Covering America

Robert Wood Johnson Foundation

NOTE: Click on author's name to get full report.

	Market-Based				Blend Government & Market								Replace the Current System				
	Steuerle	***Miller***	***Butler***	***Pauly***	***Calabrese***	***Kendall/Levine/ Lemeiux***	***Feder/Levitt/ O'Brien/Rowland***	***Gruber***	***Holahan/Nichols/ Blumberg***	***Seltman***	***Singer/Garber/ Enthoven***	***Wicks/Meyer/ Silow-Carroll***	***Halpin***	***Weil***	***Hacker***	***Morone***	***Kronick/Rice***
General approach	Modest, but gradually increasing, tax credit available as an alternative to a capped tax exclusion. Modest tax penalties for those not buying coverage. Employers required to offer but not pay for coverage.	Tax credits available to all to provide 30% subsidy for high-deductible coverage. Strengthen safety net and establish high-risk pools for the uninsurable. Strong incentives for consumers to economize.	Would make refundable tax credits available to working households. States would get grants to expand health coverage to more residents and make insurance more affordable. Coverage obtained at work or from a range of other organizations such as churches or unions.	A refundable tax credit/ voucher system would make some level of coverage affordable to lower-middle-income people who currently have no health insurance. Very-low-income households would initially be eligible for publicly financed zero-premium comprehensive insurance.	Individual mandate, federal tax credits to limit medical expense, employer pay or play, insurance pools.	Tax credits to low- and middle-income individuals and families to be used in either individual or group market. States receive performance-based grants to improve coverage rates, access, quality, and outcomes.	Expand Medicaid and the State Children's Health Insurance Program for low-income people. Possible combination with tax credit to small, low-wage firms to expand employer offerings.	Establishment of purchasing pools in every state through which households with incomes up to 300% of the federal poverty level would be eligible for no-cost or reduced-cost coverage on a sliding-scale basis; automatic plan enrollment for lowest-income households.	Extend the type of subsidized coverage that is currently available under S-CHIP to all lower-income people and subsidize insurance for the highest risk.	All employers required to offer coverage, but can postpone deadline by buying government-issued "allowances" to not cover. Coverage "floors" rise each year.	Combines refundable tax credits and insurance exchanges to promote lower cost, higher-value health coverage while allowing employers and individuals to continue current arrangements if they desire.	Tax credits for all households, varying by income. Universal coverage achieved by mandating that everyone have or buy health coverage and having Medicare automatically cover anyone temporarily uninsured. Builds on present system of private health plans and employer-based coverage.	Incentives to encourage people to enroll in a public plan that would ultimately be a single payer. Employers offer coverage or pay 6.5% payroll tax. Subsidies to limit premiums to 2.5% of income.	A new Medical Security System would be created to provide universal coverage, making coverage a "right."	A modified "play or pay" approach that creates incentives for workers and employers to buy into "Medicare Plus," a national program based on Medicare.	"Single-payer" approach. All legal residents covered by Medicare, with expanded and rationalized benefits package and no co-payments. Particular emphasis on community medicine. States could choose to opt out for residents under age 65 by designing their own system under federal guidelines.	All non-elderly legal residents would be guaranteed comprehensive health insurance as a "right" (at no direct cost) through a public insurance approach designed by each state and monitored by the federal government.
Target population	The entire non-Medicare population.	Working uninsured, including individuals, and people who decline public coverage.	Working uninsured individuals and families; the plan would achieve near-universal coverage for all working households of legal U.S. residents.	Principal target group is lower-middle income families and individuals with incomes above the federal poverty line, or about half of the uninsured. Very low-income families covered publicly, at least initially.	All the uninsured.	Low- and middle-income individuals and families.	People below 150% of poverty level covered at no cost; those between 150% and 200% of poverty would pay some premiums and cost sharing. Higher-income people could buy-in to public coverage and pay a sliding-scale premium. Employees of small, low-wage firms benefit from tax credit.	Individuals and households under 300% of the federal poverty level would receive subsidies. Households with incomes below 150% of poverty level would be eligible for no-cost coverage.	Individuals with incomes under 250% of the federal poverty level and those at high health risk. Subsidies available only to those who enroll through the state purchasing pool.	Workers in firms not offering coverage.	Low and moderate-income people who are not eligible for Medicare.	All of the uninsured.	The entire population.	All legal U.S. residents under age 65.	All Americans not covered by Medicare or employer sponsored insurance.	All legal residents.	All non-elderly legal residents.
