HEALTH CARE REFORM RETURNS TO THE NATIONAL AGENDA: THE 2004 PRESIDENTIAL CANDIDATES' PROPOSALS

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EXECUTIVE SUMMARY

National health reform has emerged as a major campaign issue during the 2004 presidential election. Both President George W. Bush and Senator John Kerry have proposals to extend health insurance coverage to millions of uninsured Americans. Each of the candidates' proposals builds on the existing system of private and public health insurance in the United States rather than fundamentally reforming the health care system. President Bush would provide tax incentives for coverage in the individual market and allow the formation of new group purchasing arrangements for small businesses. Senator Kerry would increase the affordability of employer-sponsored coverage by reinsuring catastrophic expenses and provide expanded access to new forms of employer-sponsored coverage and existing state insurance programs.

This report explores why the nation's chronic health insurance problem is back on the national agenda and examines the plans of the presidential candidates as of October 1, 2004. Cost and coverage estimates for health reform proposals are highly uncertain given that they are basic outlines of what the candidates plan to do if elected. At least five sets of estimates are now available, from the U.S. Treasury Department and Office of Management (OMB) and Budget, the U.S. Congressional Budget Office (CBO), Kenneth Thorpe of Emory University, the American Enterprise Institute (AEI) and the Lewin Group.[1] This report cites all these estimates over a comparable time period.[2]

The factors that led to widespread public support for health care reform in the 1992 presidential campaign—growing numbers of uninsured, rapid growth in health care costs, and economic insecurity—have reemerged in recent years. After a brief period of decline, the number of Americans without health insurance climbed to nearly 45 million in 2003, 5 million more than three years earlier. In addition, after health care expenditures grew more slowly than historical rates during the 1990s, expenditures are once again rising rapidly, consuming an increasing share of U.S. economic output—the largest of any

[1] U.S. Department of the Treasury, *General Explanations of the Administration's Fiscal Year 2005 Revenue Proposals,* February 2004; U.S. Congressional Budget Office, *An Analysis of the President's Budgetary Proposals for Fiscal Year 2005,* March 2004; Kenneth E. Thorpe, *Federal Costs and Savings Associated with Senator Kerry's Health Care Plan,* Emory University, April 2, 2004; Kenneth E. Thorpe, *Federal Costs and Newly Insured Under President Bush's Health Insurance Proposals,* Emory University, May 5, 2004; J. Antos et al., *Analyzing the Kerry and Bush Health Proposals: Estimates of Cost and Impact* (Washington, D.C.: American Enterprise Institute, September 13, 2004); and the Lewin Group, *Bush and Kerry Health Care Proposals: Cost and Coverage Compared,* September 21, 2004.

[2] The Lewin Group and the American Enterprise Institute estimated costs for the 2006–2015 period. The U.S. Treasury Department/OMB, CBO, and Thorpe estimated costs over 2005–2014, which is the federal government's current 10-year budget projection period. For purposes of comparison, we use the 2005–2014 time period throughout this report. With the exception of the U.S. Treasury and CBO estimates, all estimates assume plan implementation beginning in 2006. Therefore, the cost estimates shown in the report by Thorpe, the Lewin Group, and AEI span a 9-year time period.

industrialized nation. Health insurance premiums also are on the rise and employers are increasing cost-sharing, limiting benefits, and shifting more financial risk to employees. The Institute of Medicine estimates that the economic value lost from preventable morbidity and mortality associated with being uninsured is $65 to $130 billion annually.

Over the past year, health care industry leaders, physicians, academics, and elected officials have responded to growing evidence of distress with proposals for action. With opinion polls showing that the issue of health care is high on the list of public concerns, the 2004 presidential candidates are proposing their own solutions to the nation's health care problems.

THE PLANS

The plans of President George W. Bush and Senator John Kerry offer a few similar features within very different designs (Chart ES-1). Both rely on tax credits to make coverage more affordable. Senator Kerry's plan builds on group health insurance, while the President's plan is structured around the individual insurance market. Both proposals leave employer-sponsored health insurance intact, with the Senator's plan seeking to strengthen it by making coverage more affordable for companies and workers. The Kerry plan also incorporates public program expansions. While President Bush's plan is designed to be highly targeted to select groups, Senator Kerry's plan aims to cover greater numbers of uninsured people.

Chart ES-1

Comparison of Major Health Care Reform Proposals

	Bush	Kerry
Aims to Cover All Americans		X
Tax Credits for Premiums	X	X
Automatic Enrollment/ Individual Mandate		X
Employer Mandates, Incentives or Penalties		X
New Group Option for Small Firms, Individuals	X	X
Low-Income Public Expansion		X
Medicare Buy-In for Older Adults		

As of October 2004

Source: The Commonwealth Fund.

The specific features of the plans determine the number of uninsured covered, where the uninsured will find insurance, and costs (Chart ES-2). Out of the 45 million people currently without health insurance coverage, President Bush's plan is estimated to cover between 2 and 8 million people while Senator Kerry's plan is estimated to cover between 25 and 27 million people. Senator Kerry covers most uninsured people through Medicaid and the State Children's Health Insurance Program (CHIP) and a new group insurance option, based on the one available to members of Congress and federal employees. President Bush would cover most people through the individual insurance market and new group purchasing arrangements for small businesses.

Chart ES-2

Comparison of Candidates' Health Insurance Expansion Proposals: Coverage and Costs

	Bush	Kerry
Total Uninsured Covered, Millions	2 to 8	25 to 27
Employer-Sponsored Coverage	—	2 to 3
New Group Insurance Option	—	2 to 6
Private Insurance Market	2 to 8	—
Medicaid/CHIP	—	18 to 21
Medicare	—	—
Uninsured Not Covered, Millions*	37 to 43	18 to 20
Total Cost, 2005–2014 $Billions**	$90.5 to $195.4	$653.1 to $1,304.3

As of October 2004

* Based on 2004 Current Population Survey estimate of 45 million uninsured.
** The Lewin Group and the American Enterprise Institute estimate costs over 2006–2015, but only costs which would occur over 2005–2014 are shown here. See Appendix for full explanation.

Source: The Commonwealth Fund, based on U.S. Department of the Treasury; Congressional Budget Office; Kenneth E. Thorpe, Emory University; the Lewin Group; and AEI.

Reflecting their scope, the estimated costs of the proposals to the federal budget over 2005 to 2014 range from $90.5 billion to $195.4 billion (Bush) to $653.1 billion to $1.3 trillion (Kerry) (Charts ES-3, ES-4).[3]

[3] The Lewin Group and AEI estimated costs for the 2006–2015 period. The Lewin Group estimated a net federal government cost of President Bush' plan of $227.5 billion over that period and $1.25 trillion for Senator Kerry's plan. AEI estimated a net federal cost of $128.6 billion (Bush) and $1.5 trillion(Kerry).

Chart ES-3

Comparison of Coverage and Cost Estimates for President Bush's Health Plan, 2005–2014*

	Treasury	CBO	Thorpe	Lewin Group	AEI
Uninsured Covered (Number in Millions)	NA	NA	2.1 to 2.4	8.2	6.7
Net Federal Government Cost ($Billions)	$104.4	$113	$90.5	$195.4	$110.1
Low Income ($Billions)	70.1	61	49.2	119.6	71.1
HSA Deductions ($Billions)	24.8	25	32.8	36.9	17.3
Small Employer Tax Credit ($Billions)	NA	NA	NA	4.5	17.7
Other ($Billions)	25.2	27	8.5	51.8	4.0
Gross Federal Government Cost ($Billions)	120.1	113	90.5	212.8	110.1
Offsetting Savings ($Billions)	(15.7)	NA	NA	(17.4)	NA
State and Local Government Cost ($Billions)	NA	NA	NA	(17.2)	NA
Net Federal, State, and Local Government Cost ($Billions)	NA	NA	NA	$178.2	NA

As of October 2004

* The Lewin Group and the AEI estimate costs over 2006–2015, but only costs which would occur over 2005–2014 are shown here. See Appendix for full explanation.

