmeriCare would be secondary payer to Medicare. Medicaid and FEHBP would be prohibited from providing benefits that are duplicative to AmeriCare (that is, if enrollees have already received medical care under AmeriCare, Medicaid and FEHBP would not be permitted to provide those services as well).	Enrollees would not be required to receive and would not be prohibited from obtaining benefits from other public health care programs, such as Medicaid, SCHIP, and programs sponsored by the Departments of Defense and Veterans Affairs. The new program would be the primary payer over other public health care programs.
Administration and oversight of the coverage expansion	Under Choice 1, the administrative structure of AmeriCare would be based on the current Medicare program, including the use of Medicare's certification, provider qualifications, and Medicare Administrative Contractors (MACs). Medicare fraud provisions also would apply. HHS would be required to negotiate with pharmaceutical manufacturers to reduce the cost of outpatient prescription drugs and biologicals, using strategies already employed in other federal programs. The new outpatient drug fee schedule would also apply to Medicare prescription drug coverage. Under Choice 2, HHS would enter into contracts with private health plans. These private plans would be subject to the same or similar requirements that govern insurance plans under Medicare Advantage (Medicare Part C). Private health insurance plans would be permitted to offer supplemental coverage to AmeriCare enrollees, but would be required to comply with standards established by HHS. These standards would include consumer protections and the prohibition of duplication of benefits.	Under Choice 1, HHS would consult with the Medicare Payment Advisory Commission (MedPAC) to set a payment schedule for providers and suppliers. Additional payments would be made to those providers and suppliers who achieve certain levels of quality established by HHS. These quality standards would include the use of health information technology. Under Choice 1, HHS also would enter into contracts with health care providers, taking into account the types of contracts currently used with participating providers under Medicare. Under Choice 2, HHS would enter into contracts with private health plans so long as the plans meet the following requirements: • The plans would be required to offer a package of benefits equivalent to those provided to members of Congress and federal employees under FEHBP; • The plans would be prohibited from offering financial payments or rebates to enrollees; • The plans would be required to provide enrollees with a level of beneficiary safeguards no less protective than required under both FEHBP and Medicare Advantage (Part C); and • The plans would have to comply with requirements established by HHS relating to licensure and solvency, protection against fraud and abuse, inspection, disclosure, periodic auditing, and administrative operations and efficiencies. HHS would take into account similar requirements under FEHBP and Medicare Part C in arriving at this set of requirements.
Changes to federal or state oversight of health coverage	None specified.	None specified.

Bill name	AmeriCare Health Act of 2006	Medicare for All Act
Financing	A new AmeriCare trust fund would be based on the Medicare trust fund model and would be used to support program operations. All premiums would be deposited into the AmeriCare trust fund, as would new "maintenance of effort" payments that states could be required to pay. These payments would be equal to the amount that the state would have paid under Medicaid and SCHIP in the absence of AmeriCare. Employers would be required to contribute 80 percent of the premium for AmeriCare coverage or to provide coverage equivalent to AmeriCare. HHS would be authorized to impose additional liability for employers to the extent it is necessary to prevent adverse selection. Employer contributions for part-time employees would be reduced based on the ratio of hours worked per week divided by 40 hours. Employers would begin contributions on January 1, 2010, although employers with fewer than 100 employees would have until January 1, 2012, to comply. Under Choice 1, payments to health care providers for benefits would be made on the same basis as under the Medicare program. Balance billing—billing an individual for charges or services other than on an assignment-related basis—would be prohibited. HHS would establish a global fee for obstetrical services provided throughout the course of pregnancy with a 5 percent increase in the fee schedule amount for women presenting for prenatal care during the first trimester. HHS would establish a fee schedule for outpatient prescription drugs. Under Choice 2, participating private plans would be paid a per-enrollee rate by HHS. This amount, referred to as the "annual per capita amount," would be calculated by HHS based on the average cost of benefits per enrollee under the entire new program.[27]	In addition to existing taxes, the new program would be financed through a new tax imposed on employees (1.7 percent of wages) and a new tax on employers (7.0 percent of wages). Self-employed individuals would be subject to a new tax (8.7 percent of self-employment income). A new Medicare for All Trust Fund would be established. Funds accrued under the new payroll taxes would be placed directly into the Trust Fund. Private plans participating under Choice 2 would be paid a per-enrollee rate by HHS. This amount, referred to as the "annual per capita amount," would be calculated by HHS based on the average cost of benefits per enrollee under the entire new program.[28] Payments to private health plans by HHS would be risk-adjusted. Risk adjustment factors would be similar to those used for payments to private plans under Medicare Advantage (Medicare Part C), but HHS also would ensure that payments are adjusted to reflect the health status of enrollees.
Key implementation dates	January 1, 2010	18 months after date of enactment of statute

Bill name	AmeriCare Health Act of 2006	Medicare for All Act
Other key elements of the bill	HHS would develop an enrollment process, including a process for automatic enrollment of individuals at birth, for four classes of enrollees: (1) Individuals; (2) Married couples without children; (3) Unmarried individuals with children; and (4) Married couples with children. Individuals could opt-out of AmeriCare coverage upon showing they have coverage under a group health plan that is at least equivalent to AmeriCare coverage. HHS would establish standards for an electronic system to verify an individual's entitlement to benefits, track out-of-pocket spending, and verify enrollment of qualified providers within 12 months of the bill's enactment. HHS also would establish a Web site accessible to providers and private health plans to verify enrollees' eligibility and liability for cost-sharing. HHS would establish national standards for claims submission within six months of enactment. The standards would be developed in coordination with standards for electronic medical records and would take into account recommendations of current task forces. HHS would promulgate standards for electronic medical records no later than January 1, 2008. Health care providers that fail to comply with uniform and electronic claims requirements would be subject to a civil monetary penalty of either $100 per day or the amount of the claim, whichever is greater, for each violation. Providers would have 36 months after the effective date of the bill to comply with the new standards. Health care providers would be required to maintain electronic medical record data for all patients and transmit electronically upon request by HHS as a condition of participation by January 1, 2009. Civil monetary penalties of $100 would be levied on any AmeriCare supplemental plan that fails to comply with electronic medical record standards. During or after FY 2007, hospitals would be required to use uniform cost reporting.	Individuals would be deemed to be enrolled automatically upon birth in the U.S. or upon time of legal immigration into the U.S. Enrollees would not be prohibited from obtaining supplemental coverage through private health insurance. Under Choice 2, there would be an annual open enrollment process when individuals could enroll, terminate enrollment, or change health plans. This process would be similar to the FEHBP annual open enrollment process. The legislation places a "maintenance of effort" requirement on states' Medicaid plans. States would be prohibited from reducing standards of eligibility or benefit levels provided under their Medicaid plans. Violation of this requirement could lead to ineligibility for federal financial participation.