Form of public programs	Modest federal tax credits available to all, growing over time. The present unlimited tax exclusion for employer-paid premiums would be reduced and capped at a fixed level.	Medicaid, S-CHIP, and Medicare would continue for the time being. Better-funded high-risk pools.	Refundable tax credit, funded via repeal of federal income tax provision that makes employer contributions to employees' health insurance non-taxable income; federal tax revenues would fund grants to states to help low-income families buy coverage.	A voucher or tax credit large enough to cover one-half to two-thirds of the premium for moderately comprehensive coverage. The credits would be in the form of coupons worth $1,500 for individual coverage and $3,500 for family coverage. No-cost publicly financed coverage for very low income households.	Refundable, advanceable, income-related tax credits; medical expenses limited to 10 percent of income except 0 percent when income below 150 percent of federal poverty level.	Advanceable and refundable tax credits for low- and middle-income people. Medicaid, S-CHIP, and Medicare would continue. Federal government provides grants to states to improve coverage, access, quality, and outcomes. States subsidize costs of coverage when credits are not large enough to make coverage affordable; may use purchasing pools or high-risk pools.	S-CHIP expansion, federally subsidized, with some state match, for those with limited incomes, and a federal tax credit subsidy for small employers to help cover workers.	Household income determines eligibility for no-premium plans (for households under 150% of poverty level) or reduced-premium plans (for households under 300% of the federal poverty level on a sliding-scale basis but premium not more than 10% of income).	Individuals with incomes under 250% of the federal poverty level and those at high health risk. Subsidies available only to those who enroll through the state purchasing pool.	State subsidies cover 100% of employee premium share for workers below 100% of the federal poverty level (FPL) and 80% for those under 200% of FPL. Federal government provides much of financing for subsidies.	Continuation of Medicaid/ S-CHIP for eligible individuals and families who choose to stay in these programs; refundable tax credits equal to 70% of median-cost health plan; federal payments to states equal to 50% of the tax credit to cover the costs of running "default plans" for people who do not enroll.	Refundable tax credits for all households but varying according to income—minimum credit approximately $700 a year for an individual and $1,200 a year for a family. People below 100% of poverty would get credit sufficient to buy coverage comparable to Medicaid. Those above that level up to median income would get gradually reduced subsidies.	Premiums reduced on a graduated basis for those choosing coverage through new public plan; no family would pay more than 2.5% of income; those below 150% of poverty would pay nothing.	Payroll tax, Medicaid, and S-CHIP funds.	Premiums for those buying into Medicare Plus would be scaled to income, with lower income citizens paying only a small percent of income. Employers would be eligible for transitional subsidies and for reductions in their contribution rate based on firm income.	Medicare covers all legal residents, but Medicaid remains as a source of long-term care, disability coverage, and wraparound coverage for Medicare. Many other programs (maternal and child benefits, for example) would be subsumed under new program.	Federal subsidies to states to finance availability of no cost coverage to all legal residents.
Mandates for coverage	Individuals failing to acquire coverage would be denied certain tax benefits otherwise available.	None.	None, but to receive tax credit, individual or family would have to buy a health plan that included a minimum set of benefits. High-level of voluntary compliance expected among most workers since employees required to tell employers which health plan they wished to join.	None.	Individuals must buy; employers must pay 6% of payroll.	After five years, a commission would decide whether to establish an individual mandate.	None.	None.	After five years, states could mandate that everyone be covered.	All employers must provide coverage, but some firms might take 20 years by acquiring allowances.	None.	Every individual and family would have to have health coverage at least as comprehensive as Medicare's, plus prescription drugs and well-child care. Those who fail to show proof of purchase would pay a premium plus a penalty for Medicare backup coverage for every month without other coverage.	None.	All employers and employees would pay a new payroll tax. All people would have to enroll or be enrolled by default.	None initially but individual mandate would apply eventually if a nontrivial share of Americans remained uninsured.	All legal residents covered by Medicare or state alternative.	All legal residents under age 65 automatically covered by comprehensive benefits. Everyone would have at least one health insurance option that would not require payment of premiums. There would be a mandatory payroll tax.
