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Health Insurance Reform and the 110th Congress

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Summary

Congress last debated comprehensive health insurance reform in the 1990s. At that time, the Health Security Act, a bill originating with President Clinton and then First Lady Hillary Clinton, was considered alongside a number of bills introduced by Senators Chafee, Daschle, and Dole, and Representatives Gephardt and Bilirakis, among others. The Health Security Act (H.R. 3600) would have established universal health coverage for all U.S. citizens, reformed existing public health insurance programs, and established caps on health care spending. At the time, escalating health care and health insurance costs, declining numbers of individuals with private coverage, and state experimentation and innovation spurred the federal debate. Today, similar conditions may be setting the stage for reconsideration of major health insurance reform.

Health insurance reform bills introduced in the 110th Congress can be classified into the following categories:

- National health insurance (or a national health service).
- Expanding existing public programs.
- Expanding privately sponsored coverage — including proposals to
  - expand employer-based health insurance,
  - expand the individual market for health insurance, and
  - improve the private market for health insurance.
- State-based reforms.
- Combinations of above approaches.

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 110th Congress. The potential impact of various reform 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. The relative impact of different bills on their varying objectives is likely to vary widely. This report will be updated periodically as new bills are introduced.

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Introduction

Congress last debated comprehensive health insurance reform in the 1990s. At that time, the Health Security Act, a bill originating with President Clinton and then First Lady Hillary Clinton, was considered alongside a number of bills introduced by Senators Chafee, Daschle, and Dole, and Representatives Gephardt and Bilirakis, among others. The Health Security Act (H.R. 3600 — for legislative text, see H.R. 3600 from 103rd Congress) would have established universal health coverage for all U.S. citizens, reformed existing public health insurance programs, and established caps on health care spending. At the time, escalating health care and health insurance costs, declining numbers of individuals with private coverage, and state experimentation and innovation spurred the federal debate. Reforming the one-seventh of the U.S. economy composed of health care would have been no small feat, however, and despite considerable efforts by the 102nd and 103rd Congresses, universal coverage and comprehensive health insurance reform did not succeed. Support for the Health Security Act began to decline well before its formal consideration was complete. Among the many concerns raised were the secretive process under which the plan was developed and the level of government intrusion that would result from its implementation.[1] Many of the bills considered after H.R. 3600 were rejected for not extending coverage far enough among the uninsured.

Today, similar conditions may be setting the stage for reconsideration of major health insurance reform. The cost of health insurance and health care services in general is rising faster than inflation, while the percentage of individuals without health insurance is rising. States are innovating and experimenting, providing useful trials and errors to potentially inform the debate at the federal level. The prominence of the issue among the 2008 presidential candidates may be elevating interest in health reforms among the electorate.[2] Finally, President Bush's proposal to end the

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[1] There are a large number of articles and books examining the failure of H.R. 3600, including Skocpol, T., "The Rise and Resounding Demise of the Clinton Plan," *Health Affairs*, Spring 1995; Blendon, R., Brodie, M., Benson, J., "What Happened to Americans' Support for the Clinton Health Plan?" *Health Affairs*, Summer 1995; Clymer, A., Pear, R., and Toner, R., "The Health Care Debate: What Went Wrong?" *New York Times*, August 29, 1994; "National Health Program, President's Grandest Goal, Is Declared Dead in Congress," *New York Times*, September 27, 1994; Starr P., "What Happened to Health Care Reform?" *American Prospect*, vol. 6. no. 20, December 1995:20-31.

[2] For comparative information and summaries of presidential candidates' proposals, see Collins, S., Kriss, J., *Envisioning the Future: The 2008 Presidential Candidates' Health*

(continued...)

existing tax exclusion for employer-provided health insurance, replacing it with a standard deduction, suggests a potential source of funding for health reforms.[3]

This report presents basic background on health insurance that may be useful to legislators considering health insurance reforms. It describes health insurance reform approaches and provides brief descriptions of health insurance reform bills introduced in the 110th Congress. The potential impact of various reform 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. The relative impact on such objectives probably varies widely.

What Is Health Insurance Reform All About?

Health insurance reform is a broad term that could potentially span a large range of policy options, all of which have their own inherent strengths and weaknesses. Some health insurance reform bills address a discrete health insurance problem or issue, such as expanding public health insurance coverage for uninsured children or reducing the number of costly state mandates on private health insurance plans. At the opposite end of the spectrum, however, are proposals that 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 scope of 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 bills introduced in the 110th Congress have surprisingly different primary objectives, which can include the following:

- **Reducing the number of people without health insurance.** Most health insurance reforms seek to improve access to needed medical care. In the United States, access to a great deal of expensive medical care is dependent on whether an individual has health insurance.

- **Reducing the reliance on health insurance for at least some portion of needed medical care.** A number of bills 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

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[2] (...continued)
Reform Proposals, The Commonwealth Fund, January 2008, and the Kaiser Family Foundation interactive website at [http://www.health08.org/sidebyside.cfm].

[3] For a description of the proposal, see pages 19-22 of "General Explanations of the Administration's Fiscal year 2009 Revenue Proposals," at [http://www.treas.gov/offices/tax-policy/library/bluebk08.pdf].

both the demand for and the prices of medical care, whether necessary or unnecessary, to grow too quickly. Those bills include provisions to increase cost-conscious use of health insurance and health services 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, 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 costly state laws 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.

