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# Health Reform and the 111th Congress

Hinda Chaikind
*Congressional Research Service*

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# Health Reform and the 111th Congress

**Abstract**
[Excerpt] The health reform debate in the 111th Congress has continued and expanded upon the work begun in the 110th Congress. On November 12, 2008, the Chairman of the Senate Finance Committee, Senator Baucus, released a white paper detailing his principles for health reform. This provided a framework for work within the committee for the 111th Congress. Several bills were introduced when the 111th Congress first convened, and these bills focused on a broad spectrum of approaches to health reform. Most recently, the House and Senate committees of principle jurisdiction on health reform have been formulating their legislation. On July 15, one of the two committees with principle jurisdiction in the Senate, the Committee on Health, Education, Labor, and Pensions, ordered reported S. 1679, the Affordable Health Choices Act. In the House, the principle jurisdiction for health reform is divided among the Committees on Education and Labor, Ways and Means, and Energy and Commerce. Jointly, the committees released for consideration H.R. 3200, America's Affordable Health Choices Act, on July 14. The Committees on Education and Labor and Ways and Means each ordered reported, as amended, their versions of H.R. 3200 on July 17. The Committee on Energy and Commerce ordered reported its version of H.R. 3200 on July 31, 2009. The Senate Finance Committee ordered reported the Chairman's mark, as amended, known as America's Health Future Act of 2009, on October 13.

The health reform bills being considered by the House and Senate committees of principle jurisdiction focus on simultaneously expanding private and public coverage options. Some of the other bills introduced in the 111th Congress take a similar approach to health reform. Additionally, other bills have focused on other solutions, attempting to expand coverage using one of the following approaches:

• Largely replace existing coverage with a national government-provided health insurance program (or a national health service).

• Expand existing public programs for certain individuals.

• Expand privately sponsored coverage.

• Encourage state-based reforms.

• Simultaneously expand private and public coverage options.

This report presents basic background on health insurance that may be useful to legislators considering health insurance reforms. It describes reform approaches and provides brief descriptions of health insurance reform bills introduced in the 111th Congress, as well as some of the general principles currently being considered by the Congress. The potential impact of the various approaches and bills is not analyzed in this report, however. As a result, it does not provide evaluations of how well different bills, once enacted, would meet their objectives. This report will be updated periodically to reflect recent congressional activity in health reform.

**Keywords**
health reform, Congress, public policy, health care, public coverage, private coverage

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Congressional Research Service

# Health Reform and the 111th Congress

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October 14, 2009

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**CRS Report for Congress**
*Prepared for Members and Committees of Congress*

# Summary

The health reform debate in the 111th Congress has continued and expanded upon the work begun in the 110th Congress. On November 12, 2008, the Chairman of the Senate Finance Committee, Senator Baucus, released a white paper detailing his principles for health reform. This provided a framework for work within the committee for the 111th Congress. Several bills were introduced when the 111th Congress first convened, and these bills focused on a broad spectrum of approaches to health reform. Most recently, the House and Senate committees of principle jurisdiction on health reform have been formulating their legislation. On July 15, one of the two committees with principle jurisdiction in the Senate, the Committee on Health, Education, Labor, and Pensions, ordered reported S. 1679, the Affordable Health Choices Act. In the House, the principle jurisdiction for health reform is divided among the Committees on Education and Labor, Ways and Means, and Energy and Commerce. Jointly, the committees released for consideration H.R. 3200, America's Affordable Health Choices Act, on July 14. The Committees on Education and Labor and Ways and Means each ordered reported, as amended, their versions of H.R. 3200 on July 17. The Committee on Energy and Commerce ordered reported its version of H.R. 3200 on July 31, 2009. The Senate Finance Committee ordered reported the Chairman's mark, as amended, known as America's Health Future Act of 2009, on October 13.

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# Introduction

The health reform debate in the 111th Congress has continued and expanded upon the work begun in the 110th Congress. On November 12, 2008, the Chairman of the Senate Finance Committee, Senator Baucus, released a white paper detailing his principles for health reform. This provided a framework for work within the committee for the 111th Congress. Several bills were introduced when the 111th Congress first convened, and these bills focused on a broad spectrum of approaches to health reform. Most recently, the House and Senate On July 15, one of the two committees with principle jurisdiction in the Senate, the Committee on Health, Education, Labor, and Pensions, ordered reported S. 1679, the Affordable Health Choices Act. In the House, the principle jurisdiction for health reform is divided among the Committees on Education and Labor, Ways and Means, and Energy and Commerce. Jointly, the committees released for consideration H.R. 3200, America's Affordable Health Choices Act, on July 14, 2009. The Committees on Education and Labor and Ways and Means each ordered reported, as amended, their versions of H.R. 3200 on July 17, 2009.[1] The Committee on Energy and Commerce ordered reported its version of H.R. 3200 on July 31, 2009. The Senate Finance Committee ordered reported the Chairman's mark, as amended, known as America's Health Future Act of 2009, on October 13.

This report presents basic background information on health insurance that may be useful to legislators considering health insurance reforms.[2] It describes health insurance reform approaches and provides brief descriptions of health insurance reform bills introduced in the 111th Congress. The discussions in this report will not summarize all currently introduced legislation, but may be helpful in understanding the range of options that are currently being considered by Congress. The potential impact of various reform approaches and bills is not analyzed in this report. As a result, it does not provide evaluations of how well different bills, once enacted, would meet their objectives.

However, all of these bills have a common focus: to address some or all of the current issues surrounding health insurance and health services. The costs of health insurance and health care services are consuming a growing portion of workers' compensation, and the percentage of individuals with job-based health insurance coverage is declining. Some states are seeking reforms in their state systems, providing useful trials and errors to potentially inform the debate at the federal level. Just as the federal debate in the 1990s was spurred by rising health care and health insurance costs, declining numbers of individuals with private coverage, and state experimentation and innovation, those same issues are at the center of the debate today. Many of the issues addressed through health reform legislation are exacerbated by the existing recession.

## What Is Health Insurance Reform All About?

Health insurance reform is a broad term spanning a large range of policy options, each of which has its own inherent strengths and weaknesses. Health insurance reform can focus on a discrete health insurance problem or issue, such as expanding public health insurance coverage for uninsured children or reducing the number of costly state benefit mandates and premium taxes on private health insurance plans. At the opposite end of the spectrum, however, are proposals that

[1] For more information on H.R. 3200, see CRS Report R40724, *Private Health Insurance Provisions of H.R. 3200*.

[2] For more information on health care reform, see CRS Report R40517, *Health Care Reform: An Introduction.*

operate on a broader scale—changing the way people access public and/or private health insurance, investing large amounts of government resources to assist individuals with the cost of health care or health insurance, reducing costs and improving quality. The wide variation across proposed reforms is one factor that makes a simple yet comprehensive discussion of all of the important options challenging. Other fundamental differences separating health insurance reform approaches include different objectives of reforms and different priorities among important stakeholders.

## Different Objectives

Health insurance reform may have a wide range of primary objectives, which can include the following:

- **Reducing the number of people without health insurance.** Most health insurance reforms seek to improve access to health insurance. In the United States, access to medical care is largely dependent on whether an individual has health insurance.
- **Reducing the reliance on health insurance for at least some portion of needed medical care.** Some approaches to reform reflect the position that part of the insurance problem in the United States is that people have too much of it—that the presence of insurance has desensitized Americans to the cost of health care services, allowing both the demand for and the prices of medical care, whether necessary or unnecessary, to grow too quickly.[3] Legislation may include provisions intended to encourage cost-consciousness in individuals' choices of health insurance and health care and include a group of approaches sometimes referred to as promoting "consumer directed" health care.[4]
- **Reducing the cost of health insurance.** Some advocates of reform believe that the rising cost of health insurance must be addressed before other problems can be dealt with. Their reform approaches reflect the belief that more people will purchase insurance once more affordable plans are available. Thus, they assert reducing the number of uninsured is secondary to reducing the cost of the insurance. Cost-reducing approaches span the continuum, from preempting the application of state laws which increase the price of insurance, to establishing a single government payer for all health insurance. Advocates of single payer approaches believe such a system would improve administrative efficiencies, thereby reducing overall health insurance costs.