Source: The Commonwealth Fund, based on U.S. Treasury; CBO; Kenneth E. Thorpe, Emory University; the Lewin Group; and AEI.

Chart ES-4

Comparison of Coverage and Cost Estimates for Senator Kerry's Health Plan, 2005–2014*

	Thorpe	Lewin Group	AEI
Uninsured Covered (Number in Millions)	26.7	25.2	27.3
Net Federal Government Cost ($Billions)	$653.1	$1,075.0	$1,304.3
Low Income ($Billions)	518.0	474.7	752.3
Employer Reinsurance and Premium Assistance ($Billions)	323.6	548.2	601.7
Employee Premium Assistance ($Billions)	110.2	206.2	52.7
Gross Federal Government Cost ($Billions)	951.8	1,229.1	1,406.7
Offsetting Savings ($Billions)	(298.8)	(154.1)	(102.4)
State and Local Government Cost ($Billions)	NA	(301.7)	NA
Net Federal, State, and Local Government Cost ($Billions)	NA	$773.3	NA

As of October 2004

* The Lewin Group and the AEI estimate costs over 2006–2015, but only costs which would occur over 2005–2014 are shown here. See Appendix for full explanation.

Source: The Commonwealth Fund, based on Kenneth E. Thorpe, Emory University; the Lewin Group; and AEI.

CONCLUSION

These proposals provide a unique opportunity for the nation to discuss whether to expand health insurance coverage and, if so, how best to do it. The plans offer a range of policy options and differing perspectives on how to address the nation's chronic uninsured problem. The public would benefit from thorough vetting of the plans and informed debate on the goals of health care reform and the details of how to achieve them. No matter who prevails in the 2004 election, this debate may help the public and the policy community reach consensus on how to solve one of the country's most vexing and intransigent problems.

PRESIDENT GEORGE W. BUSH

Overall approach: Tax credits to buy individual policies for low-income uninsured, health savings accounts, association health plans

Special focus: Individual choice, responsibility, and ownership

Number of uninsured covered: Estimated at 2.1–2.4 million (Thorpe); 6.7 million (AEI); 8.2 million (Lewin).

Remaining uninsured: 36.8–42.9 million (out of 45 million people who were uninsured in 2003).

Net federal cost for 2005–2014: $90.5 billion (Thorpe); $104.4 billion (U.S. Treasury, Office of Management and Budget); $110.1 billion (AEI); $113 billion (CBO); $195.4 billion (Lewin).[1,2,3]

SENATOR JOHN KERRY

Overall approach: Mixed public–private with employer and individual tax credits, new employer group option, public program expansion

Special focus: Cost containment and affordability

Number of uninsured covered: Estimated at 25.2 million (Lewin); 26.7 million (Thorpe); 27.3 million (AEI)

Remaining uninsured: 17.7–19.8 million (out of 45 million people who were uninsured in 2003).

Net federal cost for 2005–2014: $653.1 billion (Thorpe); $1.08 trillion (Lewin); $1.3 trillion (AEI).[1,2,3]

HEALTH CARE REFORM RETURNS TO THE NATIONAL AGENDA: THE 2004 PRESIDENTIAL CANDIDATES' PROPOSALS

INTRODUCTION

National health reform has emerged as a major campaign issue during the 2004 presidential election. Both President George W. Bush and Senator John Kerry have proposals to extend health insurance coverage to millions of uninsured Americans. Each of the candidates' proposals builds on the existing system of private and public health insurance in the United States rather than fundamentally reforming the health care system. President Bush would provide tax incentives for coverage in the individual market and allow the formation of new purchasing arrangements for small businesses. Senator Kerry would increase the affordability of employer-sponsored coverage and provide expanded access to new forms of employer-sponsored coverage and existing state insurance programs.

This report explores why the nation's chronic health insurance problem is back on the national agenda and examines the plans of the presidential candidates as of October 1, 2004. Cost and coverage estimates for health reform proposals are highly uncertain given that they are basic outlines of what the candidates plan to do if elected. At least five sets of estimates are now available, from the U.S. Treasury Department and Office of Management and Budget, U.S. Congressional Budget Office (CBO) Kenneth Thorpe of Emory University, the American Enterprise Institute (AEI) and the Lewin Group.[1] This report cites all these estimates over a comparable time period.[4]

WHY HEALTH INSURANCE COVERAGE HAS AGAIN BECOME A NATIONAL PRIORITY

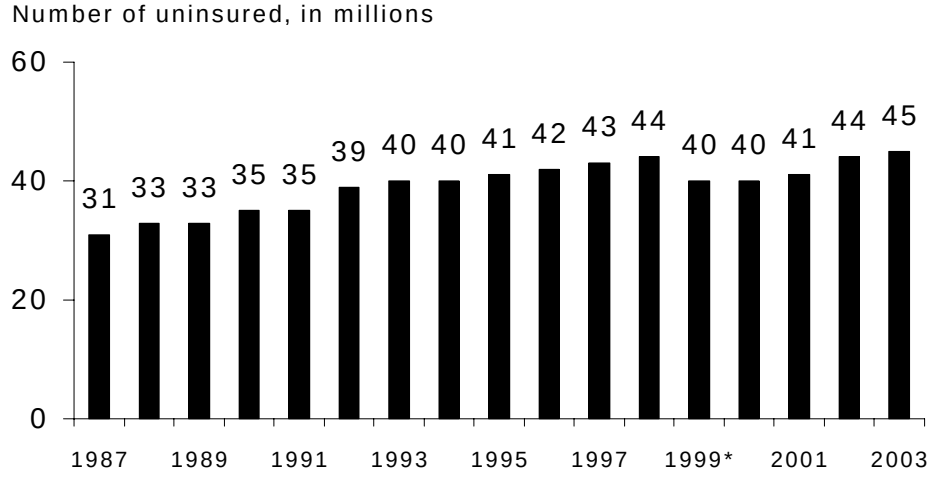
Health care became a central issue in the campaign for the presidency in 1992.[2] More than 37 million people went without health insurance that year and both health care costs and health insurance premiums rose rapidly over the late 1980s and early 1990s. In addition, the economy was in recession and job insecurity was high. These conditions created unease about health insurance coverage among insured, as well as uninsured, people. Many worried that job-based coverage would become more costly, less comprehensive, or simply less available.[3] Consequently, a number of bold proposals to expand coverage

[4] The Lewin Group and the American Enterprise Institute estimated costs for the 2006–2015 period. The U.S. Treasury Department/OMB, CBO and Thorpe estimated costs over 2005–2014, which is the federal government's current 10-year budget projection period. For purposes of comparison, we use the 2005–2014 time period throughout this report. With the exception of the U.S. Treasury and CBO estimates, all estimates assume plan implementation beginning in 2006. Therefore, the cost estimates shown in the report by Thorpe, the Lewin Group, and AEI span a 9-year time period.

emerged from presidential candidates, including Governor Bill Clinton and President George H. W. Bush, as well as from members of Congress, academics, and health care industry leaders.[4]