A number of bills in the 110th Congress feature other 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 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. citizen is a stakeholder whose preferences and needs differ from those of others. Reform approaches reflect different choices about the relative importance of needs among stakeholder groups, including health care providers; medical researchers; insurance carriers; federal, state, and local governments; employers; workers; and consumers.

Needs can vary considerably between stakeholder groups, and even among them. For example, health care consumers may prefer low-cost health insurance, while health insurance carriers may prefer to maximize profits on their services and products. Within consumer groups, there are healthy people who may prefer limited

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

[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.

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 — or developed based on the experience of a large group — can reduce rates (relative to rates developed based on past experience) for individuals with expensive medical conditions. On the other hand, community-rated rates could rise for the healthiest individuals in the group.

Scope of Reform. Following the challenging and acrimonious health insurance reform debate of the early 1990s, Congress has not again revisited comprehensive health insurance reform. A number of incremental health insurance reforms have, however, been enacted (see **Text Box 1**). Health insurance reform bills introduced in the 110th Congress reflect little consensus about whether continued incremental improvements building on our current patchwork of coverage, or reforms with much broader scope, changing the way people access health insurance, are necessary to achieve the objectives of increasing coverage or reducing costs.

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

Eligibility for Medicaid, initially passed in 1965 along with Medicare, 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*, by Jean Hearne.)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) addressed a number of problems in the offering and rating of health insurance 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*, by Hinda Chaikind et. al.)

The Balanced Budget Act of 1997 created the State Children's Health Insurance Program (SCHIP), establishing grants for states to use to provide health insurance to children. (See CRS Report RL30473, *State Children's Health Insurance Program (SCHIP): A Brief Overview*, by Elicia Herz et. al.)

The Trade Act of 2002 created two new programs: grants for states to set up or expand high-risk pools for individuals who cannot find health insurance in the individual market and 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 Authorized by the Trade Act of 2002*, both by Bernadette Fernandez.)

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

A number of incremental reforms enacted over the past 15 years have improved the availability of health insurance to at least limited populations. They have also, however, built on a system where some individuals have no access to any insurance and others to only unaffordable options, where the number of uninsured has continued to rise, and where such changes may have exacerbated individuals losing privately sponsored coverage. For example, a body of research has concluded that expanding Medicaid and the State Children's Health Insurance Program (SCHIP) has generated some crowd-out of private coverage.[6]

Questions about the scope of reforms extend to the cost of the reform plans. At one end of the federal financing spectrum are bills 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]

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 purchasing 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 will find health insurance products are more affordable and available, and that meet, but do not exceed, their needs.

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

General Approaches to Health Insurance Reform

Health insurance reform bills introduced in the 110th Congress can be classified into the following categories:[8]

- National health insurance (or a national health service).
- Expanding existing public programs.
- Expanding privately sponsored coverage — includes proposals to
  - expand employer-based health insurance,
  - expand the individual market for health insurance, and
  - improve the private market for health insurance.
- State-based reforms.
- Combinations of above approaches.

National Health Insurance

A number of proposals introduced in the 110th and earlier Congresses 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 bills all share at least two common features: universal entitlement to health care or health insurance and government-provided health coverage.

There are a two approaches that national health insurance legislation in the 110th Congress take: social insurance and national health service. Under a social insurance approach, individuals 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 is such a system.

Because of the magnitude of the scope of such approaches, they would be subject to criticism, particularly about the level of governmental intrusion they would potentially introduce. On the other hand, with the complications raised by incremental measures of the last two decades, such as crowd-out of private coverage and the continuing rise in the number of people without any health insurance, questions are raised as to whether more incremental changes can be relied on to achieve universal or near universal coverage.

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[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].

Expanding Existing Public Programs

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 SCHIP) must be considered great successes. A number of bills offered in the 110th Congress would build on those programs to extend coverage to more uninsured individuals. Public program expansions have an advantage over other types of reforms in that the programs are already operational, and their administrative costs are lower, relative to the costs of benefits, than for typical privately sponsored health insurance plans.[9] If the target population of a reform proposal are predominantly those who cannot afford private coverage, or if the proposal includes sliding scale subsidies, utilizing existing programs that already conduct income determinations and administer subsidies may be efficient.

Proposals to expand public coverage while maintaining the existing private market for insurance face an obstacle in "crowd out." There is evidence that expanding public coverage can drive loss of coverage in the existing private market that would not have otherwise occurred. Analyses of the crowd-out impact 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.[10]

The majority of bills in the 110th Congress to expand public health insurance programs would do so only for certain targeted groups of individuals. For example, some bills would allow younger adults (for example, those between ages 55 and 65) to enroll in Medicare. Other bills would eliminate the two-year waiting period for people who are disabled to obtain Medicare benefits. Yet other bills would extend SCHIP and Medicaid, with an objective of achieving universal coverage for children. 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.[11]

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[9] 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.

[10] *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].

[11] Some of these limited scope bills, if enacted, however, 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.

Private Insurance Options

Private health insurance sponsored by employers covers more than 60% of the U.S. population.[12] As a result, a major portion of health insurance in this country is funded privately by workers and their employers. Reforms that do not carefully consider this large population and how to retain or replace this source of funds for health care are at a disadvantage. Bills aimed at strengthening and building on existing private markets for insurance recognize this reality. 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.[13] 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.

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,[14] 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, however, have limited impact on people who have no or tenuous ties to the workforce, people who are rejected by insurers, and those who change jobs but would like to maintain their coverage.