Sources of funding	Revenues generated from a reduction in tax exclusion and tax penalties on persons not buying coverage.	Reductions and other federal health and non-health spending.	Savings from elimination of existing tax exclusion, and federal general tax revenues.	Federal budget revenues; those who buy more expensive coverage would pay out-of- pocket. Full coverage for those with incomes below 125% of the federal poverty level would be financed through a combination of state and federal revenues.	6% employer payroll tax and 4% employee tax, cap on tax exclusion.	Not specified; presumably general revenue, but alcohol and tobacco tax mentioned.	Federal general revenues, with state matching payments.	Federal general revenues, savings from replacement of Medicaid and S-CHIP health programs, and limits on tax exclusion for employer-provided insurance.	Federal general revenues, and cuts in existing programs since the need would be reduced as health reform is implemented.	Employers, state, and federal governments.	Phased-in cap on current federal tax exclusion; general revenues; and savings over time from changing consumer behavior and increasing health plan competition.	Federal general revenues, but partially offsetting savings would be realized from the elimination of Medicaid and S-CHIP and from making employer-paid health premiums taxable income for employees.	Employer payroll taxes, new federal "sin" taxes, state savings from public program reductions, tax on cross-border transactions between U.S. and Mexico.	Payroll tax, premiums, and federal subsidies.	Payroll contributions and premiums, general revenues, and other smaller sources.	Earmarked value added tax (VAT).	Primary revenue source would be a payroll tax levied on employers and employees, supplemented by federal general revenues, state revenues, and, in some states, premium payments from individuals.
Major tax changes	The present tax exclusion is capped at a fixed level.	Advanceable tax credits as an option to exclusion of employer premium. More flexible tax treatment of MSAs and IRA-type health savings accounts to encourage growth.	Repeal of the federal income tax provision that makes employer contributions to employees' health insurance a non-taxable form of income.	No major tax code changes, but tax credits in the form of coupons would help people purchase qualified health insurance. The new vouchers would be viewed and treated as tax reductions for those who use them.	Tax exclusion remains for premiums (paid by employer and employee) for minimum benefit package, but premiums for additional benefits are taxable as income.	None apart from tax credit for coverage.	Explores tax credits to individuals or employers, the latter to subsidize the offering of coverage to uninsured workers with modest incomes.	Limits the tax exclusion for employer-provided insurance equal to no more than the cost of the median-cost plan in each purchasing pool.	Federal taxes would be increased if surplus not available.	None.	Phased-in cap on current federal tax exclusion for employer-paid premiums.	The tax exclusion for employer-paid health premiums would be eliminated.	Employers not offering coverage would pay 6.5% payroll tax (5.5% for small employers).	New payroll tax would be established for employers and employees.	Cap on tax exclusion of employer-provided health insurance at level of twice the average premium of Medicare Plus coverage.	Medicare payroll taxes and premiums abolished and replaced with VAT. Medicare's claim on general revenues (Part B) ends. Tax relief for state Medicaid programs.	Payroll tax substitutes for employer and employee premiums, which has implications for tax exclusion provision of employer premium contributions.
Level of benefits	Not specified.	Minimum equal to services covered in minimum-cost FEHBP plan but with significant front-end deductible (e.g., 5% of income) and maximum out-of-pocket obligation; thus catastrophic coverage.	To qualify for the tax credit, families would have to enroll in a health plan that included at least the minimum insurance package, which would be primarily catastrophic coverage.	To qualify for the credit, the plan would have to cover effective medical and surgical services, prescription drugs, and medical devices based on a standard definition. Patient cost sharing would be permitted, as would managed care.	Adequate but not "luxury" coverage, determined by a commission.	Not regulated, but states have responsibility to prevent underinsurance; after five years, a commission would assess adequacy of benefits.	Comprehensive but not specifically delineated.	Physician services, inpatient and outpatient hospital, prescription drugs, nominal payments for well-child care, prenatal care, and immunizations.	States determine a new standard benefit package—within federal guidelines—for everyone under 250% of poverty and those at high health risk.	Actuarially equivalent to the most popular FEHBP plan. Employer must pay at least 50% of premium.	Generally determined by the market, with minimum standards set by the Insurance Exchange Commission, including goods and services known to be medically effective and provided at reasonable cost.	A package of benefits comparable to Medicare's plus a prescription drug benefit and well-child care coverage.	Initially equal to benefits of Kaiser Permanente with reduced co-payments for low income people.	Guarantee is for basic coverage, but individual may supplement with own funds to buy more comprehensive.	A defined benefit package similar to Medicare plus outpatient prescription drugs, preventive services, mental health benefits, and maternal and child health care.	Similar to Medicare but with addition of prescription drugs, maternal and child health services, mental health services, emphasis on primary care, including neighborhood health centers and extensive new home health benefits.	A federally-defined standard benefit package. Benefits would include prescription drug coverage; dental and long-term care would not be required.