Legislation has also been introduced in the 111th Congress that features objectives related to improving the quality of medical care or the quality of health insurance products. Proposals to improve health outcomes, increase the availability of information about high-quality health care and providers, and establish disease management systems are raising interest among private insurers, government programs, and employers. These provisions alone, however, will not reduce

[3] See CRS Report RL34767, *The Tax Exclusion for Employer-Provided Health Insurance: Policy Issues Regarding the Repeal Debate*, specifically the section on "Excess Insurance."

[4] Goodman, J., *What Is Consumer-Directed Health Care? Health Affairs Web Exclusive*, at http://content.healthaffairs.org/cgi/content/full/25/6/w540.

the number of people without any insurance, and their effect on medical costs is as yet undetermined.[5]

What constitutes adequate health insurance is an important consideration that is beyond the scope of this report. Nonetheless, sponsors of bills extending coverage are likely to grapple with complex questions about the kind of coverage that should be extended. Sponsors of bills offering generous government subsidies for health insurance may feel that it is their duty to set a minimum standard for qualifying coverage as a way to ensure that taxpayers' funds are being used responsibly.

## Prioritizing Among Stakeholders

One of the challenges of undertaking comprehensive health insurance reform is that every U.S. legal resident is a stakeholder whose individual preferences and needs may differ. Reform approaches reflect different choices about the relative importance of needs among stakeholder groups, including federal, state, and local governments, health care providers, medical researchers, insurance carriers, employers, workers, and consumers.

Needs can vary considerably among stakeholder groups, and even within them. For example, health care consumers may prefer low-cost health insurance obtained through lower profits to health insurers while, according to standard economic theory, those health insurers will seek to maximize profits. Within consumer groups, there are healthy people who may prefer limited insurance coverage or none at all, while elderly or less healthy consumers may prefer more comprehensive coverage. Sometimes meeting the needs of one group can exacerbate the problems encountered by others. For example, requiring health care premiums to be community rated—that is, based on the average costs of everyone in a large group—can reduce premiums for individuals with expensive medical conditions. On the other hand, community-rated rates could lead to higher premiums for the healthiest individuals.

## Scope of Reform

Since the early 1990s, a number of incremental health insurance reforms have been enacted (see **Text Box 1**). Health insurance reform in the 111th Congress may use a variety of approaches, ranging from incremental improvements that build on the nation's current patchwork of coverage to reforms of a much broader scope.

A number of incremental reforms enacted over the past 15 years have improved the availability of health insurance for some populations. However, they have been built on a system in which some continue to have no access to any insurance and others to only unaffordable options, and the number of uninsured has continued to rise; such changes may also have exacerbated the loss of privately sponsored coverage. For example, a body of research has concluded that expanding Medicaid and the State Children's Health Insurance Program (CHIP) has generated some crowd-out of private coverage; on the other hand, children are the only subpopulation in which uninsurance rates have fallen over the past decade.[6]

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[5] Mattke, S., Seid, M., Ma, S., "Evidence for the Effect of Disease Management: Is $1 Billion a Year a Good Investment?" *American Journal of Managed Care*, vol. 13, 2007.

[6] Crowd-out occurs when public funds substitute for, rather than supplement, private funding. For more information, (continued...)

**Text Box 1. Incremental Federal Health Insurance Reforms Since the Early 1990s**

Eligibility for Medicaid (under Title XIX of the Social Security Act), initially passed in 1965 along with Medicare (under Title XVIII of the Social Security Act), was delinked from cash welfare programs, and eligibility thresholds were raised for children, pregnant women, and certain aged. (See CRS Report RL33019, *Medicaid Eligibility for Adults and Children*.)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) addressed a number of problems in the offering and rating of private health insurance, particularly in the small group and individual markets for insurance. Ostensibly about improving portability of health insurance, its insurance provisions reduced the length of preexisting condition exclusion periods for certain individuals in the small group market, guaranteed the availability of plans for certain eligible people, and reduced discrimination against individuals within small groups based on health conditions. (See CRS Report RL31634, *The Health Insurance Portability and Accountability Act (HIPAA) of 1996: Overview and Guidance on Frequently Asked Questions*.)

The Balanced Budget Act of 1997 created the State Children's Health Insurance Program (CHIP), establishing grants for states to use to provide health insurance to uninsured low-income children. On February 4, 2009, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, H.R. 2, P.L. 111-3) was signed into law. It provides CHIP appropriations through FY2013 and makes other changes. (See CRS Report R40444, *State Children's Health Insurance Program (CHIP): A Brief Overview*.)

The Trade Act of 2002 provided (1) grants for states to set up or expand high-risk pools for individuals who cannot find health insurance in the individual market, and (2) health coverage tax credits for certain unemployed individuals and people whose pensions are guaranteed by the Pension Benefit Guarantee Corporation. (See CRS Report RL31745, *Health Insurance: State High Risk Pools*, and CRS Report RL32620, *Health Coverage Tax Credit*.)

The American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5) includes provisions to subsidize health insurance coverage through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and expand tax credits to unemployed workers through the Health Coverage Tax Credit (HCTC). (See CRS Report R40420, *Health Insurance Premium Assistance for the Unemployed: The American Recovery and Reinvestment Act of 2009*.)

**Note:** Does not include reforms to Medicare or Medicaid unless they extended eligibility.

Questions about the scope of reforms extend to the cost of the reform plans. At one end of the federal financing spectrum are approaches that feature subsidies for individuals to use toward the cost of health insurance. Such bills presume that a financial commitment from the federal government is essential to achieve universal or near-universal coverage, whether coverage is provided through government programs or private plans. A fair amount of research supports the notion that significant subsidies would be needed to induce many of the uninsured to purchase coverage.[7]

(...continued)

see Gruber, J., Simon, K., *Crowd-out Ten Years Later: Have Recent Public Insurance Expansions Crowded out Private Health Insurance?* National Bureau of Economic Research Working Paper 12858 http://www.nber.org/papers/w12858; *Crowd-Out and SCHIP Reauthorization*, An Alliance for Health Reform Toolkit, at http://www.allhealth.org/publications/Child_health_insurance/Crowd-out_and_SCHIP_toolkit_70.pdf; Long S., Marquis, S., "Participation in a Public Insurance Program: Subsidies, Crowd-Out, and Adverse Selection," *Inquiry*, vol. 39, no. 3, Fall 2002.

[7] Reschovsky, J., Hadley, J., *Employer Health Insurance Premium Subsidies Unlikely to Enhance Coverage Significantly*, Center for Studying Health System Change Issue Brief No. 46, December 2001; Thomas, K., "Are Subsidies Enough to Encourage the Uninsured to Purchase Health Insurance? An Analysis of Underlying Behavior," *Inquiry*, vol. 31, no. 4 (Winter 1994-95); Pauly, M., Herring, B., and Song, D., *Tax Credits, the Distribution of Subsidized Health Insurance Premiums, and the Uninsured*, Forum for Health Economics & Policy, 2002, (Frontiers in Health Policy Research), Article 5 http://www.bepress.com/fhep/5/5; Marquis, S., Long, S., *State Efforts to Insure the Uninsured, An Unfinished Story*, a RAND Research Brief, 2005.

On the other end of the spectrum are a number of market reform approaches that reflect the position that government laws and regulations have raised the cost of insurance, reduced the number of options available to people, and created disincentives to purchase low-cost insurance. For example, state benefit mandates are blamed for increasing costs and reducing choices. Bills at this end of the spectrum aim to make the market for insurance work better, proposing to achieve higher coverage rates without subsidies because people would find health insurance products are more affordable by meeting, but not exceeding, their insurance needs.

# General Approaches to Health Insurance Reform

While the 111th Congress is still relatively new, several health insurance reform bills have already been introduced. These bills, as well as other proposals currently under consideration, can be classified as expanding coverage using one of the following approaches:[8]

- Largely replace existing coverage with a national government-provided health insurance program (or a national health service).
- Expand existing public programs for certain individuals.
- Expand privately sponsored coverage.
- Encourage state-based reforms.
- Simultaneously expand private and public coverage options.