Nonetheless, many bills propose to subsidize workers' or employers' share of premiums (either 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.[15] A number of bills are intended to address the disadvantages that small 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,[16] its

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[12] CRS Report 96-891, *Health Insurance Coverage: Characteristics of the Insured and Uninsured Populations in 2006*, by Chris L. Peterson and April Grady.

[13] For a background on the ways in which people obtain health insurance and the markets for insurance, see CRS Report RL32237, *Health Insurance Primer*, by Bernadette Fernandez.

[14] See Figure 1 in CRS Report 96-891.

[15] Risk pools are large 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.)

[16] 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

(continued...)

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 confers 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. (See footnote 7 for citations.) Even bills that require individuals to purchase coverage tend to include assistance with costs, because health insurance premiums for a family at twice the federal poverty level can easily encompass more than 25% of a family's income.

Three alternative ways to subsidize health coverage are proposed in bills offered in the 110th Congress. Some bills would 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 and build subsidies into the existing annual federal tax filings. Under the second approach, tax filers would attest to their coverage during the past 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. A final group of bills would provide tax credits or subsidies directly to employers to encourage more generous 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. Many low-income individuals or families without tax liability do not file annual tax returns; getting them into the system is difficult. And employer subsidies may or may not ultimately help workers.

For bill writers, other complications arise in evaluating subsidies, whether delivered directly or through the tax system. The goal of setting subsidy amounts is 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. Finally, subsidies could exacerbate budgetary problems by encouraging crowd-out of existing employer or individual payments for coverage.

There are other ways to subsidize insurance via less direct routes. One of those, re-insurance, has appeared in a number of health insurance reform bills during this 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 to the government.

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[16] (...continued)
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.)

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 — employers often contribute to the cost of group health insurance as a workplace benefit, and payments for group plans have tax-advantaged status.[17] Further, the cost of group plans are calculated for an entire group, whereas individuals 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 may even refuse to sell to individuals with health conditions, or sell policies that exclude coverage for particular conditions and sometimes for entire body systems.[18]

Bills offered in the 110th Congress are intended to address some of those problems, in the hopes of making 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 you leave your 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 individually sponsored coverage.

Some bills would eliminate the tax benefits for employer-based health insurance premiums and replace them with new tax benefits for individually sponsored coverage. (See **Text Box 3** for summaries of tax policies related to health insurance.) These provisions are 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, but not others. For example, employer contributions fund a large portion of the nation's health insurance bills.

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[17] Under current law, people buying health insurance through their employers and self-employed individuals are able to exclude premiums for health insurance from taxable income. Others may deduct medical costs but 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 income.

[18] 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].

Without replacing those funds, some people may find individual insurance less affordable than their employer-sponsored plan, at least in the short run.[19] In addition, risk pooling in the individual market in many states is limited, and individual underwriting common. This could mean that once employers drop coverage, healthy people easily find replacement policies in the individual market, but those less healthy and arguably most in need of health insurance 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 individual market solutions tend to be combined with other reforms addressing some of these issues.

Text Box 3. Tax Benefits for Health Insurance

Many of the health reform bills introduced in the 110th Congress utilize the U.S. tax system to help meet the objectives of the bills. Below are brief descriptions of the 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*, by Bob Lyke and Julie M. Whittaker.

Tax subsidies for the purchase of health insurance. A number of bills propose tax credits for the purchase of health insurance. Some proposals 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 refundable and/or advanceable credits. Advanceable credits may improve the timeliness of those payments to assist individuals with payment for premiums when they are due.

Expanded deduction for health insurance payments. Several bills 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 tax payer itemizes or claims the standard deduction and would be available to all tax-payers, 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 for employment-based health insurance may be excluded from 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 be significant and could provide a funding source for other health insurance expansions or subsidies. Proposals to end the exclusion usually would replace it with a standard above-the-line deduction. See above description.

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. These proposals are often intended to improve cost conscious use of health services, or to encourage savings.

[19] 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.

Market Reforms. A number of bills offered during the 110th Congress include other market improvements intended to make private health insurance more accessible and affordable. These approaches include proposals 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
- 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 and instructions on how insurance carriers may develop the rates charged for their products, and describe procedures for approval of those rates. They address how entities in the business of selling health insurance fund their enterprises and prepare 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 appealing 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.[20]

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 each states' laws are significantly different from every other states' laws. 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. Very small groups are not able to spread health risk broadly. As a result, premiums for small firms, particularly those with older or less healthy workers (or workers' dependents) are relatively higher 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 Congress and were ostensibly about such pooling. In addition, those bills would have provided

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[20] See also CRS Report RS22476, *Standardizing State Health Insurance Regulation* by Jean Hearne and Bernadette Fernandez.

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 have raised the size of the risk pools.

Raising 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. At least one plan would be available in all areas of the country, and enrollment would be offered either to all small employers or to both small employers and individuals. The coverage offered through the groups would be modeled on the plans offered through the FEHBP. In general, the bills would establish that premiums for plans offered through the program would be averaged across all of the enrollees for each plan — the largest possible risk pool.[21] 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 of actual or anticipated services used by all subscribers in a specific geographic area [or state]) 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 rising relative to their perceived need, incentives are created for them to drop coverage altogether, making the pool increasingly costly and undermining the objective of spreading risk. A number of states have established community rating laws that effectively pool a great deal of the risk together. 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.[22]

"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 cost growth. 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 must be drawn from their savings account.

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

[22] 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.