Role of federal government	Fund tax credits; administer tax penalties.	Fund tax credits, help fund high-risk pools, and additional funding for safety net. Require guaranteed renewable options for coverage eligible for tax credits.	Would establish a default system of health insurance regulation to encourage availability of affordable insurance; would establish a benchmark health plan with basic features and catastrophic protection. Would monitor state compliance and work with states on a plan to eliminate uninsurance.	Would make information about insurance purchasing and plans available, including price and quality and could subsidize the production and distribution of such information. It also would be (or contract with) an insurer of last resort.	Fund tax credits, some grants to states.	Finances and oversees tax credits. Provides performance-based grants to states. Establishes commission to study health benefits and technology and a federal information exchange/clearinghouse to report and disseminate information on quality and outcomes.	Would make federal funds available at enhanced Medicaid matching rates to states willing to cover targeted uninsured.	Funds subsidies, sets minimal rules, provides oversight of purchasing pool administration.	Financial support, monitor state compliance of minimum rules, oversee state spending and enforcement.	Set yearly coverage floors; issue allowances; collect user fees per allowance; fund state subsidies; monitor and enforce compliance with coverage requirements.	Establish the Insurance Exchange Commission to oversee insurance exchanges, distribute tax credits and make default plan payments. Establishes U.S. Insurance Exchange as backup in markets without private exchanges.	Would fund all tax credits. Would establish general guidelines for states setting up the aggregate purchasing arrangements (APA). Would continue to operate Medicare, for the elderly and as a temporary back-up plan for people who do not have proof of private coverage.	Fund subsidies, update benefit package, collect payroll tax, monitor state administration, develop risk-adjustment system.	Would set up and regulate insurance exchanges, forward tax revenues, and determine size of payroll tax.	The Health Care Financing Administration would have primary responsibility for administering Medicare Plus. In addition to offering standard fee-for-service coverage, Medicare Plus would also allow beneficiaries to enroll in private health plans that contracted with the program.	New Department of Health organizes and runs expanded Medicare program. Oversees optional state waiver programs. IRS designs and implements a value-added tax. The earned income-tax credit expanded to offset regressive effects of VAT.	Would impose payroll taxes on employers and employees, calculate money needed and provide funds to each state health care system, monitor state implementation of expansions, measure quality and health outcomes, determine and update standard benefit package, monitor and regulate quality of care in states.
Role of state government	Unchanged.	Would compete for insurers by adopting an attractive insurance regulation.	Would develop a mechanism to supplement federal tax credit for eligible workers and help cover those who did not purchase minimum insurance. Would have to use additional federal funds to expand existing or develop new programs to achieve target levels of coverage. Would work with health insurers on insurance reform that keeps benefits affordable.	Would have primary role of selecting or managing the public plan for poor people not currently covered by Medicaid. Could continue to regulate individual insurance and regulate risk-rating. In addition, states could choose to provide payments for people with high medical expenses, possibly allowing smaller deductibles or less-constraining upper limits in low-cost plans.	With grant from federal government, must establish Community Insurance Pools (CIP) to facilitate purchase of coverage.	Uses federal grants to supplement tax credits, strengthens safety net, assures health plan choices (e.g., through pools), and measures quality and outcomes. Continues operating Medicaid and S-CHIP.	Would provide coverage to low-income uninsured residents, consistent with federal rules affecting eligibility, benefits, administration, and other program aspects.	Not addressed, except for continued responsibility for remaining parts of Medicaid.	Increases role of states significantly while granting more flexibility.	Provide subsidies to low-income workers; establish mandatory purchasing pools/cooperatives for smaller firms.	Continue to provide Medicaid and S-CHIP, use new federal funds to pay for care under default plans by reimbursing safety-net providers.	Each state would be required to establish an aggregate purchasing arrangement through which small employers and individuals would purchase coverage. In exchange for no longer financing the acute portion of Medicaid or S-CHIP, states would assume greater responsibility for long-term care services under Medicaid.	Pay subsidies for Medicaid and SCHIP enrollees who switch to new public program; administer new program; contract with HMOs.	States would continue to pay some Medicaid costs to keep coverage at current levels; would subsidize co-payments under basic plan for low-income residents.	Would transform from provider of insurance to a portal for coverage under the new Medicare Plus system. States would continue to finance care for the eligible aged, blind and disabled. In addition, they would have to reach out to and enroll non-workers, provide wraparound coverage for those who would have been in Medicaid, and subsidize premiums for unemployed people.	Long-term care portion of Medicaid remains. Have the option of designing and paying for 25% of costs to operate federally approved and modern alternative to federal Medicare.	States would have much flexibility in designing a system— how to pay health care providers (e.g., single payer vs. competing health plans), be responsible for raising revenue to supplement federal financing, meet federal requirements, and enroll residents in health plans. Would provide information on enrollment options and procedures, negotiate with health plans and providers, regulate health plans, and collect data to evaluate the system.