## National Government-Provided Health Insurance Program

Some of the proposals introduced in the 111th are directed at the creation of a national health insurance program. While the legislation can take a variety of forms, the general thrust of such proposals is to make basic health insurance available to all Americans so that access to health care would not be contingent on individuals' ability to pay or their employment status. These proposals all share at least three common features: replacement of most or all of the existing sources of coverage, universal entitlement to health care or health insurance, and government-provided health coverage.

National health insurance legislation in the 111th Congress generally takes one of two approaches: social insurance[9] or a national health service. Under the social insurance approach, all individuals

[8] For other classification schemes, see Collins, S., Schoen, C., Davis, K., Gauthier, A., Schoenbaum, S., *A Roadmap to Health Insurance for All: Principles for Reform*, Commonwealth Fund, October 2007; *Insuring America's Health: Principles and Recommendations*, Institute of Medicine, Committee on the Consequences of Uninsurance, January 2004 http://www.iom.edu/CMS/3809/4660/16675.aspx.

[9] The definition of "social insurance" used in this instance is based on its traditional definition, referring to "government-sponsored programs with all of the following characteristics: a. The program, including benefits and financing method, is prescribed by statute. b. The program provides for explicit accountability of benefit payments and income, usually in the form of a trust fund. c. The program is financed by contributions (e.g., taxes or premiums) from or on behalf of participants, which in some programs are supplemented by government income from other sources. Investment income on program assets may also be used to finance the program. d. The program is universally (or almost universally) compulsory for a defined population, or the contribution is set at such a subsidized level that the vast majority of the population eligible to participate actually participate." From Actuarial Standard of Practice No. 32, *Social Insurance*, Actuarial Standards Board, Doc. No. 062, http://www.actuarialstandardsboard.org/pdf/asops/asop032_062.pdf.

would obtain their health insurance through a government-administered and financed system. Medicare is an example of a social insurance program for elderly and disabled individuals. Private insurers can retain a role in such a system, essentially acting as contractors. In contrast, the national health service approach, modeled after systems like Britain's National Health Service, includes universal coverage, as well as reforms of some or all of the factors of health care production—such as public ownership of hospitals, or public employment of physicians. Private insurers may or may not have a role in such a system.

Because of the magnitude of the changes in such approaches, they could be subject to criticism, particularly about the level of governmental intrusion they would potentially introduce. The counterargument could be that the continuation of more incremental changes cannot be relied on to achieve universal or near universal insurance coverage.

## Expand Existing Public Programs for Certain Individuals

Members of the 111th Congress have also introduced bills that would expand public health insurance programs for certain targeted groups of individuals. For example, legislation has been introduced to eliminate the two-year Medicare waiting period for people who are disabled. Other bills would expand Medicaid coverage to individuals who are not currently eligible for the program. None of these partial coverage bills are summarized at the end of this report. Instead, the list of introduced legislation is focused on only those bills that are not limited to particular demographic groups.

Although the bills characterized in this section are not listed at the end of this report because of their narrow scope, that is not to suggest their impact would be insignificant.[10] If one measures the success of past health insurance reforms by the number of previously uninsured individuals who obtained health coverage, then the expansion of public programs (Medicare, Medicaid, and CHIP) must be considered great successes. For example, in the years after the creation of CHIP, the percentage of children who were uninsured fell by more than one-third; this is in contrast to a 12% increase of uninsured among non-aged adults over the same period.[11]

Legislation offered in the 111th Congress would build on those programs to extend coverage to more uninsured individuals. One advantage that public program expansions have over other types of reforms is that the programs are already operational and their administrative costs may be lower, relative to the costs of benefits, than for typical private coverage.[12] If the target population of a reform proposal is predominantly those who cannot afford private coverage, or if the

[10] Some of these limited scope bills could potentially extend coverage to more uninsured individuals than some of the bills that are listed at the end of this report. Because this report focuses on approaches and not impact, it does not address those differences in coverage.

[11] Based on the percentage of individuals uninsured for the full year, in 1996 and 2006, from the Medical Expenditure Panel Survey (MEPS), administered by the Agency for Healthcare Research and Quality (AHRQ).

[12] Reported administrative costs for Medicare and Medicaid are generally between 3% to 4% of benefits, while private plans range from between 5% to 50% of premium. Analysts argue, however, about whether the administrative public program data are complete and comparable. See Matthews, M., *Medicare's Hidden Administrative Costs: A Comparison of Medicare and the Private Sector (Based in Part on a Technical Paper by Mark Litow of Milliman, Inc.)*, Council on Affordable Health Insurance, January 2006.

proposal includes sliding scale subsidies, utilizing existing programs that already conduct income determinations and administer subsidies may be efficient.[13]

On the other hand, proposals to expand public coverage while maintaining the existing private market for insurance face an obstacle in "crowd out." There is evidence that in the presence of expanding public coverage, private coverage will be lower than it would have been. This may lead to fewer new covered lives than expected and/or greater public expenditures than expected. However, analyses have concluded that when public programs cover the lowest income people, for whom few affordable private sources of coverage exist, crowd-out is low. But when public programs extend into higher income levels, crowd-out rises.[14]

## Expand Privately Sponsored Coverage

Private health insurance sponsored by employers covers more than 60% of the U.S. population.[15] As a result, a major portion of health insurance in this country is funded privately by workers and their employers. Some of the bills focus on expanding employer-based or "group" coverage generally, and others address the particular needs of small employers or the problems present in the individual market for insurance.[16] Still other approaches focus on freeing private markets for insurance from the laws, regulations, and incentives that raise costs and reduce flexibility, with the hope that such changes would improve the availability and affordability of health coverage.[17]

### Expanding Employer-Based Coverage

Because more than 80% of uninsured individuals under age 65 are employed or are family members of a person with ties to employment,[18] efforts to expand or strengthen the employer-based, or group, market for insurance can potentially be effective in reducing the number of uninsured. Work-focused approaches, of course, have limited impact on people who have no or tenuous ties to the workforce.

Members of the 111th Congress have introduced bills that would subsidize workers' or employers' share of premiums (directly or through tax credits, exclusions or deductions; see **Text Box 2**), mandate that some or all employers offer coverage, or improve pooling in the small employer market for insurance.[19] Some of the proposals are intended to address the disadvantages that small

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[13] For a discussion of Medicaid expansions, see CRS Report R40490, *Medicaid Checklist: Considerations in Adding a Mandatory Eligibility Group*.

[14] *Public program crowd-out of private coverage: What are the issues?* The Robert Wood Johnson Foundation, Research Synthesis Report No. 5, http://www.rwjf.org/pr/synthesis/reports_and_briefs/pdf/no5_researchreport.pdf.

[15] CRS Report 96-891, *Health Insurance Coverage: Characteristics of the Insured and Uninsured in 2008*.

[16] For a background on the ways in which people obtain private health insurance and the markets for insurance, see CRS Report RL32237, *Health Insurance: A Primer*.

[17] The list of bills at the end of this report associated with this section do not include limited scope reforms that, for example, prohibit pre-existing condition exclusions for children or restrict private plans' ability to use lifetime limits.

[18] See Figure 1 in CRS Report 96-891, *Health Insurance Coverage: Characteristics of the Insured and Uninsured in 2008*.

[19] Risk pools are groups of individuals whose medical costs are combined to calculate premiums. Pooling risks together allows the costs of the less healthy to be subsidized by the healthy. In general, the larger the risk pool, the more predictable and stable the premiums can be. (From "Overview: Insurance Markets 101" presentation by Cori Uccello, American Academy of Actuaries at the National Association for Social Insurance 2008 Annual Meeting.)

employers face in providing health insurance as a benefit relative to large employers. (A number of these approaches are discussed more thoroughly in the "Market Reforms" section below.) Large employer groups are able to spread risk more broadly among their employees and enjoy economies of scale that keep per person administrative costs low. When a large employer self-insures,[20] its health benefits are not subject to state insurance laws and regulation (because it is not defined as "insurance"). This, along with the broad risk spreading and low per person administrative costs, can confer a considerable cost advantage over similar benefit plans in the small group or individual markets for insurance.

**Text Box 2. Subsidies for Private Health Insurance**

To achieve universal or near-universal private health insurance coverage, financial assistance with the cost of health insurance is likely to be necessary. Various studies examining individuals' demand for health insurance find that subsidies need to cover a significant portion of a premium before a low- or modest-income person may be willing to purchase it. Even legislation that requires individuals to purchase coverage tends to include assistance with costs, because health insurance premiums for a family at twice the federal poverty level can easily account for more than 25% of the family's income.