Supporting State 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, a number of bills have been introduced to provide grant funds for states to continue and expand health insurance reforms on their own.

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. For example, Massachusetts has implemented the following reforms: individual mandates requiring 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. (See Massachusetts Health Care Reform Plan: An Update, Kaiser Commission on Medicaid and the Uninsured, June 2007 at [http://www.kff.org/uninsured/upload/7494-02.pdf].)

Vermont's reforms include over 35 initiatives designed to contain cost, increase access, and improve quality of health care. The state has established Catamount Health, a health insurance product for people who are uninsured, ensuring all state residents have access to health insurance. In addition, the state will

- provide premium subsidies for individuals with qualifying incomes and
- implement a statewide plan for preventing illness, encouraging healthy lifestyles, managing chronic conditions, and containing health care costs.

In addition to Massachusetts and Vermont, a number of other states are developing health coverage proposals. Maine, Illinois, and California are considering reforms intended to improve access to health insurance. 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.

For further information on state health insurance reforms, see J. McDonough, M. Miller, and C. Barber, *A Progress Report on State Health Access Reform: States Are Filling the Void in Federal Reform Activity, A Health Affairs Web Exclusive*, January 2007, and *Leading the Way: State Health Reform Initiatives*, NGA Center for Best Practices Issue Brief, July 2007.

State-led reform is appealing because local solutions may better reflect local needs, particularly in smaller or more homogenous states. Access to health insurance can be very localized, reflecting the close relationship between private health insurance coverage and local labor markets and economic conditions. Access to health care providers also varies considerably by geographic areas.

State based reforms, however, have several significant drawbacks. The Employee Retirement Income Security Act of 1974 (ERISA) impedes states from passing certain laws that affect employer benefits, including health insurance.[23] As a result, states may have more limited options for reform. Further, states' track record includes a number of failed initiatives — often related to inability to fund the invariably rising costs of the reforms.[24] 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. Finally, to ensure equity across states, federal reforms may be necessary.

Other Comprehensive Reforms Utilizing Multiple Approaches

A large number of introduced bills include provisions incorporating combinations of the approaches discussed above. 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 the politically unlikely national health insurance) with its inherent strengths and weaknesses will be sufficient to get to universal coverage. Bills advocating multiple approaches often include other market improvements to extend the availability of plans and subsidies to help low-income populations pay for their health coverage. Some of these bills are new to the 110th Congress, while others have been reintroduced from earlier Congresses. The newest of the bills advocating multi-system reforms tend to include provisions to improve quality of care, chronic disease management, and encourage healthier living.

While there may be a small number of introduced bills in this category, it is a favored approach among many in the policy community. Proposals offered by America's Health Insurance Plans (AHIP, [http://www.ahipbelieves.com/]) and The Health Coverage Coalition for the Uninsured ([http://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.

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[23] 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.

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

Health Insurance Reform Bills in the 110th Congress

Brief summaries of the major provisions of health insurance reform bills are provided below. The bills are loosely classified into the reform approaches described above, including

- national health insurance (or a national health service),
- expanding existing public programs,
- expanding privately sponsored coverage,
- state-based reforms, and
- combinations of above approaches.

Many of the bills do not lend themselves to such discrete categorization. This is because most of the bills have provisions that fall into more than one category. Also, the list includes both bills with fairly limited scope, as well as those with much broader scope in an effort to provide as comprehensive a list of health reform approaches as possible. Finally, the list reflects introduced bills on the date of publication. Other bills are likely to be introduced in between updates of this document and will be added in the next update.

National Health Insurance/National Health Service

H.R. 15. The National Health Insurance Act was introduced in January of 2007 by Representative John Dingell. 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. States and local administrative committees or officers would administer the health benefits. It would establish a National Health Insurance Board in the Department of Health and Human Services and a National Advisory Medical Policy Council. The Board would be required to (1) determine the amount of funds required for the provision of the benefits and (2) determine allotment amounts to states for services. The bill would establish a National Health Care Trust Fund, into which proceeds from a value added tax of 5% on each sale of property, performance of services, and importation of property for commercial purposes, with exceptions, would be deposited for the purpose of funding the provisions of the Act.

H.R. 676. The United States National Health Insurance Act, introduced by Representative John Conyers in January of 2007, would establish the United States National Health Insurance (USNHI) Program to provide all individuals residing in the United States and territories with all medically necessary health care at no cost. Care would be provided by public or not for profit institutional providers, HMOs, and participating physicians. It would prohibit health insurers from selling coverage duplicative of USNHI benefits; however, they could sell coverage for services not considered to be medically necessary. The bill would establish a USNHI Trust Fund to finance the Program with amounts deposited (1) from existing sources of government revenues for health care, (2) by increasing personal income taxes on the top 5% income earners, (3) by instituting a progressive excise tax on payroll and self-employment income, and (4) by instituting a small tax on stock and bond

transactions. The bill would establish a National Board of Universal Quality and Access to provide advice on quality, access, and affordability.

H.R. 1200. The American Health Security Act of 2007 was introduced by Representative Jim McDermott in February of 2007. The bill would require each participating state to establish an American Health Security Program to provide every U.S. citizen, national, or lawful resident alien with health care services. It would eliminate Medicare, Medicaid, SCHIP, the Federal Employees Health Benefits Program, 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 duplicates benefits provided under the program. It would establish a benefits standards board to (1) develop policies, procedures, guidelines, and requirements to carry out the Act; (2) establish reporting standards; (3) create several advisory councils; and (4) establish a budget for covered health care services. Finally, it would create the American Health Security Trust Fund and appropriate to the Fund specified tax liabilities and current health program receipts.