Table A-3. Side-by-Side Analysis of the Medicare Early Access Act of 2005 and the Ending the Medicare Disability Waiting Period Act of 2005

Bill name	Medicare Early Access Act of 2005	Ending the Medicare Disability Waiting Period Act of 2005
Bill number(s)	H.R. 2072	S. 1217/H.R. 2869
Bill sponsor(s)	H.R. 2072 is sponsored by Representative Stark and has 112 cosponsors.	S. 1217 is sponsored by Senator Bingaman and has 22 cosponsors. H.R. 2869 is sponsored by Representative Green and has 57 cosponsors.
Latest Congressional action	H.R. 2072 was referred to the House Ways and Means Subcommittee on Health on May 16, 2005, the Education and Workforce Subcommittee on Employer-Employee Relations on May 20, 2005, and the Energy and Commerce Subcommittee on Health on May 23, 2005.	S. 1217 was referred to the Senate Finance Committee on June 6, 2005. H.R. 2869 was referred to the House Ways and Means Health and Social Security Subcommittees on June 27, 2005, and to the House Energy and Commerce Health Subcommittee on July 1, 2005.
Basic structure of coverage expansion	Allows certain near elderly persons to buy in to Medicare. This coverage expansion would be financed fully through premiums, although individuals could claim a partial federal tax credit for the premiums. Enrollees could claim a refundable tax credit for up to 75 percent of the premium amount. The tax credit could be claimed in advance (on a monthly basis) or at the end of the year on the individual's federal income tax return. Employers offering retiree benefits could provide wraparound benefits for enrollees in the buy-in program. In addition, employers could pay 25 percent of the Medicare buy-in amount on behalf of retirees.	The bill would phase out the 24-month waiting period for individuals under age 65 to be eligible for Medicare on the basis of receiving disability insurance benefits under the Title II Old Age, Survivors and Disability Insurance (OASDI) Social Security Act (SSA). In addition, the bill would create new Medicare eligibility for individuals suffering from fatal diseases (such as amyotrophic lateral sclerosis, or ALS), as defined by the Secretary of Health and Human Services (HHS).
Description of eligible participants	This expansion would target near-elderly individuals who are not eligible for employer-sponsored coverage or coverage through a federal health program.	This expansion would target non-elderly disabled individuals and individuals suffering from fatal diseases.
Eligibility criteria	Individuals 55 to 64 years of age who would be eligible for Medicare Part A if they were 65 years of age would be able to enroll in the Medicare Early Access program as long as they are not eligible for: • Medicare, Medicaid, Federal Employees Health Benefits Program (FEHBP), TRICARE or health benefits provided to active duty military; or • Employer-sponsored health coverage. However, individuals eligible for COBRA or enrolled in a retiree health plan may enroll in the Medicare buy-in program.	Individuals under age 65 entitled to disability insurance benefits under the SSA; and Individuals with life-threatening diseases, identified by HHS as fatal without medical treatment. In compiling the list of diseases, HHS would be required to consult with the Director of the National Institutes of Health (NIH), the Director of the Centers for Disease Control and Prevention (CDC), the Director of the National Science Foundation (NSF), and the Institute of Medicine (IOM) of the National Academy of Sciences.
Benefits	Enrollees would receive the same benefits available to Medicare beneficiaries. In addition, employers offering retiree benefits could pay for items and services not covered by Medicare.	Eligible individuals would be eligible for the full range of benefits under the Medicare program. The waiting period for beneficiaries would be phased out as follows:

Bill name	Medicare Early Access Act of 2005	Ending the Medicare Disability Waiting Period Act of 2005
		• In 2006, the waiting period would be 18 months; • In 2007, 16 months; • In 2008, 14 months; • In 2009, 12 months; • In 2010, 10 months; • In 2011, 8 months; • In 2012, 5 months; • In 2013, 4 months; • In 2014, 2 months; and • In 2015 and each subsequent year, 0 months.
Premium and cost-sharing requirements	Enrollees would pay premiums, based on the average national per capita cost of providing services to near-elderly persons under this program. Premiums could vary by age. Cost-sharing for covered services would be the same as for other Medicare beneficiaries.	New beneficiaries would be subject to the same cost-sharing requirements currently in place under the Medicare program.
Incentives and federal subsidies	Individuals would be given a refundable tax credit for up to 75 percent of the premium amount. Since the credit would be refundable, the taxpayer would receive the entire amount of the credit regardless of the amount owed in taxes for the year (e.g., if the credit is more than the amount owed by the taxpayer, the taxpayer would receive the remaining amount of the credit in the form of a refund). The tax credit could be claimed at the end of the year when filing the federal income tax return or in advance on a monthly basis. If paid in advance, the Internal Revenue Service (IRS) would pay the Department of Health and Human Services (HHS) directly as a partial payment of the enrollee's premium.	None specified.
Changes to public program(s)	The bill would permit near-elderly individuals to obtain Medicare benefits. Enrollees in the Medicare buy-in program would not be eligible for Medicaid program services otherwise available to Medicare beneficiaries (e.g., Medicaid long-term care assistance). The annual capitation rate for Medicare Advantage plans (Medicare Part C) would be adjusted to reflect differences in expected costs between near-elderly buy-in enrollees and Medicare beneficiaries.	The legislation would expand the population of eligible Medicare beneficiaries.
Administration and oversight of the coverage expansion	The IRS would administer the tax credit. HHS would administer the Medicare benefits for these enrollees.	The expansion would retain the current Medicare administrative structure under HHS.

Bill name	Medicare Early Access Act of 2005	Ending the Medicare Disability Waiting Period Act of 2005
Changes to federal or state oversight of health coverage	None specified.	None specified.
Financing	A new, separate trust fund (the Medicare Early Access Trust Fund) would be established to collect premiums and pay for benefits. Coverage expansion would be paid for by a combination of enrollee premiums, general federal revenues (the tax credit), and employer contributions to enrollee premiums.	The Medicare program would be responsible for covering all beneficiaries that become newly eligible under the terms of this bill. In addition, for fiscal year (FY) 2006 and FY 2007, the bill would authorize $750,000 for the IOM report (discussed below).
Key implementation dates	To be determined (current effective date: January 1, 2006).	"No sooner than" 90 days after the enactment date of the legislation.
Other key elements of the bill	Employers offering retiree benefits whose retirees enroll in the program could provide wraparound coverage and pay a portion of the premium (25 percent) on behalf of retirees. The bill would establish limited enrollment periods, as described below: • Initial enrollment would be limited to a four-month period following initial implementation of the bill for eligible individuals; • After the initial enrollment period, individuals who subsequently become eligible would have a limited period of time to enroll (e.g., persons who turn 55 and do not have access to federal or employer-sponsored coverage or who lose access to coverage after age 55). These individuals would be required to enroll within a four-month period. An annual report on the status of the newly created Medicare trust fund would be issued by the trust fund's board of trustees. The General Accounting Office (GAO) would periodically report on the adequacy of the financing of coverage provided under this Medicare buy-in program. The legislation does not address the sale of Medigap policies to enrollees. Currently, federal law does not require insurers to sell Medigap policies to beneficiaries under age 65. Insurers may sell policies to persons under 65 voluntarily (but can charge a higher rate) or because of requirements established by some states.	The legislation would require HHS to request a study from the IOM on the range of disability conditions that could be delayed or prevented if individuals receive access to health care services and coverage before the condition renders the individual "disabled." Results of the study would be submitted to Congress within two years after the date of enactment of the legislation.