Three alternative ways to subsidize health coverage are proposed in bills offered in the 111th Congress. One approach is to create direct subsidies for health insurance that would be administered by the state or federal government's designated health agency. Individuals would apply to the appropriate office and, once determined eligible, would be provided either with a payment or voucher to use toward their insurance costs, or payments would be made directly to the insurance carrier. The second approach is to utilize the Internal Revenue Service (IRS) and build subsidies into the annual federal tax filings. Under this approach, tax filers would attest to their coverage during the prior year; and if their income is determined to be below the eligibility threshold, they would receive tax credits in the amount of the subsidy for which they are eligible. Thirdly, tax credits or subsidies could be given directly to employers to encourage employer contributions to workers' plans.

All approaches raise administrative challenges. The large variation in premium costs for different plans, combined with varying income levels of those eligible for subsidies, complicates routinized systems for subsidizing coverage. Some low-income individuals or families without tax liability do not file annual tax returns; getting them into the system may be difficult. And employer subsidies may or may not ultimately help workers.

For bill drafters, other complications arise in evaluating subsidies, whether delivered directly or through the tax system. One goal in setting subsidy amounts is often to achieve maximum health insurance purchases with fewest public funds. It is difficult to know the correct subsidy level to maximize the number of uninsured individuals or families who will become willing to buy coverage, the maximum amount of income that a low-income individual or family should be expected to contribute toward coverage, or the proper phase-out schedule for individuals or families with increasing income. Subsidies could exacerbate budgetary problems by encouraging crowd-out of existing employer or individual payments for coverage. Finally, depending on how the subsidies are set, individuals would face "cliffs", when one dollar of extra income could result in either a complete or substantial loss of a subsidy.

There are other ways to subsidize insurance via less direct routes. One of those, re-insurance, appears in some health insurance reform bills in the 111th Congress. These bills propose to transfer some of the "excess" risk for covering certain groups to either a pool funded by contributions from all insurers or from the government.

## Improving Access to Health Insurance in the Individual Market

Most health insurance in the United States is obtained through employment. This is due to a number of factors—workers perceive employers as paying for most of the cost of group health insurance, and payments for group plans have tax-advantaged status.[21] Further, the cost of group

[20] Many large employers self-insure their own health coverage instead of purchasing insurance through a traditional insurance carrier. Those employers retain the risk that costs of medical benefits for their employees exceed the collected premiums instead of passing that risk along to the insurance company (although many of them purchase a stop-loss policy that reimburses them for losses above a specified level).

[21] Under current law, employer-provided health insurance is excluded from a worker's income for determining both (continued...)

plans is calculated for an entire group, whereas people in the individual, or non-group, market are often "underwritten" based on their own health status—that is, the price of the insurance policy is based on an individual's own set of health conditions. While health underwriting could result in low-cost plans for healthy individuals seeking coverage, those with medical conditions could be at a significant price disadvantage relative to the price they might be charged if their premiums were averaged across an employment-based group. Insurers selling plans in many states can even refuse to sell to individuals with health conditions, or sell policies that exclude coverage for particular conditions and sometimes for entire body systems.[22]

Approaches addressing these issues are designed to make the individual market work better for more people. Potential advantages of improving the individual market for insurance include

- increasing individuals' choices (coverage options would not be limited to those chosen by their employer), and
- increasing the portability of health insurance (portable health insurance does not have to be discontinued when one leaves a job).

Tools utilized by individual market bills include

- giving individually purchased insurance the same tax-advantaged status as employer-sponsored coverage, and
- providing subsidies for the purchase of coverage in the individual market.

One option includes eliminating the tax benefits for employer-based health insurance premiums and replacing them with new tax benefits for coverage in the individual market. (See **Text Box 3** for summaries of tax policies related to health insurance.) This is intended, over time, to provide incentives for people to move from employer-based coverage to coverage in the individual market. However, because of the market limitations discussed above, such as health underwriting, lack of guaranteed availability of plans, and the absence of employer contributions, these proposals by themselves may improve options for some individuals, but not others. For example, employer contributions fund a large portion of the nation's health insurance bills. Without replacing those funds, some people may find individual insurance less affordable than their employer-sponsored plan, at least in the short run.[23] In addition, risk pooling in the individual market in many states is limited, and individual underwriting common. This could mean that if and when employers drop coverage, healthy people could easily find replacement policies in the individual market, but those less healthy and arguably most in need of health insurance could become a new and possibly needier group of uninsured. Finally, the administrative costs in an environment with few economies of scale are high. For these reasons, most bills proposing

(...continued)

income and employment taxes. In addition self-employed taxpayers generally can deduct the cost of their health insurance. In contract, taxpayers who purchase non-employment based health insurance may deduct their premiums only if they itemize deductions (which most taxpayers do not) and only to the extent that premiums and other unreimbursed medical expenses exceed 7.5% of adjusted gross income.

[22] Pollitz, K., Sorian, R. and Thomas, K., *How Accessible is Individual Health Insurance for People in Less-Than-Perfect Health?* Report for the Kaiser Family Foundation, June 2001, http://www.kff.org/insurance/upload/How-Accessible-is-Individual-Health-Insurance-for-Consumer-in-Less-Than-Perfect-Health-Report.pdf.

[23] Over time, employers would likely convert at least some portion of premium contributions to wages. Nonetheless, there would probably be some "leakage," and in the immediate term, not all employers have policies in place to raise wages immediately.

individual market solutions tend to be combined with other reforms addressing some of these issues. For example, some bills would establish a "connector" or "exchange" whose role could range from a simple clearinghouse for purchasing insurance (a Travelocity model) to an active participant in negotiating with plans and performing other functions. A connector or exchange might offer one plan or a selection of plans with enrollment available either to all small employers or to both small employers and individuals.

**Text Box 3. Tax Benefits to Individuals for Health Insurance**

Many of the health reform proposals being considered by the 111th Congress would utilize the U.S. tax system to help meet the objectives of the bills. Below are brief descriptions of some of the tax benefits proposed in health insurance reform bills. (For more information about tax benefits for health insurance, see CRS Report RL33505, *Tax Benefits for Health Insurance and Expenses: Overview of Current Law and Legislation*.)

**Tax credits for the purchase of health insurance**. A number of bills propose tax credits for the purchase of health insurance. Some would provide for larger credits for lower-income people, with amounts that gradually become smaller as income rises. Most of these bills would provide for credits that are refundable (so taxpayers can get the full credit even if they have no tax liability) and advanceable (so taxpayers do no have to wait until they file their returns to benefit).

**Expanded deduction for health insurance payments**. Another approach would allow a deduction in the calculation of adjusted gross income (an "above-the-line" deduction) for health insurance premiums, sometimes for a standard amount. The deduction would be available whether the taxpayer itemizes or claims the standard deduction and would be available to all taxpayers, whether or not insurance is employer-sponsored or individually purchased. This approach would establish comparable tax treatment between purchasers of employer-based and individually purchased insurance.

**Ending or capping the current tax exclusion for health insurance premiums**. Under current law, any amount paid by employers for employment-based health insurance is excluded from individuals' income. Capping the exclusion would make premium payments in excess of the cap taxable. The purpose of such a policy would be to encourage more cost consciousness among purchasers of health insurance. In addition, tax revenues raised from capping the exclusion could provide a funding source for other health insurance expansions or subsidies. Proposals to end the exclusion usually would replace it with the options above.

**Tax-advantaged savings accounts.** Recent legislation has expanded the availability of tax-advantaged savings accounts that can be used to pay for necessary health care not paid by the insurance. Sometimes these accounts are combined with high deductible health plans.

## Market Reforms

Bills offered in the 111th Congress may include other market improvements intended to make private health insurance more accessible and affordable. These approaches are intended to

- reduce state regulation of health insurance plans, with an objective of increasing affordability;
- broaden risk pools so that premiums for health insurance products are averaged over a larger group of individuals; and/or
- encourage "consumer driven" health plans and health choices.

In general, such approaches would retain the current sources of coverage.