H.R. 1841. The AmeriCare Health Care Act of 2007 was introduced by Representative Pete Stark in March of 2007. The bill would establish a new health insurance program called AmeriCare, and establish an individual entitlement to its benefits for all U.S. residents. It specifies the benefit packages to be offered as well as allowable cost sharing. Benefits under AmeriCare would be (1) the same as the benefits provided under Medicare Parts A and B or (2) equivalent to the coverage in any of the four largest health plans offered under the Federal Employees Health Benefits Program. Financing for the program would come from individual premiums, employer contributions, state maintenance of effort payments, and general revenue funds.

H.R. 3000. The Josephine Butler United States Health Service Act was introduced by Representative Barbara Lee in July of 2007. The bill would establish the United States Health Service (USHS), through which all individuals while within the United States would be eligible to receive health care and supplemental services. All health care services would be provided at federal health care facilities. Such facilities would be established by the USHS in such number and location as to ensure that every resident receives equitable access to needed health care resources funded by the federal government. Benefits provided would include health promotion; prevention; diagnosis and treatment of illness and injury; rehabilitation and therapy; drugs and therapeutics, and ambulance and other transportation; child care; homemaking and home health; and counseling and social service assistance. All current law health provisions would be repealed. A health service tax would be imposed on each individual, estate, trust, and corporation. All other health-related tax deductions and exclusions would be ended. The Health Service Trust Fund is created into which current Medicare trust fund amounts would be transferred along with health service tax receipts.

Expanding Existing Public Programs

H.R. 2034/S. 1218. The Medicare for All Act was introduced by Representative John Dingell in the House of Representatives and Senator Ted Kennedy in the Senate in April of 2007. The bill would amend the Social Security

Act to establish a new health insurance program, Medicare for All. The program would offer a choice of plans to eligible individuals, provided such individuals are not eligible for Medicare. Persons eligible for this program would include all citizens and persons with lawful status. The act specifies that the benefit packages to be offered would be (1) a comprehensive set of benefits that include (but would not be limited to) the full range of benefits under Medicare fee-for-service or (2) equivalent to the coverage in any of the four largest health plans offered under the Federal Employees Health Benefits Program. The act also specifies the cost-sharing to be imposed under this new program, including reduced cost-sharing for low-income persons. The program would be financed through new taxes on workers and employers, and would be administered by the federal government.

Expanding Privately Sponsored Coverage

H.R. 227. The Health Care Tax Deduction Act of 2007 was introduced by Representative Cliff Stearns in January of 2007. The bill would establish a standard tax deduction from gross income for health insurance premiums and unreimbursed prescription drug expenses paid for the benefit of the taxpayer, the taxpayer's spouse, and dependents.

H.R. 241. The Small Business Health Fairness Act of 2007, introduced by Representative Sam Johnson in January of 2007, would provide for the establishment and governance of association health plans (AHPs) — group health plans whose sponsors are trade, industry, professional, chambers of commerce, or similar business associations, and which meet certain certification requirements. AHP plans would be exempt from certain state regulations. The bill would establish an Association Health Plan Fund to make payments to maintain coverage for plans that become insolvent and would establish a Solvency Standards Working Group. The bill would preempt any state law that precludes a health insurance issuer from (1) offering health insurance coverage in connection with a certified AHP or (2) offering health insurance coverage of the same policy type to other employers operating in the state that are eligible for coverage under such AHPs, whether or not such other employers are participating employers in such a plan. (Similar AHP provisions are included in H.R. 324, a minimum wage bill, and H.R. 1012, which provides for tax changes for small businesses.)

H.R. 914/S. 397. Tax Equity and Affordability Act of 2007 was introduced by Senator Mel Martinez in the Senate in January of 2007 and in the House by Representative Paul Ryan in February of 2007. The bill would amend the Internal Revenue Code (IRC) to (1) allow individual taxpayers a refundable tax credit for health insurance costs paid for the benefit of the taxpayer, the taxpayer's spouse, and dependents; (2) require business taxpayers who receive payments for certain employee health insurance coverage to file informational returns; (3) direct the Secretary of the Treasury to make advance payments of health insurance tax credit amounts to health insurance providers; and (4) limit the tax exclusion for employer-provided health care coverage.

H.R. 1802. The Keeping Small Businesses Healthy Act of 2007, introduced by Representative Darlene Hooley, would amend the IRC to allow certain small business employers with 100 or fewer employees a refundable tax credit for up to

60% of the health insurance costs paid for their employees. The tax credit would be calculated on a sliding scale. The smallest businesses would receive credits that cover a greater percentage of cost.

H.R. 2132. The Small Business Health Plans Act of 2007 was introduced by Representative Thomas Allen in May of 2007. The bill would direct the Secretaries of HHS and Labor to provide for a national health pooling arrangement for eligible small employers modeled after the FEHB program. Small employers would be able to join the pool through which they could offer health insurance coverage to employees and their dependents. The bill outlines program elements and coverage requirements. Small employers would be provided access to qualified health pooling arrangements under which their employees may elect coverage modeled after FEHB plans. The bill would require the Secretary to (1) establish a program of premium assistance for small employers that provides a sliding scale of assistance based on the number of employees, the average wage, and the employer profit margin; (2) provide for reinsurance coverage for an individual's claims that exceed a specified amount for a year; and (3) provide grants to states for the establishment, initial administration, and operation of pooling arrangements.