It is easy to see parallels between the early 1990s and today. After a brief period of decline, the number of Americans without health insurance climbed to nearly 45 million in 2003, 5 million more than three years earlier (Chart 1).[5] In addition, after health care expenditures grew more slowly than historical rates during the 1990s, expenditures are once again rising rapidly, driven both by price inflation and by increased utilization of health care services (Chart 2).[6] Health care expenditures accounted for 14 percent of the gross domestic product in 2001—more than in any other industrialized nation (Chart 3). Reflecting these increased costs, as well as an upward trend in the insurance underwriting cycle, health insurance premiums also have climbed since the mid-1990s.[7,8] Employers have responded to higher premiums by increasing cost-sharing, placing limits on benefits, and turning to new insurance products that shift more financial risk to employees.[9] Some employers have dropped coverage altogether: the most important factor behind the rise in the number of uninsured over 2000 to 2003 was the decline in employer-sponsored health insurance coverage.[10]

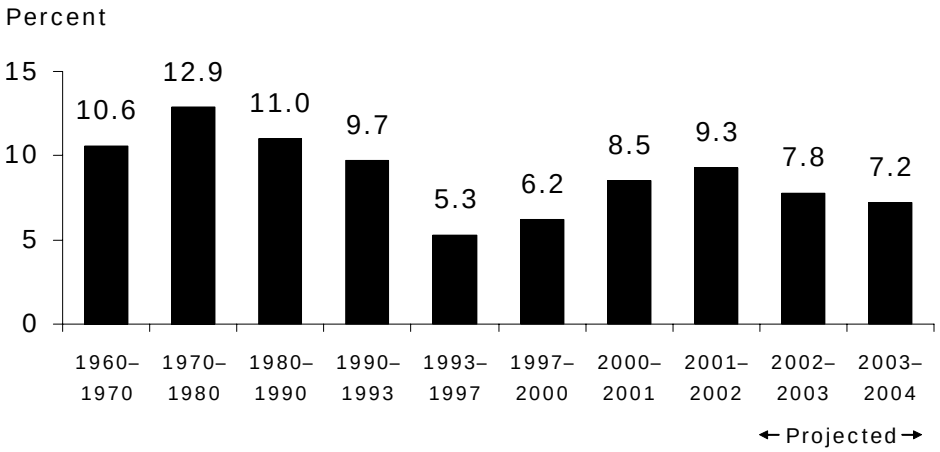
Chart 1



* 1999–2003 estimates reflect the results of follow-up verification questions and implementation of Census 2000-based population controls.
Source: U.S. Census Bureau, March CPS Surveys 1988 to 2004.

Chart 2

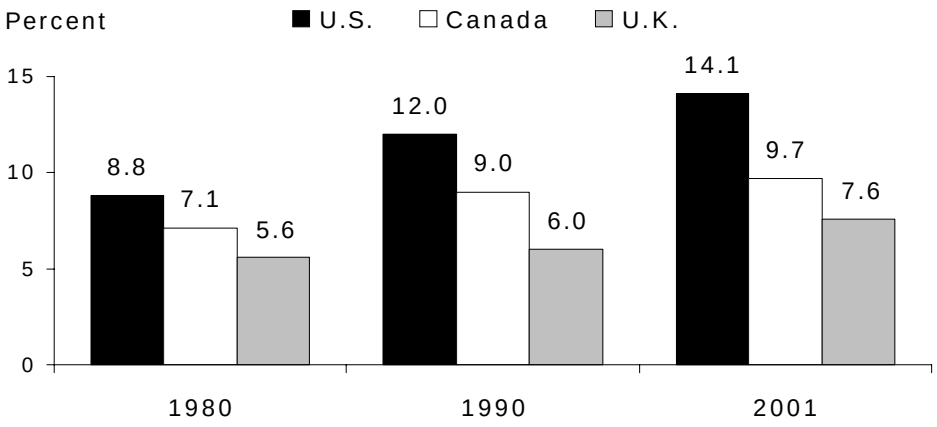
National Health Expenditures' Average Annual Percentage Growth, Selected Calendar Years, 1960–2004



Source: The Commonwealth Fund, based on K. Levit et al., "Health Care Spending Rebound Continues in 2002," *Health Affairs* 23 (Jan./Feb. 2004): 147–59; and S. Heffler et al., "Health Spending Projections Through 2013," *Health Affairs* Web Exclusive (Feb. 11, 2004): W4-79–W4-93.

Chart 3

National Health Expenditures' Percent of Gross Domestic Product, Selected Countries and Years, 1980–2001



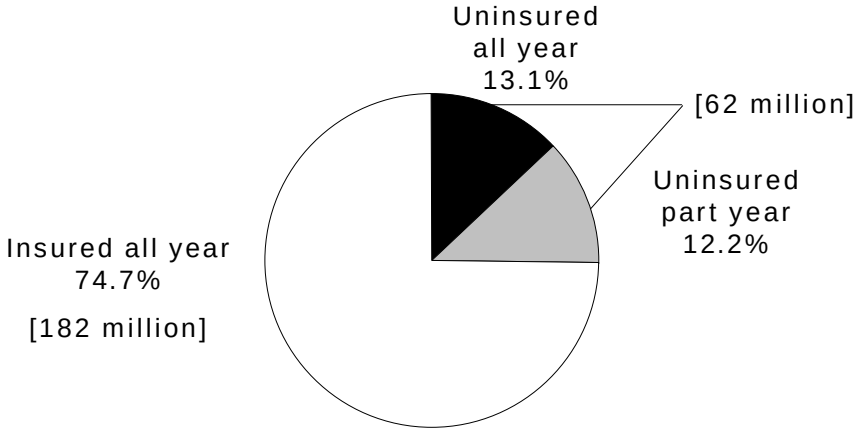
Source: The Commonwealth Fund, based on Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Expenditures Projections, 2002, Table 1; Organisation for Economic Cooperation and Development, OECD Health Data, Frequently Asked Data, 2003, Table 10.

New research underscores the magnitude and multiple costs of such problems in the U.S. health system. For the insured, coverage is far less stable than previously believed. Reports published in 2004 show that, after taking into account those who are uninsured

for at least part of the year, the total number of uninsured increases by about 40 percent to around 62 million (Chart 4).[11] New evidence also shows that leaving such large numbers of people without coverage has enormous economic and human costs. The price tag for uncompensated care provided to the uninsured through public and private health care institutions is projected to reach $41 billion in 2004.[12] The Commonwealth Fund Biennial Health Insurance Survey found that 60 percent of adults who were uninsured for a period of time in 2003 reported problems paying their medical bills or paying off accrued medical debt. [13] Yet, many people with unstable coverage fail to get medical care when they need it, resulting in poor health status and higher-than-expected mortality rates.[14] The Commonwealth Fund Survey found that three in five people who were without coverage for any time during 2003 did not get needed health care because of cost. [15] In a study of 4,700 adults followed for 13 to 17 years, lacking insurance coverage was associated with a 25 percent greater risk of death, even after taking into account other socio-demographic characteristics and risk behaviors.[16] The Institute of Medicine (IOM) calculates that lack of health insurance resulted in an estimated 18,000 deaths in 1999 among Americans, ages 25 to 64, which would otherwise not have occurred.[17] The IOM estimates that the economic value lost from preventable morbidity and mortality associated with being uninsured ranges from $65 to $130 billion annually.[18]

Chart 4

One of Four People Under Age 65 Was Uninsured During Part of 2002



Total Population Under Age 65 = 244 Million

Source: Medical Expenditure Panel Survey Statistical Brief #45—The Uninsured in America, 1996–2003. Civilian Noninstitutionalized Population Under Age 65, July 2004.