States are primarily responsible for regulating the business of insurance. Over the years, states have developed a significant body of law dealing with all aspects of health insurance. State laws and regulations include patient protections, instructions on how insurance carriers may develop the rates charged for their products, and procedures for approval of those rates. They address how entities in the business of selling health insurance fund their enterprises and guard against the risk

of insolvency. Insurance carriers are subject to fair marketing practice laws, requirements related to the filing of grievances against the plans, and appeals processes of plan decisions. States also have benefit requirements that ensure that certain medical services must be available for a product to be sold and marketed as health insurance.[24]

Proposals to reduce state regulation would move insurance markets closer to an unrestrained free market and would invariably reduce costs for some purchasers of health insurance. (However, they may increase costs for others.) They would also address insurers' complaints about the challenges of selling products across state lines when laws in some states are significantly different from others. Many of the state laws were developed, however, to protect consumers from certain business practices; bills that would preempt those state laws raise concerns about those business practices reemerging.

Pooling proposals often focus specifically on small employers. Small employers have a harder time providing insurance to their employees for a number of reasons. Small groups are not able to spread their highest health risks broadly. As a result, premiums for small firms, particularly those with older or less healthy workers (or workers' dependents), are relatively high for similar benefits than for larger employers. Proposals encouraging small employers to join into health purchasing groups (sometimes called health insurance purchasing cooperatives or regional purchasing cooperatives) are meant to pool together those small groups, raising the number of individuals over which premiums are calculated. Bills encouraging professional and trade associations to offer coverage were considered in the 109th and 110th Congresses and were ostensibly about such pooling. In addition, those bills would provide regulatory relief for insurers selling products through associations. Most of those bills, however, did not require premiums to be calculated across the entire group, and so would not increase the size of the risk pools.

Increasing the size of risk pools is one objective of bills that would establish programs similar to the Federal Employees Health Benefits Program (FEHBP). In general, those bills would identify an existing federal agency or create a new one to negotiate with a limited number of health plans. The coverage would be modeled on existing plans, such as those offered through FEHBP. In general, the bills would require that premiums for plans offered through the program would be averaged across all of the enrollees for each plan—the largest possible risk pool.[25] In addition, those bills usually include significant subsidies for low-income employees or individuals and sometimes for employers as well.

Spreading risk broadly, however, is not a panacea. Community-rating (setting the level of premiums based on the average expenses of all subscribers) in an area could result in increased prices for young healthy people with low health risk and lower prices for those who are older or have health problems. If the goal of such approaches is to increase insurance coverage among those who need it most, this trade-off may be acceptable. If, however, the healthier and younger groups find their rates excessive, they may drop coverage altogether (where enrollment is voluntary), making the pool increasingly costly and undermining the objective of spreading risk.

Only one state, New York, has "pure community rating," where no individual-market premiums can vary by any individual factor, even age. More than 15 other states have taken other steps in

[24] See also CRS Report RS22476, *Standardizing State Health Insurance Regulation.*

[25] For a discussion of that debate, see CRS Report RL31963, *Association Sponsored Health Plans: Legislation in the 109th Congress.*

the individual market, such as rate banding or adjusted/modified community rating (generally using at least age as a rating factor), that effectively pool some risk.[26] Federal policies in this area might take into account the unique state markets that have developed in response to state laws to ensure that federal policies do not undermine improvements that states have already made.[27]

"Consumer driven" reforms are those that seek to encourage more choices for individuals in terms of the cost and coverage, and to raise cost consciousness, encouraging a preference for low-cost plans and better decision making about health care use. Ultimately, these reforms are intended to reduce overall premium growth and the use of marginally beneficial health care. For example, proposals to create tax preferences for high deductible health plans combined with health savings accounts are intended to encourage price reductions in coverage through several mechanisms: high deductible health insurance plans offer limited coverage relative to what may be covered by more typical comprehensive products, and health savings accounts encourage people to think more before seeking care for which money could be drawn from their account.

## Encourage State-Based Reforms

As in the early 1990s, state experimentation with health insurance reform is generating interest and discussion at the federal level. A number of states are experimenting with comprehensive insurance reforms toward a primary objective of achieving universal or near universal coverage (see **Text Box 4**). Some of these reforms may serve as a blueprint for federal changes, providing demonstrations that can better inform a federal debate. Many legislators, however, would rather have states continue to undertake reforms to address coverage gaps for their citizens. As a result, legislative proposals may include providing grant funds for states to continue and expand health insurance reforms on their own.

Some maintain that state-led reform can better reflect local needs, particularly in smaller or more homogeneous states. Access to health insurance and health care can be very localized, reflecting the close relationship between private health insurance and local health care providers, labor markets and economic conditions.

State-based reforms, however, face several significant obstacles. The Employee Retirement Income Security Act of 1974 (ERISA) impedes states from passing certain laws that affect employer benefits, such as health insurance.[28] For example, ERISA has generally pre-empted states' ability to require employers to offer or pay for health insurance.[29] Further, states' track record includes a number of failed initiatives—often related to inability to fund the rising costs of

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[26] "Individual Market Rate Restrictions, 2007," Kaiser Family Foundation's statehealthfacts.org, http://www.statehealthfacts.org/comparetable.jsp?ind=354&cat=7.

[27] Herring, B., Pauly M., *The Effect of State Community Rating Regulations On Premiums and Coverage in the Individual Health Insurance Market*, NBER Working Paper Series 12504, http://www.nber.org/papers/w12504. Pauly, M., Herring, B., *Pooling Health Insurance Risks*, AEI Press, 1999.

[28] Although exactly how much of an impediment ERISA creates is in flux as legal challenges are considered. For more on ERISA and the legal landscape, see Butler, P., *ERISA Implications for State Health Care Access Initiatives: Impact of the Maryland "Fair Share Act" Court Decision*, prepared for AcademyHealth and the National Academy for State Health Policy, November 2006 and *Employee Retirement Income Security Act (ERISA) and State Health Reform, An Alliance for Health Reform Toolkit*, August 2007.

[29] CRS Report RL34637, *Legal Issues Relating to State Health Care Regulation: ERISA Preemption and Fair Share Laws*.

the reforms.[30] States' ability to pay for reforms can be subject to the peaks and valleys of the states' tax collections. During challenging economic times, a need for state assistance of all kinds, including health insurance, rises often at the same time that states' tax base erodes, reducing states' ability to fund such needs.[31] Finally, to ensure equity across states, federal reforms may be necessary.

**Text Box 4. State Health Insurance Reforms**

A number of states are enacting health insurance reforms of historic proportions, utilizing such tools as individual mandates, employer "pay or play" requirements, and rewriting market regulations.

Massachusetts, for example, has implemented the following reforms: individual mandates that require citizens with sufficient income to obtain health insurance, income-related subsidies, employer "pay or play" requirements (wherein employers that do not provide health insurance pay an assessment towards subsidies for the uninsured), Medicaid expansions, insurance market reforms, and statewide minimum benefit standards for private insurance. Massachusetts financed the reforms through a number of sources, with over half of those funds coming from Medicaid. The continuation of the federal Medicaid funding has been a concern, but its renewal has apparently been extended. (See, for example, "Mass. gets $10.6b for healthcare insurance," *Boston Globe*, Oct. 1, 2008.)

Vermont's reforms included over 35 initiatives designed to contain cost, increase access, and improve quality of health care. The state established Catamount Health, a health insurance product (sold by Blue Cross Blue Shield and by MVP Health Care) for people who have been uninsured over a year or who have had a qualifying event. The state also provides premium subsidies for individuals with qualifying incomes.

A number of other states are developing health coverage proposals. Other states, including Washington, Hawaii, Tennessee, and Oregon, have enacted major reforms in the past, many of which have been pulled back or repealed for lack of funding in the intervening years. Maine's DirigoChoice program offers subsidized health insurance to Maine businesses with less than 50 employees, the self-employed, and other individuals. Revenues for the program have fallen short of expectations, so a new law was passed to raise revenues from a tax on beer, wine and soda, plus other provisions. In November 2008, Maine voters overturned the law; the legislature faces a decision on how to continue to fund the program. California tried to enact health reform, but was unsuccessful. Their plan would have established an individual mandate to have insurance (with some exceptions for affordability) and create a "pay or play" system for employers.