H.R. 2302. The Health Insurance Affordability Act of 2007, introduced by Representative Steve King in May of 2007, would amend the IRC to allow a deduction from gross income for premiums paid for a high deductible health plan. The deduction would not be allowed for those premiums that are excluded from income under the existing exclusion for employer sponsored health insurance premiums.

H.R. 2626. The Comprehensive Health Coverage And Reform Enhancement Act of 2007, introduced by Representative Tom Price on June 7,2007, would amend the IRC to allow an advanceable tax credit and a deduction for qualified health insurance. It would impose a tax penalty on employers who do not make premium contributions to individually sponsored health plans in lieu of the employer's group health coverage. The bill would change federal employee's contribution requirement so that the government contribution amount would not change based on the chosen health benefits plan and would treat health care professionals negotiating with health plans as collective bargaining units for purposes of antitrust laws. The bill includes provisions regulating health care lawsuits, dispute resolution, and deems hospitals, emergency departments, physicians, and physicians groups that provide emergency care to be employees of the Public Health Service for purposes of any civil action that may arise due to items and services furnished. Includes provisions to simplify applicable state health insurance laws and would allow medical care providers (1) to immediately deduct the cost of health care information technology and (2) a business tax credit for certain telecommunication charges. It would allow certain physicians a bad debt tax deduction for their costs in providing uncompensated care to emergency room patients and would require the Secretary to establish a Technical Advisory Group to review issues related to HIPAA.

H.R. 2737. The Health Care Relief Act of 2007, introduced by Representative Leonard Boswell in June of 2007, would amend the IRC to allow (1) a refundable tax credit of up to $1,000 for the health insurance coverage costs of a previously uninsured taxpayer, the taxpayer's spouse, and dependents, and (2) certain small

business employers a business tax credit for amounts paid under a new health plan for employee health insurance coverage.

H.R. 3515. The Health Insurance Tax Relief Act of 2007 was introduced by Representative John McHugh in September of 2007. The bill would amend the IRC to (1) allow individual taxpayers a refundable and advanceable tax credit for payments for qualifying health insurance and (2) require business taxpayers who receive payments for certain employee health insurance coverage to file informational returns.

H.R. 3516. The Affordable Health Care for Americans Act of 2007 was also introduced by Representative John McHugh in September 2007. The bill would amend the IRC to allow a tax deduction from gross income for the health insurance costs of an individual taxpayer, the taxpayer's spouse, and dependents (available whether or not a taxpayer itemizes deductions).

H.R. 3975. The Health Insurance Affordability Act of 2007, introduced by Representative Steve Chabot in October of 2007, would amend the IRC to allow individual taxpayers a tax deduction for health insurance costs.

H.R. 5348. The American Health Benefits Program Act of 2008, introduced by Representative Langevin in February of 2008, would establish the American Health Benefits Program based on the Federal Employees Health Benefits Program. A limited number of health insurance plans, modeled after those offered to federal employees would be made available to all individuals who are not eligible for qualifying employer-sponsored insurance. The government would pay about 72% of the cost of the plans and sliding scale subsidies would be available to those with low-income for remaining cost sharing amounts. Includes other tax policy changes and an individual mandate for coverage.

S. 99. The Small Business Health Care Tax Credit Act was introduced by Senator John Kerry in January of 2007. The bill would provide a partially refundable tax credit to small businesses (less than 50 employees) based on a percentage of the employer's cost of providing qualified health benefits to employees and dependents. The tax credit would be calculated on a sliding scale basis, with the smallest businesses receiving credits that would cover a greater percentage of costs.

S. 733. Promoting Health Care Purchasing Cooperatives Act was introduced by Senator Russell Feingold in March of 2007. It would authorize the Secretary of HHS, acting through the Director of the Agency for Healthcare Research and Quality (AHRQ), to award grants for the development of health care purchasing cooperatives of two or more self-insured employers. It would set requirements for cooperatives, including that they (1) be nonprofit, wholly owned, and democratically governed by its member-employers; (2) exist solely to serve the membership base; (3) assist members in pooling their health care insurance purchasing power; (4) provide data to improve the ability of the members to make data-based decisions regarding their health plans; and (5) conduct activities to enhance quality improvement in the health care community. The bill would also require the Secretary to carry out an identical grant program for eligible groups of two or more employers that have 99 employees or less and purchase health insurance for their employees.

S. 1019. The Universal Health Care Choice and Access Act, introduced by Senator Tom Coburn in March of 2007, would amend the Internal Revenue Code to (1) allow participants in high deductible health care insurance plans an increased tax deduction for contributions to a health savings account and (2) allow individual taxpayers a refundable tax credit for health insurance costs paid. It would require states to establish and operate a qualified high-risk pool or a state-designated alternative that ensures access to private health insurance for medically uninsurable individuals. It includes provisions allowing a health insurer to designate a primary state. The insurance laws applicable to the individual market for insurance in that primary state would apply to individual policies sold by that insurer in that state as well as in other states. The laws of those other states would be preempted from applying. S. 1019 would provide for health promotion and disease prevention activities, including requiring the Secretary of Health and Human Services (hereinafter referred to as the Secretary) to convene an interagency coordinating committee to develop a national strategic plan for prevention.