Recent trends and national circumstances make comprehensive health reform more pressing, as well as more difficult to achieve, than when last attempted. Although

still concentrated among people with low incomes, unstable insurance coverage has spread to the middle class, to people employed by large firms, and to early retirees. Private-sector tools to control costs, such as managed care, that seemed so promising at the time of the Clinton reform plan proved unpopular.[19] Similarly, any excess has been squeezed out of public program payments to health care providers, at the federal level in the Balanced Budget Act of 1997 and at the state level during the recent budget crises. Over the next few years, the competition for federal dollars promises to intensify given the rapidly approaching retirement of the baby boom generation, the threats to national security, and record tax cuts.

There have been calls to reform the health care system from the public and private sectors. In July, a broad coalition of businesses, insurers, unions, providers, and consumers known as the National Coalition on Health Care called for legislation to cover all Americans and control health care costs. Bruce Bodaken, CEO of Blue Shield of California, last year proposed a plan to cover the uninsured.[20] Physicians for a National Health Program released a proposal for a single-payer system last summer.[21] Since the failure of health reform in 1994, many analysts have developed ideas for expanding health insurance coverage. Among them is "Creating Consensus," published in the health policy journal *Health Affairs* in April 2003 by Karen Davis and Cathy Schoen of The Commonwealth Fund. "Creating Consensus" offers a framework for expanding coverage that aims to bridge differences between proponents of public and private approaches (see text box for details).[22]

Several members of Congress, including Senators Max Baucus, Jeff Bingaman, Richard Durbin, Charles Grassley, Edward Kennedy, and Blanche Lincoln, and Representatives Michael Bilirakis, Vic Snyder, and Edolphus Towns have recently introduced insurance expansion bills. The Senate Republican Task Force on Health Care Costs and the Uninsured released a set of recommendations in the spring of 2004 to control costs and expand coverage and Senator Bill Frist separately offered a set of guiding principals on the issue.[23] House Democrats led by Representatives Sherrod Brown, John Dingell, Charles Rangel, Max Sandlin, Pete Stark, and Henry Waxman recently introduced three bills that would jointly expand insurance coverage. In 2003, Governor John Baldacci of Maine signed into law a plan to put the state on a path to universal coverage. In addition, California has a new law that requires employers either to purchase insurance for their workers or pay into a state fund that provides coverage.[24] With surveys and opinion polls showing that the issue of health care is high on the list of public concerns, the 2004 presidential candidates are proposing their own solutions to the nation's health care problems.[25]

In April 2003, Karen Davis and Cathy Schoen of The Commonwealth Fund released a framework for expanding health insurance coverage.* In "Creating Consensus," the authors show that, rather than being mutually exclusive, private and public approaches can work in tandem to increase coverage. These diverse approaches can either be part of a plan that aims to achieve universal coverage all at once or form incremental solutions that would cover the most at-risk populations over time.

The "Creating Consensus" framework builds on the existing system, embracing institutions familiar to most Americans. A new group insurance option based on the Federal Employees Health Benefits Program, called the Congressional Health Plan, would cover workers in small businesses and uninsured individuals and would be combined with tax credits to subsidize the purchase of coverage. The authors recommend federally funded reinsurance or other risk-pooling arrangements to finance the costs of potentially high health risks at the outset. Employers who do not offer insurance would be required to contribute to a fund to cover their employees under the Congressional Health Plan. Companies that do offer coverage would be required to have a plan that meets a minimum standard and has 80 percent workforce participation.

The framework would couple these employer requirements with a mandate for individual insurance coverage. All tax filers would be required to show proof of insurance coverage at the time they file their return, and the uninsured would receive tax credits to help pay for Congressional Health Plan premiums. Enrollment could be automatic, or people could opt out of coverage. Tax credits would pay for premiums greater than 5 percent of income (10 percent of income for those in higher tax brackets). Providers and patients would be able to access an online health insurance clearinghouse to check coverage options.

"Creating Consensus" also proposes policy changes to protect the most vulnerable uninsured, including expansions to the State Children's Health Insurance Program to cover low-income adults and to Medicare to cover older or disabled adults. To help the growing numbers of uninsured young adults, the plan would require companies to extend coverage to dependent adults under age 23 through their parents' coverage. To help those who lose their jobs, the plan would require companies to extend coverage to employees for up to two months, and would provide a federal tax credit worth up to 70 percent of COBRA premiums.

* K. Davis and C. Schoen, "Creating Consensus on Coverage Choices," *Health Affairs* Web Exclusive (April 23, 2003): W3-199–W3-211.

THE PLANS

President George W. Bush and Senator John Kerry both have proposals to expand health insurance coverage. Senator Kerry's running mate, Senator John Edwards, also campaigned on a proposal to expand health insurance coverage in the Democratic presidential primary.

Candidates and others designing a health care reform plan must address several key issues, all of which have implications for their public appeal and potential impact. These issues include: the overall approach that will be used to cover people; if the plan will have any special focus, such as cost containment; if tax credits will be used to make health insurance coverage more affordable and who will receive them; if the plan will include a new expanded private (group or individual market) health insurance option; if the plan will include employer requirements and incentives to provide coverage to workers; if public insurance programs will be expanded; if the plan will automatically enroll people in various coverage options; and if the plan will focus exclusively on expanding coverage or will tie expansion to cost containment and quality improvement. These design features affect two important outcomes: the plan's effect on the number of uninsured and its federal budget costs. The plans of President Bush and Senator Kerry are described below. A comparison and an assessment of the plans follow.

PRESIDENT GEORGE W. BUSH

Overall approach: Tax credits to buy individual policies for low-income uninsured, health savings accounts, association health plans

Special focus: Individual choice, responsibility, and ownership

Tax credits: President Bush has proposed providing tax credits to purchase policies in the individual market for people without access to employer-based or public insurance. Single adults would be eligible for credits worth up to $1,000 a year with eligibility phasing out at annual incomes between $15,000 and $30,000. Families with two or more children would receive credits worth up to $3,000 per year, with eligibility phasing out at incomes between $25,000 and $60,000. Alternatively, those eligible for the tax credits could elect to receive about one-third of their tax credit as a contribution to a Health Savings Account (HSA) with the remaining two-thirds to be used towards the purchase of a high deductible health plan. Small businesses that contribute to their employees' HSAs would be eligible for a tax credit towards the first $200 contributed per worker for those with single coverage and the first $500 contributed per worker for those with family coverage. The President would make premium payments for long-term care insurance fully tax-deductible. He also proposes an additional personal tax exemption for people who take time out to care for parents or children who need long-term assistance.

New/expanded private insurance option: Tax credits would subsidize only non-group, individual market coverage that meets certain minimum standards. President Bush proposes to expand HSAs by allowing participants to deduct their premiums for high-deductible health plans in the individual insurance market from their taxable income. HSAs were created by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 and allow people who buy high-deductible health plans (those with deductibles of $1,000 or more for individuals and $2,000 or more for families) to make tax-deductible contributions to a savings account that can be used for unreimbursed medical expenses, as well as for some other health costs.[26] The President also supports legislation that would federally license health plans sponsored by professional and trade associations and other groups outside the workplace—so-called Association Health Plans (AHPs). These plans would be exempted from most state insurance laws including rating rules, financial reserves, and benefit mandates.[27] He would provide up to $4 million in grants for states to use to establish insurance purchasing pools for low-income individuals. And he would establish a national marketplace for the purchase of individual coverage, allowing people to buy coverage across state lines.

Public program expansions: Would launch a two-year, $1 billion Cover the Kids campaign to enroll children who are currently eligible for Medicaid and the State Children's Health Insurance Program (CHIP), but not enrolled. This effort would provide grants to faith-based, community, and American Indian organizations as well as states. The President would also enlist schools to aid in outreach efforts and establish an information hotline. He also proposes to add 600 new or expanded health center sites.