## Simultaneously Expand Private and Public Coverage Options

Another legislative approach is to include provisions incorporating combinations of the approaches discussed above. Proponents of such proposals tend to rely on existing sources of private insurance in combination with expanding public programs to extend coverage among the uninsured. They reflect a view that no single approach (except for what some maintain is politically unlikely national health insurance) with its inherent strengths and weaknesses will be sufficient to get all Americans insured. Bills advocating multiple approaches often include market improvements to extend the availability of plans and subsidies to help low-income populations pay for their health coverage, and allowing individuals to keep the health insurance they currently have. Health reform bills in the 111th Congress include both new and reintroduced bills from earlier Congresses. Bills advocating multi-system reforms may include provisions to improve quality of care, better manage chronic diseases, and encourage healthier living.

[30] Klein, E., "Over State: Why the Laboratories of Democracy Can't Achieve Universal Health Care," the *Washington Monthly*, July/August 2007, p. 26.

[31] In such times, states and their advocates are quick to note that all but one state (Vermont) must annually balance their budgets.

The combination approach is favored among many in the policy community and has been advocated by the President. Proposals offered by America's Health Insurance Plans (AHIP, www.americanhealthsolution.org) and The Health Coverage Coalition for the Uninsured (www.coalitionfortheuninsured.org/amuninsured/amuninsured.html), which includes groups such as AARP, Blue Cross Blue Shield Association, and the American Hospital Association, among many others, advocate such multidimensional approaches.

# Health Insurance Reform Bills in the 111th Congress

Brief summaries of the major provisions of most of the health insurance reform bills introduced in the 111th Congress are provided below. The bills are loosely classified into the following reform approaches, similar to the discussion above:

- Largely replace existing coverage with a national government-provided health insurance program (or a national health service).
- Expand privately sponsored coverage.
- Encourage state-based reforms.
- Simultaneously expand private and public coverage options.

As discussed previously, there are some bills that have been introduced in the 111th Congress to expand public health insurance programs for certain targeted groups of individuals—for example, to waive the two-year waiting period for disability coverage under Medicare. None of these narrow scope bills are summarized in the list that follows. Similarly, bills affecting *private* health insurance that only targeted certain individuals or narrow issues—for example, to prohibit pre-existing condition exclusions for children or to restrict private plans' ability to use lifetime limits—are also excluded from the list that follows.

## National Government-Provided Health Insurance Program

### H.R. 15

The National Health Insurance Act was introduced in January 2009 by Representative John Dingell. In general, the bill would require that medical services, hospital services, and other personal health services be made available to all eligible individuals, including U.S. wage earners and their dependents who are not eligible for Medicare. Eligible individuals could choose to receive services from any qualified provider. Those not otherwise eligible for benefits could receive the same services, financed by public federal, state and local agencies. States and local administrative committees or officers would administer the health benefits. The Act would establish a National Health Insurance Board in the Department of Health and Human Services and a National Advisory Medical Policy Council. The Board's duties would include (1) determining the amount of funds required to provide benefits, (2) limiting certain personal health care services (such as home-nursing and dental services) if funds are inadequate, and (3) determining allotment amounts to states for services. The bill would establish a National Health Care Trust Fund, into which proceeds from a value added tax would be deposited for the purpose of funding the provisions of the Act.

## H.R. 676

The United States National Health Care Act, or the Expanded and Improved Medicare for All Act, was introduced by Representative John Conyers in January 2009. It would establish the United States National Health Care (USNHC) program to provide all individuals residing in the United States and territories with all medically necessary health care with no cost-sharing. Care would be provided by public or not for profit institutional providers, HMOs, and participating physicians. It would establish annual operating and capital budgets, along with methods to pay institutional providers of care and health professionals for services. It would prohibit health insurers from selling coverage that duplicates USNHC benefits; however, they could sell coverage for services not considered to be medically necessary. The bill would establish a USNHC Trust Fund to finance the program with amounts deposited by using (1) existing sources of government revenues for health care (including Medicare, Medicaid, and CHIP), (2) revenues from increasing personal income taxes on the top 5% income earners, (3) revenues from instituting a progressive tax on payroll and self-employment income, and (4) revenues from instituting a tax on stock and bond transactions. Additional sums would be appropriated annually to maintain maximum quality, efficiency and access. The bill would establish a National Board of Universal Quality and Access to provide advice on quality, access, and affordability.

## H.R. 1200/S. 703

The American Health Security Act of 2009 was introduced in the House by Representative Jim McDermott in February 2009 and in the Senate by Senator Bernard Sanders in March 2009. The bill would require each participating state to establish a State Health Security program to provide every U.S. citizen, national, or lawful resident alien with comprehensive health care services, as specified in the bill. Cost-sharing would not be allowed for acute care and preventive benefits. Special rules would apply for home and community-based long-term care services. Eligible individuals would be automatically enrolled (including newborns). The Act would eliminate Medicare, Medicaid, CHIP, FEHBP, and the Civilian Health and Medical Program of the Uniformed Services. It would require each state to prohibit the sale of health insurance in that state that duplicated benefits provided under the program and require states to establish participation agreements with providers. It would establish an American Health Security Standards Board to (1) develop policies, procedures, guidelines, and requirements to carry out the Act related to eligibility, enrollment and benefits; (2) establish uniform reporting standards; (3) create the American Health Security Advisory council to provide advice; (4) consult with other private entities; (5) review and approve State Health Security program plans; and (6) establish a national health security budget, specifying total federal and state expenditures for covered health care services, including state allocations. It would create the American Health Security Quality Council to review and evaluate practice guidelines, standards of quality, performance measures, and medical review criteria. Finally, it would create the American Health Security Trust Fund and appropriate to the Fund specified tax liabilities, including an excise tax on employers and employees, a health care income tax, as well as current health program receipts.

## H.R. 2399

The American Health Benefits Program Act was introduced by Representative James Langevin on May 15, 2009. This bill amends the Social Security Act (SSA) to establish under a new title XXII (American Health Benefits Program) a program to provide comprehensive health insurance coverage to all Americans who are (1) not covered under certain federal health insurance

programs and (2) not eligible for employer-provided insurance coverage. This bill would require provision of such coverage in a manner similar to that in which coverage has been provided to Members of Congress, federal government employees, retirees, and their dependents under the Federal Employees Health Benefits Program. The provisions encompass requiring federal government contributions toward the coverage of eligible individuals, establishing in the Treasury an American Health Benefits Program Trust Fund, directing the Administrator of Health Benefits to establish a schedule of cost-sharing subsidies for lower-income individuals, and establishing an independent Health Benefits Administration, headed by the Administrator.

## Expand Privately Sponsored Coverage

### H.R. 198

The Health Care Tax Deduction Act of 2009 was introduced by Representative Cliff Stearns in January 2009. The bill would allow an above the line deduction (i.e., a deduction that is subtracted from gross income) for health insurance and unreimbursed prescription drug expenses. It may be claimed by individuals whether they take the standard deduction or itemize.

### H.R. 502

The Health Care Freedom of Choice Act was introduced by Representative Michele Bachmann in January 2009. The bill would remove the 7.5% adjusted gross income floor that currently applies to the itemized deductions for health insurance and other unreimbursed medical expenses.

### H.R. 879

The Affordable Health Care Expansion Act of 2009 was introduced by Representative Kay Granger in February 2009. The bill would allow individual taxpayers a refundable tax credit for health insurance costs. The credit would not be allowed to someone eligible for employer-subsidized insurance or Medicare, or a participant in Medicaid or CHIP.

### H.R. 1495

The Comprehensive Health Care Reform Act of 2009 was introduced by Representative Ron Paul in March 2009. Among other things, it would allow individual taxpayers a refundable tax credit for health insurance costs and remove the 7.5% adjusted gross income floor that applies to the itemized deduction for health insurance and other unreimbursed medial expenses.

### S. 1324

The Health Care Freedom Act was introduced by Senator DeMint on June 23, 2009. The bill provides individuals without employer-based health insurance with a refundable tax credit up to $2,000 for individuals and $5,000 for families to purchase health insurance. Concurrently, it allows individuals to pay for their health insurance premiums using their health savings accounts (HSA). The bill would provide block grants to states to develop models to ensure those with pre-existing conditions can attain affordable, quality health coverage. $5 billion would be authorized

to appropriate for each fiscal year from 2010-2014. The refundable tax credit would be funded by the repealing of the Troubled Asset Relief Program (TARP. P.L. 110-343).