Table A-4. Side-by-Side Analysis of the Kids Come First Act of 2007 and the FamilyCare Act of 2005

Bill name	Kids Come First Act of 2007	FamilyCare Act of 2005
Bill number(s)	S. 95/H.R. 1668	H.R. 2071
Bill sponsor(s)	S. 95 is sponsored by Senator Kerry and has six cosponsors. H.R. 1668 is sponsored by Representative Waxman and has 70 cosponsors.	H.R. 2071 is sponsored by Representative Dingell and has 106 cosponsors.
Latest Congressional action	S. 95 was referred to the Senate Committee on Finance on January 4, 2007. H.R. 1668 was referred to the: • House Committee on Energy and Commerce, Subcommittee on Health on April 22, 2005; • House Committee on Ways and Means, Subcommittee on Health on April 27, 2005; and • House Committee on Education and Workforce, Subcommittee on Employer-Employee Relations on May 9, 2005.	H.R. 2071 was referred to the House Committee on Energy and Commerce, Subcommittee on Health on May 23, 2005.
Basic structure of coverage expansion	Expands coverage for children by increasing access to public and private coverage in several ways. The bill would: • Provide 100 percent federal financing of children in poverty in Medicaid in exchange for states expanding coverage to children in higher-income families through Medicaid or the State Children's Health Insurance Program (SCHIP) and streamlining enrollment; • Create a refundable tax credit for premiums paid to cover children through private health insurance; and • Require employers offering health coverage to offer a family coverage option. Additionally, the bill would reduce individuals' federal tax exemptions proportionate to the length of time that their dependent children are uninsured during the taxable year.	Creates FamilyCare, a new federal public health program, which would replace the current State Children's Health Insurance Program (SCHIP). The bill would expand coverage for eligible parents of low-income children, legal immigrants, children up to age 21, and pregnant women.
Description of eligible participants	Children of all income levels could be affected by the bill.	Parents of low-income children, legal immigrants, children up to age 21, and pregnant women could be affected by this bill.
Eligibility criteria	The following eligible individuals could obtain coverage through Medicaid and SCHIP expansions: • Children under age 21 (up from age 19 under both programs) in families with annual incomes not exceeding 300 percent of the federal poverty level (FPL) (up from SCHIP's current limit of 200 percent FPL);[29]	Eligibility criteria under Medicaid would change in the following ways: • Children ages 19 or 20 in families with income above Medicaid income limits could be covered. • A new optional category of Medicaid eligibility would be established for parents of categorically eligible children who are low-income and not otherwise

Bill name	Kids Come First Act of 2007	FamilyCare Act of 2005
	• Legal immigrant children under age 21 lawfully residing in the U.S.; and • Low-income children under age 21 of state employees. All taxpayers regardless of income could claim a refundable tax credit for premiums paid to cover children in the private market. Since the tax credit is refundable, taxpayers would receive the entire amount of the credit regardless of the amount owed in taxes for the year (e.g., if the credit is more than the amount owed by the taxpayer, the taxpayer would receive the remaining amount of the credit in the form of a refund). In addition, employees who have employer-based health coverage must be offered the option to enroll in family coverage.	eligible for medical assistance under Medicaid.[30] (Categorically eligible children are those that states are required by federal law to cover to receive federal funds for Medicaid.) • Pregnant women with annual incomes greater than 185 percent FPL could be covered.[31] • The presumptive eligibility period under Medicaid would be expanded to provide eligibility for parents of presumptively eligible children.[32] Eligibility criteria under SCHIP would change in the following ways: • Eligibility for children born to parents receiving coverage under FamilyCare (formerly SCHIP) would be automatic. • Presumptive eligibility under FamilyCare (formerly SCHIP) would be expanded to include pregnant women and parents. • Parents of SCHIP-covered children not otherwise eligible for Medicaid would be eligible for coverage under FamilyCare (formerly SCHIP). Legal immigrants who are pregnant women, children up to age 21, or parents of such children could be covered under Medicaid or FamilyCare (formerly SCHIP).
Benefits	Children under age 21 in families with annual incomes not exceeding 300 percent FPL would receive: • Benefits under SCHIP if their families' incomes are between 100 and 300 percent FPL; or • Coverage through the state-subsidized purchase of dependent coverage under a group health plan (so long as HHS determines that the coverage is consistent with the benefit standards under SCHIP, and the state provides wraparound coverage either under Medicaid or SCHIP to ensure that all children receive the same level of benefits regardless of how they are covered). States also would be required to permit children under 21 from families with incomes exceeding 300 percent FPL who already receive coverage under Medicaid or any group health plan to purchase full or wraparound coverage under SCHIP. States could either provide wraparound coverage for free or could require payment at full cost.	Current Medicaid and SCHIP benefit packages would not change.

Bill name	Kids Come First Act of 2007	FamilyCare Act of 2005
	States would no longer be prohibited from providing SCHIP coverage to low-income children of state employees. In addition, states could provide coverage for legal immigrant children under age 21 through Medicaid or SCHIP. Under current law, states are generally prohibited from providing anything other than emergency medical services under their Medicaid or SCHIP programs to legal immigrants until such individuals have been in the country for at least five years.[33] States would be required to pay health care providers for services provided to eligible children at payment rates that are no less than the average rates for similar services established under benchmark benefit packages for SCHIP. (These benchmark benefit packages include FEHBP-equivalent children's health insurance coverage, state employee coverage, or coverage offered through the HMO with the largest insured commercial, non-Medicaid enrollment). States also would be required to ensure that payment rates are adequate to guarantee that children enrolled under Medicaid or SCHIP have adequate access to comprehensive care. The bill does not address coverage requirements for individuals claiming the refundable tax credit or for coverage provided through an employer-sponsored plan.	
Premium and cost-sharing requirements	Not specified.	FamilyCare (formerly SCHIP), would not permit cost-sharing for pregnancy-related services. States would be prohibited from imposing aggregate annual cost-sharing involving low-income children in excess of 2.5 percent of the family's annual income.
Incentives and federal subsidies	The Federal government would provide 100% Federal Medicaid Assistance Percentages (FMAP) for coverage of children in poverty in Medicaid, and SCHIP funding would no longer be capped, if states agreed to: • Cover children in families up to 300% of poverty in Medicaid or SCHIP; • Permit higher-income children to purchase SCHIP coverage, either full or wraparound coverage; and • Remove enrollment and access barriers while maintaining current Medicaid eligibility levels for children. A new refundable tax credit would be created for health insurance coverage of	The federal government would provide enhanced Federal medical assistance percentages (FMAP) and SCHIP allotments in exchange for coverage expansions, as described below. Payments for the following would not count against a state's SCHIP allotment: • The amount that states are already paid under the regular FMAP rates for currently providing coverage to pregnant women with incomes above 133 percent FPL; • Payments for services provided to parents under FamilyCare (formerly SCHIP); and