Cost containment and quality improvement provisions: Would address the rise in malpractice premiums by imposing minimum standards on the medical liability system, including a $250,000 cap on non-economic damages. The President's 2005 fiscal year budget would increase the amount of funding for broad adoption of information technology in health care by $100 million. President Bush has called for electronic medical records for all Americans within 10 years and encourages the adoption of electronic medical records by the federal government. His budget would reduce federal Medicaid payments by limiting states' use of intergovernmental transfers.

Uninsured covered: Estimated at 2.1–2.4 million (Thorpe); 6.7 million (AEI); 8.2 million (Lewin).

Remaining uninsured: 36.8–42.9 million (out of 45 million people who were uninsured in 2003).

Net federal cost for 2005–2014: $90.5 billion (Thorpe); $104.4 billion (U.S. Treasury, Office of Management and Budget); $110.1 billion (AEI); $113 billion (CBO); $195.4 billion (Lewin) (See Appendix).

SENATOR JOHN KERRY

Overall approach: Mixed public–private with employer and individual tax credits, new group option, public program expansions.

Special focus: Cost containment and affordability

Tax credits: Senator Kerry would provide tax credits to uninsured individuals who buy coverage in a new group insurance option for premiums exceeding 6 to 12 percent of income. Firms with fewer than 50 employees and their workers would be eligible for refundable tax credits worth up to 50 percent of their premium contribution for the new group option. Older adults ages 55 to 64 would receive a 25 percent tax credit to buy coverage under the new group option. Low-income people eligible for unemployment benefits could receive up to a 75 percent tax credit to offset the costs of coverage under COBRA or the new group option.

New/expanded private insurance option: Senator Kerry would establish a new group insurance pool within the Federal Employees Health Benefits Program (FEHBP), which serves members of Congress and federal employees. The plan, called the Congressional Health Plan, would be open to all individuals and employers who need affordable coverage. A reinsurance pool, called a "premium rebate pool," would protect the plan from adverse selection and catastrophic costs. Large employers could participate, provided they pay a one-time enrollment fee and do not selectively segment their workforce into the Congressional Health Plan. Participants with domestic partners would have the right to family health benefits.

Employer requirements and incentives: Strengthens and expands coverage in the employer system by giving employers protection against catastrophic health care costs through the premium rebate pool. Employer health plans would be reimbursed for 75 percent of catastrophic costs incurred above an annual threshold, approximately $50,000 in 2013 (about $30,000 in 2006). To participate, firms would be required to provide affordable health insurance for all their workers, pass on cost savings from the pool by reducing their workers' share of premiums, and establish disease management programs.

Public program expansions: The federal government would assume costs of all children enrolled in Medicaid if states agreed to expand CHIP to include children in households with incomes up to 300 percent of poverty; expand Medicaid to parents of children eligible for Medicaid/CHIP with incomes up to 200 percent; and eventually expand Medicaid to all adults with incomes at or below poverty. Senator Kerry would

remove the current five-year waiting period for legal immigrant pregnant women and children to enroll in Medicaid. He would also retain eligibility for children with disabilities when their parents go to work. States would receive the CHIP enhanced matching rate for the cost of children and parents covered through CHIP and Medicaid.

Automatic enrollment/individual mandate: Includes measures to improve enrollment of eligible children in public programs, such as automatically enrolling children when they go to school, requiring continuous coverage for 12 months, and requiring eligibility workers to be available at community health centers to help enroll families. The plan also provides financial incentives for states to successfully enroll uninsured children.

Cost containment and quality improvement provisions: The premium rebate pool aims to reduce costs for employers and enrollees in the Congressional Health Plan. The plan would address rising pharmaceutical costs by allowing reimportation of FDA-approved drugs, requiring the federal government to negotiate lower prices for prescription drugs in programs such as Medicare, and requiring pharmaceutical benefit managers that do business with the federal government to disclose any fees or discounts paid by the pharmaceutical industry. Other cost-containment issues include ending loopholes that keep generic drugs off the market and helping states extend discounts that they receive for Medicaid beneficiaries to other populations. The plan responds to the recent cost increases in malpractice insurance by proposing to review cases for reasonable claims, sanctioning cases that make improper claims, requiring states to offer nonbinding mediation before permitting plaintiffs to proceed to trial, and not allowing punitive damages except with proof of intentional misconduct, gross negligence, or reckless indifference to life. The Senator believes that a national commitment is needed to support private sector efforts to improve quality. The "Quality Bonus" plan would provide financial incentives to help providers and purchasers reduce errors and improve outcomes; reward providers that invest in modern information systems; provide financial incentives to computerize prescribing systems, and improve reporting of medical errors. The Senator's "Technology Bonus" would seek to reduce administrative costs in health care by ensuring that all Americans have secure, private electronic medical records by 2008. In addition, it would ensure that the federal government adopts modern, computerized methods for health care transactions like those used in other industries and would also require private insurers who contract with the federal government to use those methods. It would require employers who participate in the premium rebate program to establish disease management and health promotion programs.

Number of uninsured covered: Estimated at 25.2 million (Lewin); 26.7 million (Thorpe); 27.3 million (AEI).

Remaining uninsured: 17.7–19.8 million (out of 45 million people who were uninsured in 2003).

Net federal cost for 2005–2014: Estimated at $653.1 billion (Thorpe); $1.08 trillion (Lewin); $1.3 trillion (AEI) (See Appendix).

ASSESSING THE PLANS

The plans of President George W. Bush and Senator John Kerry offer a few similar features within very different designs (Chart 5). Both rely on tax credits to make coverage more affordable. Senator Kerry's plan builds on existing group forms of health insurance, while the President's plan is structured around the individual insurance market. Both proposals leave employer-sponsored health insurance intact, with Senator Kerry seeking to strengthen it by making coverage more affordable for companies and workers. The Kerry plan also incorporates public program expansions. While the President's plan is highly targeted to select groups; the Senator's plan would cover greater numbers of people.

Chart 5

Comparison of Major Health Care Reform Proposals

	Bush	Kerry
Aims to Cover All Americans		X
Tax Credits for Premiums	X	X
Automatic Enrollment/ Individual Mandate		X
Employer Mandates, Incentives or Penalties		X
New Group Option for Small Firms, Individuals	X	X
Low-Income Public Expansion		X
Medicare Buy-In for Older Adults		

As of October 2004

Source: The Commonwealth Fund.

New proposals for expanding health insurance coverage offer a unique opportunity to discuss the ways to tackle the many challenges confronting the health care system. The following are potential questions the public might pose to candidates with health care reform plans:

1) How many uninsured people does the plan cover?
2) How much will the plan cost the federal government and the health system as a whole, and how might it be financed?
3) Does the plan improve coverage for people who currently have inadequate health coverage (e.g., high costs or limited benefits)?
4) Does the plan increase stability of insurance coverage? Will the plan make it less likely that people will experience gaps in coverage?
5) Is it likely to improve access to care, the quality of care, or health outcomes?
6) Does it include provisions to reduce costs and improve efficiency in the administration of insurance or delivery of care?
7) Is it easy to administer or does it require a new and untried administrative structure?
8) Could the plan be phased in over time?