### S. 93

The Small Business Empowerment Act was introduced by Senator Sherrod Brown in January 2009. The Secretary of Health and Human Services would establish a national program to make quality, affordable health insurance available to small employers and self-employed individuals which spread risk on a national basis, modeled on FEHBP. The Secretary would contract with an eligible entity for administration of the program to provide health insurance coverage to employees of participating employers and individuals. The entity would (1) establish a pilot program to provide for the offering by carriers of a model health benefits plan and (2) contract with the Institute of Medicine to assess the impact of the program on health care coverage costs and access. Existing state mandated benefit laws for plans would remain in place. The bill would set minimum standards for health benefits plans. The National Health Coverage Commission would be established, whose duties would include developing (1) a model that ensures adequate coverage for medically necessary services, promotes disease and chronic disease management, and provides incentives for health provider compliance with best practices protocols, and (2) model cost-sharing mechanisms that do not discriminate and that accommodate lower income individuals. The Secretary would establish a program to provide reinsurance to qualified carriers. The reinsurance program would be funded by the newly created Small Business Health Coverage Trust Fund, with amounts appropriated to or credited to the fund through assessments on each participating health insurance issuer offering health insurance coverage.

### S. 207

The Health Insurance Tax Relief Act was introduced by Senator Barbara Boxer in January 2009. The bill would allow individual taxpayers an above the line deduction for health insurance costs, limited to $2,000 ($4,000 in the case of a married couple filing jointly). There would be income ceilings for eligibility.

### S. 979/H.R. 2360

The Small Business Health Option Program act of 2009 (the SHOP Act) was introduced by Senator Durbin and Representative Kind in May 2009. The bill would amend the Public Health Service Act to establish a nationwide health insurance purchasing pool for small businesses and the self-employed. The Secretary would designate an office within the Department of Health and Human Services to administer the program under this bill that would (1) enter into contracts with health insurance issuers to provide health insurance coverage to individuals and employees who enroll in health insurance coverage under this Act, (2) ensure that insurers comply with requirements, (3) ensure that employers meet elibiglity requirements, and (4) collect premiums, among other duties. There would be established a Small Business Health Board to monitor implementation of the program. Entities would apply to the Administrator to serve as a navigators who would coordinate with the Administrator on education activities, distribute information on enrollment, the availability of a tax credit and perform other duties. The Administrator could enter into contracts with qualified health insurance issuers to provide health benefit plans to employees of participating employers and self-employed individuals. Participating employers could not offer a comprehensive health insurance plan, other than a plan offered under this Act. For 2012 and 2013, state rating rules would apply, but premiums could not vary based on health status related

factors. The National Association of Insurance Commissioners (NAIC) would study and develop recommendations for Congress, with federal fallback rating rules specified if Congress does not enact legislation on rating rules beginning in 2014. The Act would also apply 3% risk corridor to insured gains/losses during the first three years. Pre-existing conditions exclusions would be limited. The Secretary would contract with the Institute of Medicine to develop a minimum set of benefits to be offered by nationwide plans. Qualified small businesses would be eligible for a health insurance tax credit.

### S. 988

The SIMPLE Cafeteria Plan Act of 2009 was introduced by Senator Snowe on May 6, 2009.[32] This bill would amend the Internal Revenue Code of 1986 to allow small businesses (those with an average of 100 or fewer employees during a two-year period) to set up simple cafeteria plans to provide nontaxable employee benefits to their employees, and to make changes in the requirements for cafeteria plans, flexible spending accounts, and benefits provided under such plans or accounts. In addition, this bill sets a dollar limit (equal to the sum of $7,500, or $10,000 for employees with one or more dependents) on employer-provided coverage of health flexible spending arrangements. It would require employers to make a contribution to the cafeteria plan for employees who are not highly compensated, subject to limits.

## Encourage State-Based Reforms

### H.R. 956

The Health Coverage, Affordability, Responsibility, and Equity Act of 2009, or the HealthCARE Act of 2009, introduced in February 2009 by Representative Marcy Kaptur, would allow states to apply to the Secretary of Health and Human Services (HHS) for waivers of federal statutes to make comprehensive, affordable health coverage available for state residents. A refundable tax credit would be available for the cost of qualified health insurance, and advance payments would be made to health insurance providers for the costs of eligible low-income individuals. The Secretary would establish a program to ensure that eligible individuals could enroll in private group health insurance through a purchasing pool operator in participating states. The Secretary would establish the National Advisory Commission on Expanded Access to Health Care to assess the effectiveness of programs designed to expand health care coverage. The bill would also expand Medicaid and CHIP.

### S. 898

The States' Rights to Innovate in Health Care Act of 2009, introduced in April 2009 by Senator Bernard Sanders, would encourage states to develop plans for universal health care systems for their residents. The Secretary would establish a State-based Universal Health Care Coverage Commission to provide guidance to states regarding the application for grants, reviewing and recommending the approval of applications, and suggesting appropriate levels of funding for applications for planning grants, among other responsibilities. A state could apply for a grant to

[32] SIMPLE stands for Savings Incentive Match Plan for Employees, originally used to refer to Individual Retirement Accounts (IRA) plans offered by small businesses.

develop a state plan to offer universal comprehensive health care, with simplified administration and to improve the cost-effectiveness of the health care delivery system. A state that developed a state plan could apply to the Secretary for approval of a demonstration grant. Up to five states could be awarded a demonstration grant for up to five years each. The state plan would be required to provide for health benefits that are at least actuarially equivalent to the Standard Blue Cross/Blue Shield FEHBP, with assurances that the plan would not reduce benefits or increase cost-sharing and premiums for any allowed federal programs that are incorporated in to the plan.

## Simultaneously Expand Private and Public Coverage Options

### H.R. 109

The America's Affordable Health Care Act of 2009 was introduced by Representative Jeff Fortenberry in March 2009. The bill would permit the Secretary of HHS to create three health insurance coverage policies that could be available in the individual market in any state, would be subject to specified federal requirements without regard to state benefit requirements, and would require such plans to cover inpatient hospital services and physicians' surgical and medical services. The Secretary would be required to review the impact of this bill, as implemented, on the availability and purchase of health insurance coverage. The bill would amend the Public Health Service Act to increase funding for grants to states for the creation and operation of qualified high risk health insurance pools. States would be required provide the Secretary with evidence-based information on the operation of their pools for purposes of creating best practice guidelines, as a condition of their eligibility for a grant. The Secretary would be required to (1) recommend and publicly post a list of best practices on the operation of qualified high risk pools and (2) give a bonus grant to states that demonstrate that their pool was operated in accordance with such best practices.

### H.R. 193

The AmeriCare Health Care Act of 2009 was introduced in January 2009 by Representative Pete Stark. All U.S. residents would be eligible for AmeriCare and would be automatically enrolled (including at birth). Individuals could opt out of AmeriCare if they were covered under an employer-sponsored group health plan that was at least equivalent to AmeriCare coverage.[33] AmeriCare benefits would include those provided under Medicare parts A and B (Hospital and Supplementary Medical Insurance, with certain adjustments including deductibles and catastrophic limits). Prescription drug coverage would be equivalent to the Blue Cross Blue Shield standard plan of FEHBP. Additional coverage would be provided to children under age 24, pregnant women, and low-income individuals. Medicare, CHIP, and other federal health programs would be modified to avoid duplication of coverage with AmeriCare. Policies to provide supplemental coverage would be regulated. The bill would establish the AmeriCare Trust Fund. Financing for the program would come from individual premiums, employer contributions, state maintenance of effort payments, and general revenue funds. Premium subsidies would be available for individuals based on income.

[33] This bill was placed in this category, because while it creates "National government-provider health insurance," it also would allow individuals to maintain their employer-sponsored health insurance.