Bill name	Kids Come First Act of 2007	FamilyCare Act of 2005
	dependent children. Forfeiture of the personal tax exemption would be instituted for any taxpayer whose children are without health care coverage. The legislation would create a new refundable tax credit for health insurance coverage for children. The credit would be equal to the amount paid for qualified health insurance for a dependent child during the tax year that exceeds 5 percent of the taxpayer's adjusted gross income. Any deductions taxpayers would have taken for medical expenses or high-deductible health plans would be reduced by the credit allowed under this bill. The personal tax exemption available to taxpayers for dependent children would be reduced according to the length of time the dependent children go without qualified health insurance. Failure to provide proof of health coverage for a dependent child would be penalized by a full reduction in a taxpayer's personal tax exemption. These provisions would *not* apply to taxpayers in the lowest tax bracket.	• The amount that states are already paid under the regular FMAP rates for currently providing coverage to children ages 19 and 20 from families with incomes above Medicaid limits.
Changes to public program(s)	The bill would provide states with increased federal Medicaid matching funds for coverage expansions for children in poverty under age 21, if they agreed to expand coverage in Medicaid and SCHIP to children up to 300% FPL, allowed children in families with incomes greater than 300% of poverty to purchase coverage in SCHIP, and simplified enrollment procedures. States also would be provided with greater options for coverage of low-income children under their SCHIP programs, and SCHIP funding caps for states would be eliminated. States could receive 100 percent FMAP rates for certain coverage expansions. The increase in FMAP would not apply to disproportionate share hospital payments, payments made under the Temporary Assistance for Needy Families (TANF) program, or SCHIP. Eligibility determination and re-determination processes would be revised as follows: • States could not require face-to-face interviews for initial eligibility determinations or re-determinations for children under Medicaid or SCHIP. Applications and renewals by mail, telephone, and internet would be sufficient.	The SCHIP program would be renamed FamilyCare. New coverage expansions, under both FamilyCare and Medicaid, would be available. Under their current Medicaid programs, states would be eligible for an enhanced FMAP rate for expanding coverage to: • Parents of covered children, so long as the state currently has a SCHIP program with a maximum income limit of at least 200 percent FPL, does not have a wait list for any eligible children under its SCHIP program, and the income limit set by the state for the parent expansion coverage is not lower than the state's SCHIP income limit; • Pregnant women, so long as the current income limit for Medicaid benefits for pregnant women is at least 185 percent FPL, higher-income pregnant women are not provided coverage where lower-income pregnant women are not, the income limit for the pregnant women coverage expansion is not less than the limit already in place under the state's Medicaid program, the state has a SCHIP program with a maximum income limit of at least 200 percent FPL, and the state does not wait list any eligible children for its SCHIP program; and

Bill name	Kids Come First Act of 2007	FamilyCare Act of 2005
	• States would be required to use all information already in their possession and to avoid duplication of information requests. States would have to maintain eligibility income, resources, and methodologies no more restrictive than those already currently applied to children under Medicaid. States would be prohibited from imposing any waiting lists, waiting periods, or other limitations or barriers on the eligibility or enrollment of children for assistance under SCHIP.	• Children ages 19 and 20 from families with incomes that exceed Medicaid limits. For FY 2006–2007, an enhanced FMAP rate of 100 percent would be available for the parent coverage expansions. Under FamilyCare (formerly SCHIP), states would have the option of providing new coverage for low-income parents, low-income pregnant women, or both, as long as: • The state currently has a SCHIP program with a maximum income limit of at least 200 percent FPL; • The state does not wait list any eligible children for its SCHIP program; • The state ensures via the income limits it establishes that parents will be in the same program as their children, to the greatest extent possible; • The current restriction under SCHIP that total cost-sharing may not exceed 5 percent of a family's annual income will apply to: 1) entire families; or 2) pregnant women individually. In exchange for the FamilyCare coverage expansions, states would receive greater federal funding via new allotments, and redistribution of unused funding would only be made to states with FamilyCare programs. Under Medicaid or FamilyCare (formerly SCHIP), states would have the option of providing coverage for legal immigrants who are pregnant women, children up to age 20, or parents of these children. Under Medicaid, states *must* provide 12-month continuous eligibility for children up to 19 years old (or older, if a state has elected to offer coverage under its state plan for children older than 19). A state's FamilyCare (formerly SCHIP) program would be required to provide continuous eligibility no less generous than offered under its Medicaid program. States would have the option to extend eligibility for low-income families for up to 12 additional months (instead of the mandatory six) for transitional medical assistance (TMA). This option would not be available for families with incomes exceeding 185 percent FPL. States would have the option to waive the requirement that families receive Medicaid benefits for three of the previous six months to qualify for TMA. The TMA sunset also would be repealed.

Bill name	Kids Come First Act of 2007	FamilyCare Act of 2005
Administration and oversight of the coverage expansion	No new administrative or oversight measures responsibilities would be added.	Not specified.
Changes to federal or state oversight of health coverage	Not specified.	Not specified.
Financing	States that expand coverage under the legislation would be guaranteed funding through the elimination of SCHIP payment caps for the fiscal year(s) at issue. The increased FMAP rate that states would receive for expanding coverage under the legislation would be paid to states through grants. A partial repeal of the rate reduction in the highest federal income tax bracket would be used to help finance the coverage expansions. The Secretary of Health and Human Services (HHS) would determine what the new rate would be, based on the funding necessary to provide sufficient revenues to offset any federal outlays required by the legislation.	For the coverage expansions under the Medicaid program, appropriations from the state's SCHIP allotment would be authorized. In addition, for FY 2006–2007, an enhanced FMAP rate of 100 percent would be available for the parent coverage expansions. After that states would continue to be eligible for an enhanced FMAP rate. For the coverage expansions under the FamilyCare (formerly SCHIP) program, the federal government would appropriate the following funds for new, additional allotments: • For FY 2006, $7 billion, • For FY 2007, $7 billion, • For FY 2008, $3 billion, • For FY 2009, $3 billion, • For FY 2010, $6 billion, • For FY 2011, $7 billion, • For FY 2012, $8 billion, • For FY 2013, $9 billion, and • For FY 2014 and after, the amount of the allowable allotment would be the preceding fiscal year amount increased by the percentage increase in the medical care expenditure category of the Consumer Price Index for All Urban Consumers. The above total allotments would be distributed among states in the same proportion of their current allotment (without regard for redistributions) to 98.95 percent of total allotments. The remaining allotments would go to commonwealths and territories, distributed according to the proportion of their current allotment to 1.05 percent. Redistribution of unused allotments would go only to states providing FamilyCare coverage. Current SCHIP base allotment levels would be made permanent, beginning in FY 2008. These amounts would be increased annually by the percentage increase in the medical care expenditure category of the Consumer Price Index for All Urban Customers.