Covering the uninsured. President Bush's plan would cover an estimated 2.1 million to 8.2 million of the currently uninsured and Senator Kerry's plan would cover 25.2 million to 27.3 million of those currently uninsured. [28](Chart 6)

The plans differ in terms of where they would cover those who are currently uninsured. President Bush would cover the uninsured in the individual insurance market. Senator Kerry would cover most people under Medicaid/CHIP, through a new group option, and through employers

Chart 6

Comparison of Candidates' Health Insurance Expansion Proposals: Coverage and Costs

	Bush	Kerry
Total Uninsured Covered, Millions	2 to 8	25 to 27
Employer-Sponsored Coverage	—	2 to 3
New Group Insurance Option	—	2 to 6
Private Insurance Market	2 to 8	—
Medicaid/CHIP	—	18 to 21
Medicare	—	—
Uninsured Not Covered, Millions*	37 to 43	18 to 20
Total Cost, 2005–2014 $Billions**	$90.5 to $195.4	$653.1 to $1,304.3

As of October 2004

* Based on 2004 Current Population Survey estimate of 45 million uninsured.
** The Lewin Group and the American Enterprise Institute estimate costs over 2006–2015, but only costs which would occur over 2005–2014 are shown here. See Appendix for full explanation.
Source: The Commonwealth Fund, based on U.S. Department of the Treasury; Congressional Budget Office; Kenneth E. Thorpe, Emory University; the Lewin Group; and AEI.

Cost of the plans to the federal budget. Costs to the federal budget over a 10-year period range from $90.5 billion to $195.4 billion (Bush) to $653.1 billion to $1.3 trillion (Kerry) (See Appendix Tables 1 and 2). Senator Kerry's plan is more expensive than President Bush's plan since it would cover more people and provide substantial financial relief from high premiums to employers, state governments, and insured individuals.

Senator Kerry would allow businesses to buy into the new group option and provide tax credits worth up to 50 percent of premium costs to small businesses. He would also include a reinsurance mechanism for the new group option, which would be available to employers, as well. These provisions make coverage more affordable for employers and individuals without covering many additional people.[29] Estimates of the value of the Senator's employer subsidies range from $323.6 billion to $548.2 billion over 2005–2014 (See Appendix Table 2). The President's plan has a lower cost, due to its limited scope and because it relies on potentially cheaper, less comprehensive coverage, such as high deductible health plans.

Senator Kerry's plan also would provide significant fiscal relief to states and local governments. For example, in exchange for covering more children and adults through expansions to CHIP and Medicaid, states would be allowed to shift their current costs of insuring children in the Medicaid program to the federal government. In addition, states

would receive an enhanced federal matching rate for the new Medicaid/CHIP expansions. Estimates of the value of state and local government subsidies in the Kerry plan range from $263 billion to $301.7 billion over 10 years (See Appendix Table 2).[30] Because of this cost shift, the net local, state and federal government cost of Senator Kerry's plan is less than its total federal cost. Similarly, there are some state and local savings in President Bush's plan.

Senator Kerry proposes to finance the cost of his health plan by repealing some of the federal income tax cuts enacted since 2001 (i.e., for those in the top tax brackets). He would also roll back extra payments to Medicare managed care plans passed as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. President Bush has not yet proposed a financing mechanism for his health plan, but does include a small Medicaid savings proposal in his budget.

Improving the quality of health insurance coverage. Many Americans with health insurance coverage have limited benefits or high cost-sharing requirements that limits their access to the health care system.[31] People who buy coverage in the individual market are particularly at risk of having coverage that fails to meet their medical needs or leaves them at risk for high out-of-pocket costs.[32] This is due to the fact that, in the individual market, preexisting conditions, age, and sex all play a role in determining premium levels, extent of coverage, deductibles, and cost-sharing. Proposals that increase coverage by relying on employer plans, new group plans, or public programs may result in higher-quality coverage than those that rely on the individual market.

President Bush and Senator Kerry both emphasize themes of affordability for individuals and small businesses. The President believes that HSAs coupled with high-deductible health plans and tax deductions for premium costs for those plans would reduce costs for individuals. He maintains that association health plans would reduce insurance costs for small businesses and their employees. He would provide tax credits to people with low incomes to buy coverage on the individual market. Senator Kerry would make coverage more affordable for individuals and for both large and small businesses by allowing them to buy into a new group pool within the FEHBP. He would provide tax credits for individuals and small businesses who buy into the program. Kerry also proposes a premium rebate pool that would protect the new group option and employers from catastrophic health care costs.

Regarding the comprehensiveness of benefit packages, Davis and Schoen's "Creating Consensus" framework suggests that companies that offer coverage should be required to meet a minimum benefit standard.[33] Both Senator John Breaux and Bruce

Bodaken, CEO of Blue Shield of California, would require that individuals have insurance and mandate a "basic" or "essential" benefit package, defined either by the federal government (Breaux) or by medical professionals (Bodaken).[34]

Senator Kerry proposes that those individuals participating in the Congressional Health Plan would have access to the same policies offered to members of Congress and federal employees under FEHBP.[35] President Bush stipulates that his proposed tax credits for people with low incomes would subsidize only non-group, individual market coverage that meets certain minimum standards, though he has not yet defined those standards.

Stabilizing insurance coverage. One of the effects of having a fragmented health insurance system is that people are likely to experience gaps in coverage when they undergo life transitions. Insurance status can change, for example, when people reach the age of 19, graduate from college, lose or change a job, have fluctuations in income, or become widowed or divorced.[36] More universal plans, such as the one proposed by Senator Kerry, would stabilize coverage by providing alternative options when people lose one form of coverage. President Bush offers some alternatives for people without access to employer-sponsored coverage. Automatic enrollment mechanisms that Senator Kerry proposes for children would more efficiently link children without coverage to the programs for which they are eligible. The Kerry plan also includes stabilizing features for groups vulnerable to gaps in coverage. He includes special provisions for older adults and tax credits that would make it easier for people who lose or change their jobs to gain coverage through COBRA. The Senator's running mate, Senator John Edwards, proposed in his health plan as a presidential candidate, that insurers and employers be required to let families buy coverage riders for dependent young adults under age 25.

Improving health outcomes. There is ample evidence that having health insurance increases access to care and improves health status.[37] Expanding comprehensive insurance coverage to more people would enhance the health and productivity of the U.S. population.

President Bush and Senator Kerry identify additional ways to improve the quality of health care. Kerry's "Quality Bonus" would offer financial incentives to encourage providers and purchasers to reduce errors and improve outcomes. Both candidates emphasize the application of information technology. The President's 2005 fiscal year budget would increase the amount of funding for broad adoption of information technology in health care by $100 million. Senator Kerry would provide financial incentives to providers to update information systems and computerize prescribing

systems. Kerry also would require that employers who participate in the premium rebate pool establish disease management and health promotion programs. Kerry emphasizes the need to reduce racial and ethnic disparities in health care.

Ease of administration. The candidates' plans generally build upon institutions familiar to most Americans, which will facilitate public understanding of the plans and their implementation. Similarly, the plans rely on instruments common to U.S. social policy, such as public program expansions and reinsurance mechanisms. President Bush and Senator Kerry would enhance current coverage options by opening up existing institutions to more people and attempting to make coverage more affordable for businesses and individuals. The only new entities that would be created in either of these proposals are the new group options, but even they are to be created within an existing program—the FEHBP.

There would likely be some administrative hurdles in implementing the plans, however. In the case of President Bush's plan, the wide variation in insurance premiums across states in the individual insurance market would mean the purchasing power of a flat tax credit would vary significantly for those eligible, depending on where they lived.[38] In contrast, Senator Kerry's tax credits are tied to income. In the case of the Senator's plan, determining who is eligible for different components of the plan will likely be challenging, just as getting eligible people enrolled in different programs has proven difficult in the past. Other similar proposals, such as "Creating Consensus" and the plan of former presidential candidate Governor Howard Dean, have suggested that eligibility for insurance coverage be determined automatically through the tax code.