Effects on existing public programs	Essentially unchanged.	Medicaid, S-CHIP, and Medicare continue for the time being.	Medicaid and S-CHIP would continue as now.	Medicaid and S-CHIP would continue, and more low-income people would be subsidized to enroll in these programs or some other public program.	Medicaid (except long-term care and the disabled) and S-CHIP eliminated.	Continue largely unchanged.	Medicaid and S-CHIP would continue and be expanded.	Gradual phase out of Medicaid and S-CHIP (and accompanying federal subsidies) for those families who qualify on income alone. Medicaid remains in place for the elderly and disabled.	Participating states would receive enhanced federal S-CHIP matching rate for all current Medicaid and S-CHIP beneficiaries under 250% of poverty; all states must continue smaller, residual Medicaid program for children and adults with special needs as well as all long term care services; would eliminate federal payments to states covering individuals with incomes above 250% of poverty. No change in non-participating states.	Essentially unchanged.	Medicare remains intact; people enrolled in Medicaid and S-CHIP may stay in these programs or opt instead for tax credits to be used in the private market.	S-CHIP and Medicaid largely replaced, except for disabled and elderly.	Would continue to be available, but many eligible people would choose to enroll in new public plan instead.	S-CHIP would be subsumed; Medicaid would be mostly subsumed.	Would eventually replace existing public programs for the uninsured with a single national program based on Medicare. Medicaid and S-CHIP would be phased out with eligibles automatically enrolled in the new Medicare program or employer-sponsored plans.	Medicare vastly expanded to all legal residents with expanded benefits. Medicaid continues for long-term care. Many other programs replaced by new Medicare.	Would vary by state, but new state program could replace S-CHIP and portions of Medicaid.
Role of insurers/ health plans	Essentially unchanged.	Similar to present but with greater flexibility to sell MSAs and other new insurance products.	Would continue to be a major source of coverage. Would have to bring premium rates into line with federal or state underwriting and benefit requirements, but would benefit from administrative savings associated with the automatic enrollment system.	Would continue to be major source of coverage. Would be required to guarantee renewability in the individual market and to set premiums on modified community-rating basis in the small-group market. Insurers would redeem vouchers or certificates.	Largely as now, but would also sell through CIPs.	Essentially unchanged.	Would stay the same as today, although some market reforms might be necessary.	Could participate in state-established purchasing pool or continue to operate outside of such arrangements.	Health plans participating in the new state plan would be required to accept all applicants, with premiums set at a statewide community rate. Payments to plans would be risk adjusted. Insurers would not be subject to any new federal market regulations outside the state purchasing pool.	Essentially unchanged.	Would compete to provide low-cost, high-quality care; collect and report quality of care and health outcomes data.	Would continue to be major source of coverage but would be required to offer a policy that covers the services comparable to Medicare plus prescription drugs and well-child care, to participate in purchasing pools, and to community rate in individual and small-group markets.	Could continue to offer coverage, but strong incentives encourage people to enroll in new public plan, which would offer only HMOs or new HMO-like plans.	Plans would contract with health insurance exchanges to offer range of plans, including a "no-cost" plan (that is, no enrollee contribution); would market plans and monitor quality of care.	Would stay the same as today; would compete for business from Medicare Plus system.	Can offer supplementary coverage to expand benefits beyond Medicare level.	In some states, plans would compete for business from states and would have to include services specified in a federally-defined benefits package. Some states might choose to pay providers directly and eliminate the role of insurers/health plans.