Bill name	Kids Come First Act of 2007	FamilyCare Act of 2005
		$10 million would be appropriated for demonstration projects for outreach to homeless individuals and families.
Key implementation dates	To be determined (current effective date: after October 1, 2005).	The bill's provisions were to be effective after October 1, 2005, except for the sections pertaining to coverage expansion for children ages 19 and 20, which were to take effect January 1, 2006.
Other key elements of the bill	To qualify for increased FMAP rates, states would have to agree to several measures that would remove enrollment and reenrollment barriers. States would be required to adopt 12-month continuous eligibility rules (i.e., eligibility for assistance under Medicaid and SCHIP could not be re-determined more than once every year for children described under this legislation). Families of children applying for Medicaid or SCHIP would be allowed to self-declare and certify under penalty of perjury their family income for purposes of submitting eligibility information to states. States also would have to accept determinations made by other federal or state agencies regarding an individual's or family's income level, as long as these agencies have fiscal liabilities or responsibilities affected by the determination, and the information furnished is only used for determining eligibility for Medicaid or SCHIP. States would be prohibited from applying any asset or resource tests for eligibility for children applying for Medicaid or SCHIP. States would be required to provide presumptive eligibility for children under Medicaid and SCHIP.[34] Employers offering coverage would be required to offer enrollees the option of purchasing dependent coverage for their children, up to age 21. The employer would not have to contribute to the premium for the dependent.	No later than July 1, 2007, GAO would submit a report to Congress on the funding of FamilyCare (formerly SCHIP). The report would include an examination of the adequacy of overall funding, the formula for determining allotments, and the effect of waiting lists and caps on enrollment. The Secretary of Health and Human Services (HHS) would be authorized to award demonstration grants for up to seven states for programs designed to improve outreach to homeless individuals and families under Medicaid, SCHIP, Temporary Assistance for Needy Families (TANF), the Substance Abuse and Mental Health Services Administration (SAMHSA) block grant program, and other non–health care programs.

Table A-5. Analysis of the Health Care for Working Families Act of 2005

Bill name	Health Care for Working Families Act of 2005
Bill number	H.R. 2197
Bill sponsor(s)	H.R. 2197 is sponsored by Representative Pallone and does not have any cosponsors.
Latest Congressional action	H.R. 2197 was referred to the House Subcommittee on Military Personnel on June 21, 2005.
Overview of employer mandate	Requires large employers to offer employees and their dependents the opportunity to enroll in a qualifying health plan. Employees could decline coverage unless they are covered by a federal health insurance program (e.g., Medicaid or Medicare). Most employees covered by a federal health insurance program would be required to accept the offer to enroll, along with their dependents, in the employer-sponsored qualifying health plan.
Description of affected employers and employees	Large employers, defined as employers that employed an average of at least 50 full-time employees on business days during the prior calendar year and who employed at least 50 employees on the first day of the plan year, would be subject to the provisions of the bill. Employers that do not meet the definition of large employer also would be affected if the majority of the services performed by the employer are performed on behalf of a single large employer. Employees of large employers, including those who were contract workers or who have coverage under certain federal health insurance programs, could be affected by the bill. Federal health insurance programs specified by the bill include Medicare, Medicaid, the Federal Employee Health Benefit Program (FEHBP), and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).
Participation requirements for employers and employees	Large employers would be required to contribute to the cost of any qualifying health benefit plan offered to its employees. Employers also would be required to provide coverage to new employees no later than 30 days after the employee begins work. A contract worker of a large employer would be considered an employee, meaning the employer would have to offer the coverage provided for under the bill. Employees covered by a federal health insurance program would be required to accept the offer to enroll in an employer-sponsored qualifying health plan unless they had coverage under a different employer's qualified health benefit plan. Dependents of these employees also would be required to accept the offer to enroll as well, unless they had other qualified coverage.
Benefits	The health benefit plan would provide coverage equivalent or greater in value than the benefits offered as of January 1, 2006, under the Blue Cross/Blue Shield Standard Plan provided under FEHBP. For individuals covered by a federal health insurance program, the employer-based health benefit plan would be the primary payer and the federal program would be the secondary payer for costs and services not covered by the employer's plan.

Bill name	Health Care for Working Families Act of 2005
Premium and cost-sharing requirements	The premium contribution made by the employer could not be less than the total premium that the federal government contributes under the Blue Cross/Blue Shield Standard Plan provided under FEHBP. • For employees who work less than 30 hours per week, the employer contribution would be reduced. This reduction would be based on the hours worked and would be proportional to the employer contribution for employees who worked at least 30 hours of service per week. For example, the minimum employer provided premium would be the product of the employer provided for an employee who completes 30 hours of service per week and the ratio of the number of hours worked to 30. • Employers would not be required to contribute for employees who work less than 10 hours per week. Large employers would be required to withhold the employee's share of the premium from their wages. Employees who would otherwise be covered by a federal health insurance program could have their share of the premium paid by the federal government. The employee would be responsible for requesting this payment.
Incentives and penalties	Some of the civil monetary penalties of section 502 of the Employee Retirement Income Security Act of 1974 (ERISA) would apply to large employers.
Requirements for private insurers or health plans	The bill would require a health insurance issuer offering health insurance coverage to an employer to ensure that the coverage complies with the requirements of the bill.
Administration and oversight of mandate	The Secretary of Labor could bring civil actions against non-compliant large employers.
Changes to federal or state oversight of health coverage	The bill would not prevent states from establishing, implementing, or continuing to require standards relating to employer-provided health insurance coverage unless the requirements prevent the application of this bill. States could not prevent employers from withholding the amount of premium due by the employee from the payroll of the employee.
Financing	Not applicable.
Key implementation dates	The current effective date is January 1, 2006. With respect to collective bargaining agreements, the requirements apply on the first day of the first plan year beginning after January 1, 2006.
Other key elements of the bill	Not applicable.

Table A-6. Side-by-Side Analysis of the Small Business Health Plans Act of 2006 and the Small Employers Health Benefits Program Act of 2006