Ability to be phased-in over time. Given the current budgetary climate, it is likely that a plan that aims to expand health insurance would need to be phased-in over time. For example, the multiple-component nature of Senator Kerry's plan (a new group option, tax credits for individuals to purchase coverage, new incentives for employers, expansion of Medicaid/CHIP, and a COBRA subsidy) lends itself to phased in implementation. This means that components of the plan could be phased in separately, which would provide up-front cost savings and also allow policymakers to fine tune particular features, based on experience.

Reducing costs and improving efficiency. By and large, these plans focus on expanding coverage rather than reducing costs, although research presented above shows that expanded health insurance coverage would likely result in savings for private and public providers of uncompensated care, for people who currently lack coverage, and for

the economy overall. Yet, President Bush and Senator Kerry include provisions that specifically aim to reduce costs or improve efficiency in the administration and delivery of care. Senator Kerry emphasizes reducing administrative costs in the health care system, particularly those costs associated with the preparation and payment of medical bills. Through his Technology Bonus, he would promote the use of electronic medical records and the adoption of computerized information systems for health care transactions, starting with the federal government and with insurers that do business with the federal government. The President also supports electronic medical records, calling for electronic medical records for all Americans within 10 years and encouraging their adoption by the federal government. The candidates both propose strategies to reduce the costs of malpractice insurance. Kerry proposes several measures to control pharmaceutical costs.

In addition, some features of the candidates' plans would result in indirect cost savings or reductions in costs for particular groups. For example, Senator Kerry's emphasis on expanding group forms of coverage, like employer-sponsored coverage, will likely realize administrative efficiencies as people or small businesses switch from the individual or small group market. In "Creating Consensus," Davis and Schoen estimate that a new group option based on FEHBP would have total administrative costs of 19 percent, compared with administrative costs of 30 percent to 50 percent for plans offered in the individual market.[39] In addition, premiums would likely be lower for people insured through group options than through individual market plans.[40]

CONCLUSION

These proposals provide a unique opportunity for the nation to discuss whether to expand health insurance coverage and, if so, how best to do it. The plans offer a range of policy options and differing perspectives on how to address the nation's chronic uninsured problem. The public would benefit from thorough vetting of the plans and informed debate both on the goals of health care reform and the details of how to achieve them. No matter who prevails in the 2004 election, this debate may help the public and the policy community reach consensus on how to solve one of the country's most vexing and intransigent problems.

APPENDIX. COVERAGE AND COST ESTIMATES

The range of estimates on the number of people newly covered under each proposal and their costs to the federal government reflects differing assumptions made by the analysts and officials who assessed the coverage potential and cost impact of these plans. The differences in the estimates by the different features in the proposals are shown in Appendix Tables 1 and 2 below.

There is a debate right now over which estimate is the most accurate. But there is general agreement that Senator Kerry's plan covers more people than President Bush's plan and is therefore more expensive. As discussed in the report, Senator Kerry's plan also provides health insurance cost relief to employers, even those who already offer coverage. It also provides direct fiscal relief to states. Both the employer and state relief raise the costs of the Kerry plan to the federal government. Yet, the state fiscal relief also means that the net costs of the Kerry plan to government as a whole (local, state, federal), are less than those to the federal government. In general, taking a step toward insuring more people will require some commitment of resources, and the more comprehensive a plan is, the more expensive it will necessarily have to be.

Cost estimates of the plans vary because of differing assumptions about time periods; the phasing in of coverage; indexing features of the plans to consumer prices or health expenditures; employer participation rates in reinsurance and business subsidies; changes in wages that affect offsetting tax revenues; and savings from quality improvement and disease management.

One of the main differences among the five sets of estimates is the period of time over which costs are estimated. Both AEI and the Lewin Group estimated costs over the 10-year period 2006–2015, assuming implementation beginning in 2006. The U.S. Treasury, OMB, and the CBO, estimate the impact of the Administration's proposals on the federal budget over 2005–2014. This is the federal government's current 10-year budget projection period. Kenneth Thorpe's cost estimates are also based on the government's current budget horizon. Like AEI and the Lewin Group, Thorpe assumes that the candidates' proposals would begin implementation in 2006. For purposes of comparison, only estimates that would occur over 2005–2014 are presented here. It is noted that, with the exception of the U.S. Treasury and CBO estimates, which assume implementation in 2005, cost estimates cover a nine-year period.

Appendix Table 1. Comparison of Coverage and Cost Estimates for President Bush's Health Plan, 2005–2014*

	U.S. Treasury[a]	CBO[b]	Thorpe[c]	Lewin Group[d]	AEI[e]
Uninsured Covered (Number in Millions)	NA	NA	2.1 to 2.4	8.2	6.7
Net Federal Government Cost ($Billions)	$104.4	$113	$90.5	$195.4	$110.1
Low Income	70.1	61	49.2	119.6	71.1
Tax credits	70.1	61	49.2	111.4	71.1
Medicaid outreach	NA	NA	NA	8.2	0.0
HSA Deductions	24.8	25	32.8	36.9	17.3
Small Employer Tax Credit	NA	NA	NA	4.5	17.7
Other**	25.2	27	8.5	51.8	4.0
Gross Federal Government Cost	120.1	NA	90.5	212.8	110.1
Offsetting Savings	NA	NA	NA	(17.4)	NA
Malpractice reforms	NA	NA	NA	(6.7)	NA
Tax revenue offsets	NA	NA	NA	(10.7)	NA
Medicaid savings	(15.7)	NA	NA	NA	NA
State and Local Government Cost	NA	NA	NA	(17.2)	NA
Net Federal, State, and Local Government Cost	NA	NA	NA	$178.2	NA

* The Lewin Group and the American Enterprise Institute estimated costs for the 2006–2015 period. The Lewin Group estimated a net federal government cost of $227.5 billion over that period; AEI estimated $128.6 billion. For purposes of comparison, only estimated costs that fall within the federal government's current 10-year budget projection period, 2005–2014, are shown in this exhibit. With the exception of the U.S. Treasury and CBO estimate, all estimates assume plan implementation beginning in 2006. Therefore, the cost estimates presented here by Thorpe, the Lewin Group, and AEI span a 9 year time period.

** The Bush Administration, as part of its Fiscal Year 2005 Budget Proposal, proposed to make premium payments for long term care insurance fully tax-deductible and to add a personal tax-exemption for people who take time out to care for parents or children who need long term care assistance. These costs are included in the U.S. Treasury estimates and the Lewin Group estimates.

Sources: [a] U.S. Department of the Treasury, *General Explanations of the Administration's Fiscal Year 2005 Revenue Proposals,* February 2004; [b] Congressional Budget Office, *An Analysis of the Presidents' Budgetary Proposals for Fiscal Year 2005,* March 2004; [c] Kenneth E. Thorpe, *Federal Costs and Newly Insured Under President Bush's Health Insurance Proposals,* Emory University, May 5, 2004; [d] The Lewin Group, *Bush and Kerry Health Care Proposals: Cost and Coverage Compared,* September 21, 2004; [e] J. Antos et al., *Analyzing the Kerry and Bush Health Proposals: Estimates of Cost and Impact* (Washington, D.C.: American Enterprise Institute, September 13, 2004).