## S. 391

The Healthy Americans Act was introduced by Senator Wyden in February 2009 and would require each adult to purchase a Healthy American Private Insurance (HAPI) plan, except for those with religious objections or those covered through other qualified programs/plans, such as Medicare or an employer benefit plan. Dependent children would enroll through their family plan. There would be a late enrollment penalty for those that did not initially enroll in a HAPI plan or other qualified plan. States would establish a Health Help Agency (HHA) responsible for requiring that at least two HAPI plans were offered to provide benefits for health care items and services that were at least actuarially equivalent to benefits offered in 2009 under the Blue Cross/Blue Shield FEHBP standard plan, among other required services. Each HAPI plan would also be required to meet certain standards, such as limiting preexisting condition exclusions, providing guaranteed availability and renewability, and prohibiting discrimination based on health status. The legislation would provide for school-based health centers, would authorize states to establish and operate a State Choices for Long-Term Care Program, and would require the Secretary to establish Chronic Care Diseases Management programs and Education Centers, among other changes. There would be a federal fallback providing access to HAPI plans, for states that did not establish a HHA. The Internal Revenue Code would be amended to require employers and individuals to each make shared responsibility payments for HAPI plan premiums. The exclusion for employer-based coverage would be terminated and replaced with a premium subsidy and a standard deduction for health coverage, with some exceptions. Similarly, the deduction for employer paid health coverage is eliminated, with some exceptions. The Act would establish the Healthy Americans Public Health Trust Fund for the payment of (1) premium subsidies and (2) bonuses to states for implementing medical malpractice reform. Any amounts in the Trust Fund not expended at the end of a fiscal year would be transferred to the general revenues account of the Treasury. The bill would terminate federal health benefits coverage, including coverage provided under FEHBP, Medicaid and CHIP (Medicaid and CHIP would serve as wrap-around programs to HAPI plans).

## H.R. 1321

The Healthy Americans Act was introduced by Representative Anna Eshoo in March 2009. There are some differences between S. 391 and H.R. 1321, including but not limited to (1) differences in the timing for implementation of HAPI plans and variations in the tax changes, such as using a standard deduction for the individual shared responsibility in the Senate as compared to a refundable tax credit in the House bill; (2) provisions found only in the Senate bill relating to family planning, Part D gap coverage, and end-of-life planning; and (3) provisions in the House bill relating to comparative effectiveness research.

## H.R. 3200

The American Affordable Health Choices Act was introduced jointly by the Committees on Education and Labor, Energy and Commerce, and Ways and Means on July 14, 2009. The Committees on Education and Labor and Ways and Means each ordered reported, as amended, their versions of H.R. 3200 on July 17, 2009. The Committee on Energy and Commerce ordered reported its version of the bill on July 31, 2009. H.R. 3200 would require individuals to maintain health insurance and employers to either provide insurance or pay a payroll assessment, with some exceptions. Several market reforms would be made, such as modified community rating and guaranteed issue and renewal, which would help to level the playing field for access to and

affordability of health insurance. Also, there is the authorization to appropriate funds to create health cooperatives, in addition to a public option. In Division A, there would be an individual and employer mandates linked to acceptable health insurance coverage, which would meet required minimum standards and incorporate the market reforms included in the bill. Division B details Medicaid eligibility expansions and payment reforms in Medicare, Medicaid, and CHIP. Division C encompasses a series of provisions intended to improve the delivery of health care services. They include provisions to expand the primary care workforce, emphasize clinical community-based prevention and wellness, and promote high-quality care.

## H.R. 3400

H.R. 3400, the Empowering Patients First Act, was introduced by Representative Tom Price on July 30, 2009. This bill has various provisions that rework coverage, both for individuals and employers. There is a reliance on tax code through deductions and credits to purchase coverage in the individual market. Changes in the CHIP (Children's Health Insurance Program) expansion would be prohibited for those with incomes above 300% of FPL (federal poverty level) and restricted for those between 200% and 300%. Also, this bill would require states to cover 90% of kids below 200% of the federal poverty level (FPL) and to provide vouchers for Medicaid and CHIP beneficiaries. States would be required to offer group coverage and other private coverage options under Medicaid and CHIP. This bill provides no individual mandate. However, incentives would be given to employers to offer employees the option of a contribution toward other health insurance coverage instead of the employer plan. A tax deduction and an income-related refundable tax credit would be provided for health insurance purchased by individuals (i.e., outside the group insurance market). Insurance pooling/market reforms would allow association health plans and insurance companies to sell insurance across state lines. The tax credit is applicable only to individuals living in states operating a high-risk health insurance pool. Also, federal grant funding would be provided to states for these pools. To promote new or existing high-risk pools to offer at least one high deductible plan in combination with a health savings account (HSA), block grants would be established for states. In terms of regulation, state insurance laws would be overridden to permit the sale of individual health insurance plans across state lines. This bill provides cost containment measures in the effect of medical malpractice reform (establishing federal limits on medical liability claims), initiatives in fraud, waste and abuse prevention, reforms for the sustainable growth rate (SGR), and disproportionate share payment (DSH) reforms. In assisting in physician supply, this bill would create student loan opportunities and forgiveness to medical students. Financing of this bill would be through reduced discretionary spending, repeal of stimulus bill provisions, and other provisions.

## H.R. 3438

The Access to Insurance for all Americans Act was introduced on July 30, 2009, by Representative Darryl Issa. This bill would amend Title 5 of the United States Code, expanding the Federal Employee Health Benefit Program to individuals not employed by the federal government. This bill would establish a national health program administered by the Office of Personnel Management to offer federal employee health benefits plans to eligible individuals. Individuals enrolled or eligible to enroll in Medicare, Medicaid, or other state plans would not be eligible to enroll in the federal plans.

## S. 1679

The Senate HELP committee approved S. 1679 entitled the "American Affordable Health Choices Act" on July 15, 2009. Similarly to H.R. 3200, this bill would establish an individual and employer mandate for coverage. Individuals would attain coverage from their employer, from the newly established health insurance Gateway (similar to an exchange), or face penalties for non-compliance. An employer would be required to provide a plan or assist in covering the employee through the Gateway. More underinsured individuals would have access to innovative medicines like biologics. There are provisions meant to enrich the health care workforce, such as a commission to provide analysis of pressing needs, educational programs to promote affordability of health-related (specifically nursing) education, and grants to increase training opportunities. Concurrently, this bill would enact provisions to combat fraud, waste and abuse. This bill contains prevention and wellness provisions, which would increase access to clinical preventive services. This bill contains provisions meant to improve quality in the health delivery system, such as formulating a national strategy, interagency working groups to streamline quality initiatives, and administrative simplification. Absent from this legislation are the public financing reforms (Medicare and Medicaid) that rest solely on the jurisdiction of the Senate Finance Committee. However, the Chairman's mark does detail market reforms and makes assumptions about Medicaid expansion.

## Senate Finance Chairman's Mark, as Amended, America's Healthy Future Act of 2009

The Senate Finance committee ordered reported America's Healthy Future Act of 2009, as amended, on October 13, 2009. This bill would establish an individual mandate, requiring U.S. residents to obtain insurance or pay a penalty, with some exceptions. This bill contains market reforms such as coverage on a guaranteed issue basis, and prohibiting the exclusion from coverage based on pre-existing health conditions. Also, limited benefit plans and lifetime limits would be prohibited. This bill would establish new insurance exchanges and would subsidize the purchase of health insurance for individuals and families with income between 133% and 400% of the federal poverty level (FPL) through these exchanges. Although it would not explicitly require employers to offer health insurance, firms with more than 50 workers that do not offer coverage would be subject to a penalty for any workers who obtained subsidized coverage through an exchange. Full-time employees who were offered coverage from their employer would not be eligible to obtain subsidies through the exchange, with an exception for those not offered affordable coverage by their employer. This bill includes an authorization to appropriate the necessary funds to establish Consumer Operated and Oriented Plans (CO-OP), non-profit, member-run cooperatives that function in one or more states. Also, this bill details substantive public financing reforms to Medicare and Medicaid. Under Medicaid, eligibility levels would be expanded nationwide and prescription drugs would become a mandatory benefit. Under Medicare, there would be provisions tying hospital payments to quality through value-based purchasing programs. As with S. 1679, this bill introduces provisions such as value-based purchasing, long-term care quality reporting, and the introduction by the Secretary of national strategic goals to address quality performance measures to improve health care delivery.

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