Bill name	Small Business Health Plans Act of 2006	Small Employers Health Benefits Program Act of 2006
Bill number(s)	H.R. 5288	S. 2510 / H.R. 1955
Bill sponsor(s)	H.R. 5288 is sponsored by Representative Allen and has 17 cosponsors.	S. 2510 is sponsored by Senator Durbin and has 26 cosponsors. H.R. 1955 is sponsored by Representative Kind and has 26 cosponsors.
Latest Congressional action	H.R. 5288 was referred to the House Committee on Education and the Workforce, Subcommittee on Employer-Employee Relations on May 24, 2006, and introductory remarks on the bill were provided on June 7, 2006.	S. 2510 was referred to the Senate Committee on Finance on April 5, 2006. H.R. 1955 was referred to the following subcommittees and committee on May 20, 2005: • The House Committee on Ways and Means, Subcommittee on Health; • The House Committee on Education and the Workforce, Subcommittee on Employer-Employee Relations; and • The House Committee on the Budget.
Basic structure of coverage expansion	Creates a new small business health benefits program (SBHBP) to expand access to coverage for workers in firms with fewer than 50 employees. States could receive grants to establish a SBHBP. Employers in states without a state-established program could obtain coverage through a national SBHBP established by the Secretary of Health and Human Services (HHS). The benefits provided under the SBHBP would be similar to coverage available to federal employees. Premium assistance would be available for eligible small employers, and reinsurance for catastrophic costs would be provided to participating insurers.	Creates a new small employer health benefits program (SEHBP) to expand access to coverage for workers in firms with fewer than 100 employees. The Office of Personnel Management (OPM) would establish the nationwide SEHBP. The benefits provided under the SEHBP would meet the minimum standards for health benefits required by OPM for health coverage available to federal employees. Premium assistance would be available for eligible small employers. Insurer payments would be adjusted based on the claims experience of enrollees, and reinsurance for catastrophic costs would be available for insurers.
Description of affected small employers, employees and individuals	Small employers with fewer than 50 employees could provide coverage through a SBHBP. The bill would not address coverage for individuals buying coverage on their own.	Small employers with fewer than 100 employees could provide coverage through the SEHBP. The bill would not address health coverage for individuals buying coverage on their own.
Eligibility criteria for small employers, employees and individuals	Employers with fewer than 50 employees could obtain coverage through a SBHBP. This requirement for fewer than 50 employees could be waived on a case-by-case basis by HHS. For example, the employment of temporary and seasonal workers could be considered when determining the total number of employees. Employers that begin participating in a SBHBP and subsequently grow in size to more than 50 employees could continue to obtain coverage through the SBHBP.	Small employers with fewer than 100 employees could provide coverage through the SEHBP. This requirement for fewer than 100 employees could be waived on a case-by-case basis. In determining the size of the employer, certain affiliated employers and partnerships under common control would be considered a single employer. Employers that begin participating in a SEHBP and subsequently grow in size to more than 100 employees could continue to obtain coverage through the SEHBP.

Bill name	Small Business Health Plans Act of 2006	Small Employers Health Benefits Program Act of 2006
		Employers could not offer other comprehensive health coverage in addition to the coverage obtained though the SEHBP. Employers could provide limited benefits, such as coverage for specific diseases, on-site medical clinics, and worker's compensation, and still participate in the SEHBP. Employees of eligible small employers and self-employed individuals could obtain coverage for themselves and their dependents in the SEHBP, provided they are not eligible for coverage through the Federal Employees Health Benefit Program (FEHBP).
Benefit requirements for private insurers, health plans or other entities offering coverage	Benefits provided through a SBHBP would be similar to coverage available through one of the four largest plans (based on enrollment) participating in the Federal Employees Health Benefit Program (FEHBP). SBHBP coverage would have to comply with all state laws and regulations for group health insurance for the state in which the coverage is offered, including applicable benefit mandates and other consumer protections. Coverage could not be excluded or modified based on employee (or dependent) preexisting conditions or health status. Employers would have a choice of at least two coverage options.	Benefits provided through the SEHBP would have to meet the OPM's minimum standards for benefits provided to federal employees under the FEHBP. SEHBP coverage would have to comply with all state benefit requirements for the state in which the coverage is offered. In addition, OPM would develop a nationwide benefit plan that meets all state benefit requirements. Coverage could be excluded based on employee (or dependent) preexisting conditions for up to six months. The length of the exclusion period would be reduced on a day-for-day basis for each day the individual was covered under a health plan immediately preceding the date the individual applied for coverage in the SEHBP. **Note:** H.R. 1955 would reduce the exclusionary period for preexisting conditions on a month-by-month basis rather than day-by-day basis and would specify that time without coverage cannot exceed 63 days for prior coverage to count towards reducing the time an insurer can exclude coverage for a preexisting condition. Employers would have a range of health benefit plans available to them through the SEHBP.
Premium and cost-sharing requirements for purchasers/ beneficiaries	Not specified.	Not specified.

Bill name	Small Business Health Plans Act of 2006	Small Employers Health Benefits Program Act of 2006
Premium and cost-sharing requirements for private insurers, health plans or other entities offering coverage	The SBHBP could not vary premiums based on the health status of employees or their dependents.	The SEHBP would charge each employer group a modified community rate. A single premium (i.e., a community rate) would be established for all employers in the program, and this premium could only vary among employers based on geographic area, family size, and the age of the enrollee. The OPM would establish five age brackets for insurers to use in establishing premiums for individuals who are under 65 years of age. • Insurers could not vary premiums based on age within an age bracket. Across age brackets, insurers could not vary premiums by more than 50 percent above or below the community rate for the age of all enrollees. • For elderly individuals enrolled in Medicare, insurers could vary premiums based on age differently than for non-elderly individuals. **Note:** H.R. 1955 specifies that age brackets for non-elderly individuals cannot begin earlier than age 30. Premium rates could not vary based on factors such as health, gender, or claims experience. These premium-setting requirements would supersede state rules with two exceptions. The state rules for establishing premiums would apply when: • The state permits less variation in premiums based on age than would be permitted under the rules for the SEHBP; and • The state provides for some form of community rating. Premium adjustments would be made on a basis consistent with premium adjustments for the FEHBP. **Note:** Under H.R. 1955, premiums could be adjusted in a manner consistent with coverage for large employers and cannot vary based on factors related to the health of the enrollees.
Incentives and federal subsidies	Small employers participating in a SBHBP could receive premium assistance. Employers would be required to pay for at least 50 percent of the premiums for employees to receive the assistance. The employer would not be required to pay any portion of the premium for employees' dependents.	Small employers participating in the SEHBP could receive premium assistance in the form of a refundable tax credit. Nonprofit employers participating in the SEHBP also could receive the premium assistance even if they are exempt from taxes. Employers would be required to pay a minimum of 60 percent of the premium for

Bill name	Small Business Health Plans Act of 2006	Small Employers Health Benefits Program Act of 2006
	The amount of the premium assistance would be determined by HHS and provided on a sliding scale based on: • The size of the employer (number of employees); • The average wage level of the employer's employees relative to other employees in the same geographic area; and • The employer's profit margin. Insurers participating in a SBHBP could receive reinsurance coverage for 75 percent of covered claims that exceed, for an individual, a minimum of $100,000 during the first year of operations. The minimum amount would be increased annually by HHS according to the estimated average annual percentage increase in costs from the previous year as measured by the estimated increase in the median premium level. HHS would provide grants to states for the establishment and initial administration of a SBHBP. The bill would authorize the appropriation of funds necessary to assist states.	individual coverage and 50 percent for family coverage to receive the premium assistance. **Note:** H.R. 1955 requires employers to contribute a minimum of 60 percent of the premium amount for employees but does not specify a minimum contribution amount for family coverage for employers to be eligible for premium assistance. The credit would only be available for premiums for workers with annual wages between $5,000 and $30,000. The amount of the credit would vary depending on the employer's contribution to the premium and the employee's income. Employers contributing the minimum amount for employees with wages that are $25,000 or less could claim a full credit equal to: • 25 percent of their contribution for individual coverage; • 30 percent for coverage for two adults or one adult with one or more children; and • 35 percent for family coverage. For every 10 percent an employer contributes above 60 percent of the premium for all types of coverage, the applicable percentage of the contribution that could be claimed would increase by 5 percentage points (e.g., employers contributing 70 percent of the premium for family coverage could receive a credit for 40 percent of the contribution). The credit would be reduced for premium contributions for employees with wages between $25,000 and $30,000. Employers could not receive a credit for premiums for employees with wages exceeding $30,000. These wage limits would increase annually based on the average increases in premiums under the FEHBP. For the first year in the SEHBP, the employer could claim an additional credit for 10 percent of premium contributions for workers with wages less than $30,000. Premiums paid through a salary reduction arrangement could not be counted as employer contributions when determining eligibility for the employer tax credit (e.g., salary reductions for a separate flexible spending arrangement for employees to pay health premiums).