Appendix Table 2. Comparison of Coverage and Cost Estimates for Senator Kerry's Health Plan, 2005–2014*

	Thorpe[a]	Lewin Group[b]	AEI[c]
Uninsured Covered (Number in Millions)	26.7	25.2	27.3
Net Federal Government Cost ($Billions)	$653.1	$1,075.0	$1,304.3
Low Income	518.0	474.7	752.3
Employer Reinsurance and Premium Assistance**	323.6	548.2	601.7
Premium rebate pool	256.7	457.2	495.5
Small business tax credits	66.9	91.0	106.2
Employee Premium Assistance	110.2	206.2	52.7
Individual tax credits	65.8	31.1	10.9
Premium limits	44.4	175.1	41.8
Gross Federal Government Cost	951.8	1229.1	1406.7
Offsetting Savings	(298.8)	(154.1)	(102.4)
Disease management	(116.5)	(18.6)	0.0
Information technology	(79.9)	(8.3)	0.0
Reduced disproportionate share payments	(88.0)	(88.0)	(88.0)
Reduced Medicare Advantage payments	(14.4)	0.0	(14.4)
Other	0.0	(39.2)	0.0
State and Local Government Cost	NA	(301.7)	NA***
Net Federal, State, and Local Government Cost	NA	$773.3	NA***

* The Lewin Group and the American Enterprise Institute estimated costs for the 2006–2015 period. The Lewin Group estimated a net federal government cost of $1,249 billion over that period; AEI estimated $1,519.7 billion. For purposes of comparison, only estimated costs that fall within the federal government's current 10-year budget projection period, 2005–2014, are shown in this exhibit. All estimates assume plan implementation beginning in 2006. Therefore, the cost estimates presented here by Thorpe, the Lewin Group, and AEI span a 9 year time period.

** Thorpe and AEI incorporate tax revenue offsets in their estimates of employer premium rebates and tax credits. The Lewin Group estimates—which originally reported tax offsets as a separate line-item—were re-categorized to incorporate tax revenue offsets in the tax credit and employer rebate costs.

*** AEI estimates aggregate savings to state and local governments of $263 billion over 2006–2015, but does not present annual savings.

Sources: [a] Kenneth E. Thorpe, *Federal Costs and Savings Associated with Senator Kerry's Health Care Plan,* Emory University, April 2, 2004; [b] The Lewin Group, *Bush and Kerry Health Care Proposals: Cost and Coverage Compared,* September 21, 2004; [c] J. Antos et al., *Analyzing the Kerry and Bush Health Proposals: Estimates of Cost and Impact* (Washington, D.C.: American Enterprise Institute, September 13, 2004).

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Making Health Care Affordable for All Americans (January 28, 2004). Karen Davis, The Commonwealth Fund. In invited testimony before a Senate Committee on Health, Education, Labor, and Pensions hearing on what's driving health care costs and the uninsured, the Fund's president said that improving quality of care and streamlining administration are the keys to providing affordable health care for all Americans, not shifting rising health care costs to patients.

The Growing Share of Uninsured Workers Employed by Large Firms (October 2003). Sherry Glied, Jeanne M. Lambrew, and Sarah Little. The number of uninsured workers in large firms rose sharply from 1987 to 2001, signaling warnings about a new trend among businesses that traditionally are the most likely to offer health benefits. The authors identify several workforce changes contributing to this trend, including a decline in manufacturing jobs and the proportion of workers in large firms who are union members.

Health Insurance Scams: How Government Is Responding and What Further Steps Are Needed (August 2003). Mila Kofman, Kevin Lucia, and Eliza Bangit, Georgetown University Health Policy Institute. According to this issue brief, an unprecedented increase in unauthorized and illegal health insurance plans, spurred by rising health care costs and increasing numbers of uninsured, has left nearly 100,000 people with millions of dollars in medical debts and no coverage. The authors call for increased cooperation among state and federal fraud investigators, better training of insurance agents, and stronger criminal penalties against perpetrators.

American Health Care: Why So Costly? (June 11, 2003). Karen Davis, The Commonwealth Fund. In invited testimony before a Senate Appropriations subcommittee hearing on rising health care costs, the Fund's president outlined a number of steps that need to be taken to achieve a high-performing, accessible health system, including: public reporting of health care cost and quality data, establishment of quality standards, broad-scale demonstrations of new approaches to insurance coverage, investment in modern information technology and improved care processes, provider performance incentives, and elimination of waste and ineffective care.

Creating Consensus on Coverage Choices (April 23, 2003). Karen Davis and Cathy Schoen, The Commonwealth Fund. *Health Affairs* Web Exclusive. In this article, the authors propose an innovative framework to provide automatic, affordable health insurance to nearly all Americans. The approach would combine tax credits for private insurance with public program expansions. It would also promote insurance efficiencies through automatic enrollment, use of information technology, and group coverage. The framework could be phased in over time and modified along the way.

Time for Change: The Hidden Cost of a Fragmented Health Insurance System (March 2003). Karen Davis, The Commonwealth Fund. In invited testimony before the Senate Special Committee on Aging, Fund president Karen Davis detailed the failure of the U.S. health care system to meet the objectives of ensuring access to needed medical care and protecting Americans from the financial burden of costly medical bills. Calling the system "costly, complex, and confusing," Davis said the solution requires automatic and affordable health insurance coverage for all Americans and shared responsibility for financing coverage.

Expanding Health Insurance Coverage: Creative State Solutions for Challenging Times (January 2003). Sharon Silow-Carroll, Emily K. Waldman, Heather Sacks, and Jack A. Meyer, Economic and Social Research Institute. The authors summarize lessons from 10 states that have innovative strategies in place for health insurance expansion or have a history of successful coverage expansion. The report concludes with recommendations for federal action that could help states maintain any gains in coverage made and possibly extend coverage to currently uninsured populations.

Small But Significant Steps to Help the Uninsured (January 2003). Jeanne M. Lambrew and Arthur Garson, Jr. A number of low-cost policies could ensure health coverage for at least some Americans who currently lack access to affordable insurance, this report finds. Included among the dozen proposals outlined is one that would make COBRA continuation coverage available to all workers who lose their job, including employees of small businesses that are not currently eligible under federal rules.

Are Tax Credits Alone the Solution to Affordable Health Insurance? Comparing Individual and Group Insurance Costs in 17 U.S. Markets (May 2002). Jon R. Gabel, Kelley Dhont, and Jeremy Pickreign, Health Research and Educational Trust. This report identifies solutions that might make tax credits and the individual insurance market work. These include raising the amount of the tax credits; adjusting the credit according to age, sex, and health status; and combining tax credits with new access to health coverage through existing public or private group insurance programs.

Security Matters: How Instability in Health Insurance Puts U.S. Workers at Risk (December 2001). Lisa Duchon, Cathy Schoen, Michelle M. Doty, Karen Davis, Erin Strumpf, and Stephanie Bruegman. This report, based on The Commonwealth Fund 2001 Health Insurance Survey, finds that in the past year one of four Americans ages 19 to 64—some 38 million adults—was uninsured for all or part of the time. Lapses in coverage often restrict people's access to medical care, cause problems in paying medical bills, and even make it difficult to afford basic living costs such as food and rent.

Universal Coverage in the United States: Lessons from Experience of the 20th Century (December 2001). Karen Davis. This issue brief, adapted from an article in the March 2001 *Journal of Urban Health: Bulletin of the New York Academy of Medicine,* traces how the current U.S. health care system came to be, how various proposals for universal health coverage gained and lost political support, and what the pros and cons are of existing alternatives for expanding coverage.

Challenges and Options for Increasing the Number of Americans with Health Insurance (January 2001). Sherry A. Glied, Joseph A. Mailman School of Public Health, Columbia University. This overview paper summarizes the 10 option papers written as part of the series Strategies to Expand Health Insurance for Working Americans.

A 2020 Vision for American Health Care (December 11/25, 2000). Karen Davis, Cathy Schoen, and Stephen Schoenbaum. *Archives of Internal Medicine,* vol. 160, no. 22. The problem of nearly 43 million Americans without health insurance could be virtually eliminated in a single generation through a health plan based on universal, automatic coverage that allows choice of plan and provider. The proposal could be paid for, according to Fund President Davis and coauthors, by using the quarter of the federal budget surplus which results from savings in Medicare and Medicaid.