S. 1783. The Ten Steps to Transform Health Care in America Act was introduced by Senator Michael Enzi in July of 2007. The bill would require all adults with dependent children to obtain qualified health insurance coverage for those children and would establish an advanceable and refundable health insurance tax credit for the purchase of health insurance. It would merge the small group and individual markets for insurance, and includes provisions intended to simplify insurance standards for health plans, to improve quality of health care and to facilitate the adoption of health information technology. The bill would provide for grants for demonstration projects encouraging residential or community based settings of integrated skilled nursing care and for states to develop alternatives to tort litigation for resolving disputes over injuries caused by health care providers.

S. 1875. The Healthy Tax Reform Act was introduced in July of 2007 by Senator Jim DeMint. The bill would establish an advanceable and refundable health insurance tax credit for the purchase of qualified health insurance, limit the availability of certain tax preferences for individuals eligible for the health insurance tax credit, and repeal the alternative minimum tax after 2006. In order to be eligible for the credit, a taxpayer must be purchasing coverage in a state that has been deemed by the Secretary of HHS to be making efforts to provide its citizens with greater access to affordable private health insurance, including by establishing a state health insurance exchange, a high risk pool, a reinsurance mechanism, or other high risk solution. The bill sets requirements for state health insurance exchanges and would amend Medicaid to allow for the offering of health opportunity accounts in all states.

S. 1886. The Every American Insured Health Act was introduced by Senator Richard Burr in July of 2007. The bill would provide every American with a refundable, advanceable flat tax credit of $2,160 per individual and $5,400 per family. It would encourage the establishment of statewide insurance pools to reduce costs and help high risk individuals access affordable coverage and would expand the availability of health opportunity accounts under the Medicaid program.

S. 1899. The Universal Health Coverage Act of 2007, introduced by Senator Ben Cardin in July of 2007, would require all Americans to enroll in a qualified health care plan. The bill would require the Secretary of HHS, in consultation with

the National Association of Insurance Commissioners, to develop at least three types of low-cost health insurance plans for each State and the District of Columbia to make available, on a guaranteed-issue basis, to all individuals with incomes below 400% of the federal poverty line. Those who fail to enroll for any coverage for a continuous period greater than 60 days would be required to pay a tax equal to the average monthly premium amount for qualified coverage as defined by the state in which they reside. Funds collected by this tax would then be used to automatically enroll them in a state-approved plan.

Grants to States

H.R. 506. The Health Partnership Through Creative Federalism Act, introduced by Rep Tammy Baldwin in January of 2007, would require the Secretary of HHS to establish a State Health Coverage Innovation Commission to oversee and review proposals submitted by states (or other government entities) to expand and improve health care and health programs; submit to Congress a list of state applications that the Commission recommends for approval; report to the public concerning progress made by states; and to make recommendations. Plans may include other goals, such as improvements in quality, efficiency, cost-effectiveness, and the appropriate use of information technology. The Secretary would provide grants to those states with approved applications. The bill requires the commission and Secretary to fund a balanced diversity of approaches and link allocations to goals and performance measures. It authorizes an appropriation of such sums as are necessary.

H.R. 3507/S. 2031. The States' Right To Innovate in Health Care Act of 2007 was introduced by Representative John Tierney in the House of Representatives and Senator Bernard Sanders in the Senate in September of 2007. The bill would authorize planning and demonstration grants for states to develop cost-effective delivery systems of universal, comprehensive health care with simplified administration. It would direct the Secretary of HHS to establish a commission to review applications. State plans would be required to provide for coverage of all state residents with health benefits that are at least actuarially equivalent to the standard Blue Cross/Blue Shield preferred provider option service benefit plan under the Federal Employees Health Benefit Program.

S. 325. The Health Partnership Act was introduced bu Sen Jeff Bingaman in January of 2007. The bill would make grants available to states to carry out health care expansion and improvement programs. It would establish a State Health Innovation Commission, which would provide states with reform options; establish minimum performance measures and goals with respect to coverage, quality, and cost of such programs; and review state applications and submit to Congress a list of state applications that the commission recommends for approval. The bill sets forth rules for congressional consideration of such proposals and establishes that priority would be given to those programs that the commission determines have the greatest opportunity to succeed in expanding health insurance coverage. It authorizes an appropriation of such funds as necessary to carry out the Act.

Comprehensive Reforms that Utilize Multiple Approaches

S. 158. The Access to Affordable Health Care Act was introduced by Senator Susan Collins in January of 2007. The bill would amend the IRC to provide (1) tax credits to small businesses for qualified employee health insurance expenses, (2) tax credits for individuals and families for qualified health insurance, (3) deductions for long-term care insurance premiums, and (4) tax credits for individuals with long-term care needs. It would require the Secretary of Labor to award grants to states to assist in planning, developing, and operating qualified small employer purchasing groups for health insurance. It would direct the Small Business Administration to award grants to states, local governments, and nonprofit organizations to provide health insurance information to small employers and require the Secretary to award demonstration grants for states on the effectiveness of innovative ways to increase access to health insurance. It would amend the SCHIP program to (1) allow states to extend coverage to qualified children, parents, and pregnant women; (2) redistribute unspent FY2004 allotments; and (3) provide additional allotments to eliminate funding shortfalls. It would provide for improved outreach and enrollment in government programs for eligible children and homeless individuals and families and express the sense of the Senate that appropriations for consolidated health centers and the National Health Service Corps should be doubled over the next five fiscal years. It requires the Secretary of HHS to (1) award grants to states for the promotion of healthy lifestyles and for the establishment and operation of worksite wellness programs for small employers and their employees, (2) expand comprehensive school health education programs, and (3) establish demonstration projects related to providing low-cost, high-quality health care and attracting educators and clinical practitioners to underserved areas.