Bill name	Small Business Health Plans Act of 2006	Small Employers Health Benefits Program Act of 2006
		In addition, OPM would adjust insurer payments annually according to the claims experience of enrollees for 2007 through 2009. **Note:** H.R. 1955 would adjust insurer payments according to the claims experience of enrollees through 2010. The claims experience of enrollees would be determined based on the expenses incurred for providing benefits, excluding administrative costs. Insurers would report for the upcoming year expected benefit costs (a "target amount") based on estimated monthly premiums minus administrative expenses. Subsequently, insurers would report actual benefit and administrative costs incurred for the year. No adjustment would be provided to insurers with benefit costs within 3 percent of the target amount (i.e., between 97 percent and 103 percent of the target amount). Insurers with benefit costs above 103 percent of the target amount would be reimbursed by OPM as follows: • Insurers with costs up to 108 percent of the target amount would be reimbursed 75 percent of the benefit costs above 103 percent of the target amount. • Insurers with costs above 108 percent would be reimbursed: a) 3.75 percent of the target amount; and b) 90 percent of the difference between 108 percent of the target amount and the benefit costs. Insurers with benefit costs below 97 percent would be required to contribute to an existing contingency reserve and stabilization fund for federal health benefits. • Insurers with benefit costs above 92 percent of the target amount would pay into the fund 75 percent of the difference between 97 percent of the target amount and benefit costs. • Insurers with benefit costs below 92 percent of the target amount would pay into the fund: a) 3.75 percent of the target amount; and b) 90 percent of the difference between 92 percent of the target amount and the benefit costs.

Bill name	Small Business Health Plans Act of 2006	Small Employers Health Benefits Program Act of 2006
		The bill also would create a reinsurance fund for insurers with catastrophic claims. Insurers could be reimbursed up to 80 percent of their expenses above $50,000 for an episode of care, as determined by OPM. The amount of the reimbursement would be based on Medicare's payment rate for such claims if the Medicare rate is less than the insurer's payment amount. The reinsurance fund would terminate two years after SEHBP's first contract period. **Note:** The reinsurance fund would not terminate after two years under H.R. 1955. Starting October 1, 2010, OPM could establish a contingency fund using funds that are appropriated for the development and administration of the SEHBP but that remain unobligated. At OPM's discretion, the fund could be used to assist insurers with unanticipated financial hardships.
Requirements for private insurers, health plans or other entities offering coverage	A national SBHBP would be available to small employers located in states where the state has not established a SBHBP. The SBHBPs would be modeled on the FEHBP and would be responsible for negotiating the most affordable and substantial coverage possible for small employers. States could establish SBHBPs in accordance with the rules established by HHS for SBHBPs. For state or national SBHBPs, employee enrollment and changes in enrollment would be limited to an annual open enrollment period. Under certain circumstances specified by HHS, individuals could enroll at other times during the year, such as after a change in family status (e.g., birth or marriage). HHS would be directed to promote participation in a SBHBP by insurers with established: • Health information technology tools to promote quality; • Chronic disease management programs; • Preventive health care service coverage; and • Evidence-based medicine considerations for prescription drugs and other treatments that take into account enrollees' medical circumstances.	Insurers must be licensed in each state in which coverage is offered. Insurers would have to provide detailed information about benefits offered, ensure that a range of benefit plans are available to participating employers, and meet other requirements as determined by OPM to participate in the SEHBP. Insurers participating in the FEHBP could offer the same coverage to eligible employers through the SEHBP. Insurers could not cancel coverage for employers except in cases of fraud, over-insurance, or nonpayment of premiums. Insurers must provide to employees losing enrollment in the SEHBP a temporary extension of coverage and the option to convert to a plan in the individual market, regardless of the enrollees' health. The enrollee would be required to pay the full premium amount for the coverage in the individual market. **Note:** In addition to requiring insurers offer a conversion policy to employees losing enrollment in the SEHBP, H.R. 1955 would require insurers continue to provide SEHBP coverage to individuals who meet the eligibility criteria for continuation of coverage under FEHBP (e.g., individuals who lose their jobs).

Bill name	Small Business Health Plans Act of 2006	Small Employers Health Benefits Program Act of 2006
Administration and oversight of the coverage expansion	The national SBHBP would be established jointly by HHS and the Department of Labor, in consultation with the Office of Personnel Management. These agencies would be responsible for the implementation and oversight of the national SBHBP. HHS also would be responsible for establishing rules and regulations for all SBHBPs, including rules related to the benefits offered, permitted enrollment periods, employer premium assistance, reinsurance for insurers, and promotion of insurer participation in the program. In addition, HHS would provide regulations for the coordination of coverage through the SBHBP with other coverage provided under governmental health benefit programs. If a state established a SBHBP, the state would be responsible for the administration and oversight according to the rules established by HHS. States would not be responsible for promoting the participation of certain insurers in the SBHBP as described above (e.g., insurers that use health information technology to promote quality).	The national SEHBP would be established by OPM. The regulations for the SEHBP would be as similar as possible to those for FEHBP. However, the two programs would be entirely separate. The SEHBP could not alter premiums or benefits, or adversely affect coverage in any way for federal employees or retirees in the FEHBP. In establishing the SEHBP, OPM would develop an enrollment process that includes the use of the internet. OPM would negotiate premiums in the same manner used for FEHBP. The OPM could contract for private entities to assist in administering the program. In addition, contracts could be awarded for entities to perform certain administrative activities on a regional basis, including: • Collecting and maintaining information on participants; • Receiving, disbursing, and accounting for payments; • Facilitating communication between insurers and participants; and • Processing appeals and grievances. Insurers participating in the SEHBP would be subject to state rules and oversight with one exception. As applicable and discussed above, insurers would be subject to federal rules for establishing premiums for the SEHBP. Insurers would be subject to state rules for grievances, claims, and appeals (except as preempted by existing federal law) as well as rules related to the adequacy of provider networks.
Financing	The bill would authorize the appropriation of the necessary funds from general revenues for grants to states for the establishment and initial administration of a SBHBP.	The bill would authorize appropriations of the necessary funds each year from general revenues for OPM to develop and administer the SEHBP. **Note:** In addition, H.R. 1955 would appropriate $4 billion each year for fiscal years 2006 through 2008, and $3 billion a year in fiscal year 2009 and 2010, for payments to insurers to adjust for risk and provide reinsurance for catastrophic claims. H.R. 1955 also would extend the Pay-As-You-Go requirement to 2010. The premium assistance for employers would be paid from general revenues. In addition, the bill authorizes appropriations of the necessary funds for 2007 and 2008 from general revenues for OPM to conduct a public education campaign for the SEHBP.

