Covering America

Robert Wood Johnson Foundation

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	Blend Government & Market							
	Calabrese	***Kendall/Levine/ Lemeiux***	***Feder/Levitt/ O'Brien/Rowland***	***Gruber***	***Holahan/Nichols/ Blumberg***	***Seltman***	***Singer/Garber/ Enthoven***	***Wicks/Meyer/ Silow-Carroll***
General approach	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.
Target population	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.
Form of public programs	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.
Mandates for coverage	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.
Sources of funding	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.
Major tax changes	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.
Level of benefits	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.
Role of federal government	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.
Role of state government	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.
Effects on existing public programs	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.
Role of insurers/ health plans	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.
Role of employers	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.
Risk share/ purchasing pools/ insurance regulation	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.