Role of employers	Required to offer at least one state approved plan but would not have to pay any of the premium. Adjust employee income withholds in accordance with tax credits. Enroll employees in health plan unless they opt out.	Essentially unchanged.	Similar to present but would have to inform employees about the tax credit program and deliver the tax credit. Would serve as a clearinghouse, creating automatic enrollment mechanisms for insurance, setting up payroll deduction and payment systems for employees and providing proof of insurance for each worker.	Similar to current role.	Pay 80 of premium for minimum benefit package or pay tax equal to 6% of payroll. Withhold employee premium and transfer to health plan.	Required to offer (but not pay for) a menu of health plans, facilitate an annual enrollment for employees, withhold premiums, and administer tax credits.	Similar to present. If tax credit were pursued, small low wage employers would be encouraged to offer insurance to their employees; employers would receive the tax credit if they provided insurance.	Would continue to offer health coverage to workers, but could do so within the purchasing pool or outside of it.	Would continue to have choice to offer health coverage to their workers. If they offer, they must make state plans available, but they can also offer plans outside the state pool.	Required to offer coverage, pay at least 50% of premium, or acquire allowances to postpone the time when full coverage is required.	May become their own insurance exchange; continue to offer benefits to employees; or purchase coverage from exchanges.	Employers would be required to offer (but not necessarily pay for) coverage for employees and dependents. Benefits must be at least comparable to Medicare plus a prescription drug benefit and well-child care. Employers with 10 or fewer employees would have to offer coverage through the purchasing pool.	Required to pay 6.5% payroll tax or offer and pay for coverage. Many would find it less costly to pay tax rather than offer employer-paid coverage.	Employers would collect payroll tax but could opt out by offering own generous plans to employees.	Employers would enroll workers at workplace. They could choose to sponsor coverage at least as generous as the new program's or pay a modest payroll-based contribution to fund public coverage.	Do not contribute toward Medicare coverage but could pay for supplemental benefits (with continued tax exclusion for employees).	Employers would no longer provide or buy health coverage for their workers. Although employer role would be eliminated, both employers and employees would have to contribute to financing coverage.
Risk share/ purchasing pools/ insurance regulation	Unchanged.	Purchasing pools could accept all employers and individuals and risk-rate new entrants for two years. To further offset adverse selection, pools could require multi-year contracts of customers and impose penalties for early exit from pool. States would compete to be the single legal domicile for insurers bypassing favorable insurance regulations.	Insurance industry and states would have to work together to develop a means for adjusting risk among plans.	Few restrictions would be placed on qualifying coverage. But all policies must have a guaranteed renewability clause, and low-cost policies must be sold under modified community rating. Plans with more generous coverage could charge higher premiums to high-risk people. Insurers could impose modest waiting periods for people who did not enroll during open season.	Community rating required.	Purchasing pools are an option to meet the requirement that states assure that everyone has a choice of plans available at reasonable cost. States could use federal grants to subsidize high-risk people in the pool. Alternatively, states could impose community rating to spread risk.	Possible reforms in the individual insurance market unless tax credits could be applied to a publicly managed insurance product.	Purchasing pools are foundation of proposal: subsidies are available only for coverage purchased through the pools.	State-established purchasing pools are foundation of proposal. Medicaid (except the disabled and elderly) and S-CHIP enrollees and state employees would be included in the pool. The pool would be open to individuals and employers, and insurers could offer standard benefit package at a statewide community rate, plus add-on products priced separately."	Community-rated mandatory purchasing pools for firms with fewer than 25 employees.	The Federal Insurance Exchange Commission would develop risk- adjustment strategies. Payments would be risk-adjusted both between health plans within an exchange and across exchanges.	All health plans would have to accept all individual and small-group applicants and provide immediate and full coverage for all covered benefits with no waiting periods or exclusions for prior conditions. Insurers selling individual and small-group coverage would have to price premiums on a community-rated basis. Purchasing pools (APAs) open to all individuals and groups.	Federal government bears risk for those choosing fee-for-service providers, and HMOs bear risk for their enrollees. In essence, community rating.	Insurers selling through insurance exchanges would be required to offer guaranteed-issue, community rated standard benefit packages.	To avoid adverse selection, measures are imposed to make it more difficult for employers to shift between public and private coverage. 50% to 70% of the population might eventually enroll in Medicare Plus, providing strong bargaining leverage and broad pooling of risk. No new regulations are imposed on private insurance, and there are no insurance pools.	Medicare is the single pool and the only insurer for all citizens for the standard benefits package, so there are no risk-sharing issues.	Since coverage in no-cost plan is automatic, everyone is pooled together, though states would have latitude to decide specifics.