Bill name	Small Business Health Plans Act of 2006	Small Employers Health Benefits Program Act of 2006
Key implementation dates	The national SBHBP would be implemented on a timely basis but not sooner than January 2007.	The provisions of the bill would be effective upon the bill's enactment and would apply to contracts that take effect in calendar year 2007 and each year thereafter.
Other key elements of the bill	Not applicable.	The OPM would implement an education campaign for employers and the general public about the SEHBP. Annually for two years after implementing the education campaign, OPM would report to Congress on the campaign activities and the percentage of employers aware of the program. Individuals who terminate SEHBP coverage would have to wait at least six months to enroll again and could only reenroll during an open enrollment period. For individuals with Medicare, coverage through the SEHBP would be coordinated to the same extent and in the same manner as FEHBP.

NOTES

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

[2] Arizona, California, Georgia, Illinois, Iowa, Kansas, Louisiana, Massachusetts, Montana, New Mexico, New York, North Carolina, Ohio, Texas, and Wisconsin. In addition to California and Massachusetts, states were selected to provide regional and population diversity, variation in numbers of uninsured people, and a range of income eligibility limits in Medicaid and SCHIP.

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

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

[5] J. Sheils and R. Haught, *President Bush's Health Care Tax Deduction Proposal: Coverage, Cost, and Distributional Impacts* (Falls Church, Va.: The Lewin Group, http://www.lewin.com, Jan. 2007).

[6] K. Davis, *The 2007 State of the Union Address: The President's Health Insurance Proposal Is Not a Solution* (New York: The Commonwealth Fund, Feb. 2007).

[7] Sheils and Haught, *Bush's Proposal,* 2007.

[8] Ibid.

[9] J. Gabel, K. Dhont, and J. Pickreign, *Are Tax Credits Alone the Solution to Affordable Health Insurance? Comparing Individual and Group Insurance Costs in 17 U.S. Markets* (New York: The Commonwealth Fund, May 2002).

[10] D. Holahan, E. Hubert, C. Schoen, *A Blueprint for Universal Coverage in New York* (New York: The United Hospital Fund and The Commonwealth Fund, Dec. 2006).

[11] K. Davis, B. S. Cooper, and R. Capasso, *The Federal Employee Health Benefits Program: A Model for Workers, Not Medicare* (New York: The Commonwealth Fund, Nov. 2003); Gabel, Dhont, and Pickreign, *Are Tax Credits,* 2002.

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

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

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

[15] See, for example, K. Davis and C. Schoen, "Creating Consensus on Coverage Choices," *Health Affairs* Web Exclusive (Apr. 23, 2003): W3-199–W3-211.

[16] Lewin Group estimates based on 2006 Current Population Survey.

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

[18] Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits, 2006 Annual Survey* (Washington, D.C.: KFF and HRET, 2006).

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

[20] S. R. Collins, C. Schoen, J. L. Kriss, and M. M. Doty, *Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help* (New York: The Commonwealth Fund, updated May 2006).

[21] S. Dorn and G. M. Kenney, *Automatically Enrolling Eligible Children and Families into Medicaid and SCHIP: Opportunities, Obstacles, and Options for Federal Policymakers* (New York: The Commonwealth Fund, June 2006).

[22] Institute of Medicine, *Hidden Costs, Value Lost* (Washington, D.C.: National Academies Press, 2003).

[23] Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from a National Scorecard on U.S. Health System Performance* (New York: The Commonwealth Fund, Sept. 2006).

[24] R. Toner and J. Elder, "Most Support U.S. Guarantee of Health Care," *New York Times,* Mar. 2, 2007.

[25] These bills are similar in many ways, although the bills are not officially designated as companion bills. Significant differences are noted below.

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

[27] Annual average per capita cost is a concept already in use by HHS. Under SSA § 1876(a)(4), HHS must follow certain rules for calculating an annual average per capita cost. Current payments to health maintenance organizations (HMOs) and private plans under Medicare are determined according to an "adjusted average per capita cost," which is estimated in advance by HHS based on 1) actual costs of private plans or 2) retrospective actuarial equivalent amounts based on i) an adequate sample, ii) in a geographic area served by the eligible organization or in a similar area, iii) with adjustments to ensure actuarial equivalence.

[28] Ibid.

[29] Income limits vary depending on the maximum allowable SCHIP eligibility level in the state. State Medicaid programs are currently required to provide coverage for children up to age 19 in families with annual incomes at or below 100 percent FPL. States have the option of providing Medicaid coverage to children up to age 19 in families with annual incomes at or below 185 percent FPL. States offering SCHIP programs have the option of providing coverage to children up to age 19 in families with annual incomes up to 200 percent FPL. See SSA §§ 1902(a)(10)(A)(i)(III); 1902(a)(10)(A)(ii)(XIV); 2110(b)(1), (b)(4). Medicaid and SCHIP coverage may differ, however, if a state has been granted a waiver under SSA § 1115.

[30] States must establish income thresholds.

[31] Under current law, states are required to provide Medicaid coverage to pregnant women at or below 133 percent FPL. In addition, states have the option of providing coverage to pregnant women at or below 185 percent FPL. SSA §§ 1902(a)(10)(A)(i)(III), 1902(a)(10)(A)(ii)(IX).

[32] Applicants deemed "presumptively eligible" could begin receiving Medicaid assistance immediately based upon preliminary information provided. During this period, presumptively

eligible children would receive any items or services under the state's Medicaid plan. A period of presumptive eligibility begins on the date that a qualified entity determines a child is presumptively eligible and ends either when a full Medicaid eligibility determination is made or, if a Medicaid application is ultimately not filed on behalf of the child, on the last day of the following month, whichever is earlier. See 42 U.S.C. § 1396r-1(b)(2)(B).

[33] Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), 8 U.S.C. § 1601 *et seq.*

[34] Applicants deemed "presumptively eligible" could begin receiving Medicaid assistance immediately based upon preliminary information provided. During this period, presumptively eligible children would receive any items or services under the state's Medicaid plan. A period of presumptive eligibility begins on the date that a qualified entity determines a child is presumptively eligible and ends either when a full Medicaid eligibility determination is made or, if a Medicaid application is ultimately not filed on behalf of the child, on the last day of the following month, whichever is earlier. See 42 U.S.C. § 1396r-1(b)(2)(B).

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