H.R. 2351. The Health Coverage, Affordability, Responsibility, and Equity Act of 2007 was introduced by Representative Marcy Kaptur in May of 2007. The bill supports the use of demonstration waivers by states to implement policies that make comprehensive, affordable health coverage available for all state residents. Coverage would emphasize the use of preventive services, care coordination, and health information technology. If states choose to undertake such waivers, they would be eligible to receive the grants funds and federal tax expenditures that would otherwise be available under other provisions of this bill. If states do not undertake such waivers, then the bill would extend Medicaid to allow for the coverage of all individuals with incomes below 100% of the poverty line and amend SCHIP to provide additional funds for states that extend coverage to all targeted low-income children. The bill would provide for an advanceable, refundable tax credit for the cost of qualified health insurance; establish an FEHBP-like purchasing pool for individuals and small groups to obtain coverage; create standards for state-based reinsurance programs; and make grants available to states toward the costs of such programs.

H.R. 3163. The Healthy Americans Act was introduced by Representative Brian Baird in September of 2007. Its provisions are almost identical to those of S. 334 (described below) except instead of replacing the existing tax exclusion for payments for employer-provided health insurance with a standard deduction for premiums for all taxpayers, it would replace the exclusion with a refundable tax-credit.

S. 334. The Healthy Americans Act was introduced by Senator Ron Wyden in January of 2007. The major provisions of the bill would mandate that all individuals (with some exceptions) have health coverage. Individuals would have the opportunity to enroll in one of the private health plans ("Healthy Americans Private Insurance Plans") administered by regional insurance entities ("State Health Help Agencies"). HAPI plans would be comprehensive and include prevention and disease management programs. Full subsidies would be made available for individuals and families with income below poverty, and partial subsidies for other low income individuals. The program would be financed by individual and employer responsibility payments, reductions in Medicare and Medicaid spending, and other general treasury funds. The existing tax exclusion for payments for employer-provided health insurance would be ended and a standard deduction would be established for premiums for all taxpayers.

CRS Products on Health Insurance and Tax Policy for Health Insurance

CRS Report RL32237, *Health Insurance: A Primer*, by Bernadette Fernandez

CRS Report RL33702, *Health Insurance Basics: Roles for the Market and Government in Providing, Financing, and Regulating Private Insurance Coverage*, by Jennifer Jenson and Bernadette Fernandez

CRS Report RS22735, *Spending by Employers on Health Insurance: A Data Brief*, by Jennifer Jenson

CRS Report RL31745, *Health Insurance: State High Risk Pools*, by Bernadette Fernandez

CRS Report RS20315, *ERISA Regulation of Health Plans: Fact Sheet*, by Hinda Chaikind

CRS Report RS22476, *Standardizing State Health Insurance Regulation*, by Jean Hearne and Bernadette Fernandez

CRS Report RL31963, *Association Sponsored Health Plans: Legislation in the 109th Congress*, by Jean Hearne

CRS Report RL33759, *Health Care Markets, Prices, and Spending*, by D. Andrew Austin

CRS Report RL31374, *Health Expenditures in 2005*, by Paulette C. Morgan

CRS Report RL32545, *Health Care Spending: Context and Policy*, by Jennifer Jenson

CRS Report RL34295, *Spending by Consumers on Health Care and Health Insurance: A Data Brief*, by Jennifer Jenson

CRS Report RL33759, *Health Care and Markets*, by D. Andrew Austin

CRS Report RL34101, *Does Price Transparency Improve Market Efficiency? Implications of Empirical Evidence in Other Markets for the Health Sector*, by D. Andrew Austin and Jane Gravelle

CRS Report RL34175, *U.S. Health Care Spending: Comparison with Other OECD Countries*, by Chris L. Peterson and Rachel Burton

Insurance Coverage

CRS Report 96-891, *Health Insurance Coverage: Characteristics of the Insured and Uninsured Populations in 2006*, by Chris L. Peterson and April Grady

CRS Report 96-979, *Health Insurance: Uninsured by State, 2006*, by Chris L. Peterson and April Grady

CRS Report 97-975, *Health Insurance Coverage of Children, 2006*, by Chris L. Peterson and April Grady

CRS Report 97-310, *Health Insurance: Uninsured Children by State, 2004-2006*, by Chris L. Peterson and April Grady

CRS Report RL32944, *Health Insurance Coverage for Retirees*, by Hinda Chaikind

CRS Report RS21974, *Federal Employees Health Benefits Program: Available Health Insurance Options*, by Hinda Chaikind

Tax Policy and Health Insurance

CRS Report RL33505, *Tax Benefits for Health Insurance and Expenses: Overview of Current Law and Legislation*, Bob Lyke and Julie M. Whittaker

CRS Report RL32656, *Health Care Flexible Spending Accounts*, by Bob Lyke

CRS Report RL33257, *Health Savings Accounts: Overview of Rules for 2008*, by Bob Lyke

CRS Report RL32620, *Health Coverage Tax Credit Authorized by the Trade Act of 2002*, by Bernadette Fernandez

CRS Report RS21573, *Tax-Advantaged Accounts for Health Care Expenses: Side-by-Side Comparison*, by Bob Lyke and Chris L. Peterso crsphpgw