



## Harmonizing the Obama, Baucus and Wyden/Bennett Health Reform Proposals: Technical Feasibility

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## About The Lewin Group

The Lewin Group is a health care and human services policy research and management consulting firm. We have over 25 years of experience in estimating the impact of major health reform proposals. The Lewin Group is committed to providing independent, objective and non-partisan analyses of policy options. In keeping with our tradition of objectivity, The Lewin Group is not an advocate for or against any legislation. The Lewin Group is part of Ingenix, Inc., which is a wholly owned subsidiary of UnitedHealth Group. To assure the independence of its work, The Lewin Group has editorial control over all of its work products.

## Foreword

President Obama and Congressional leaders have set the ambitious goal of passing comprehensive health reform by the end of the summer. Fortunately, proposals exist in Congress that provide excellent platforms for reform. One of these is the proposal introduced by Senator Baucus that outlines a strategy for covering all Americans and introduces ground breaking changes in the provider payment system in federal programs. However, at this time it lacks much of the detail required to draft legislation and develop cost estimates.

Another is the “Healthy Americans Act” (HAA) introduced by Senators Wyden and Bennett. The HAA is already in legislative language and has been scored by the Congressional Budget Office as fully funded in its first full year of operation. It also has 14 cosponsors in the U.S. Senate including 6 Republicans.

In this paper, we explore the technical feasibility of merging the more developed coverage provisions of the HAA into the broader Baucus proposal. We reviewed both proposals to identify similarities and differences and present ideas on how these differences could be resolved. In keeping with our tradition of non-partisan policy analysis, we do not advocate for or against any legislation. Our purpose is only to explore ideas that might further the process of health reform.

## Harmonizing the Baucus and Wyden/Bennett Health Reform Proposals: Technical Feasibility

The President is looking to Congress to develop the specific elements of a health reform plan for the U.S. that includes both cost control and the goal of coverage for every American. In his February 2009 budget proposal to Congress the President outlined eight principles for health reform including:

- Protect families' financial health;
- Make coverage affordable;
- Aim for universality;
- Provide portability of coverage;
- Guarantee choice;
- Invest in prevention and wellness;
- Improve patient safety and quality care; and
- Maintain long-term fiscal sustainability.

In November 2008, Senator Max Baucus (D-Montana), Chairman of the Senate Finance Committee, released a report outlining a roadmap for health reform in the U.S. that generally meets the President's eight principles.<sup>1</sup> The Baucus proposal describes a phased approach to universal coverage based upon the principles of shared responsibility for employers, individuals and government. The plan envisions a "high performance" health system that promotes prevention, quality improvements and cost containment. However far reaching, the proposal generally lacks the detail required to write legislation, or develop cost estimates.

One way to advance the process of reforming health care is to incorporate into the broader Baucus proposal another more developed coverage expansion proposal that is founded on the same principles articulated by President Obama. One such bill is the "Healthy Americans Act" (HAA) S. 391 developed by Senators Ron Wyden (D-Oregon) and Robert Bennett (R-Utah). This rare example of bipartisan legislation is now sponsored by seven Democrats, six Republicans, and one Independent in the U.S. Senate. Preliminary cost estimates from the Congressional Budget Office (CBO) show that the program would be fully funded in its first full year of operation and better than budget-neutral in following years.

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<sup>1</sup> U.S. Senator Max Baucus, Chairman, Senate Finance Committee, "Call to Action: Health Reform 2009," November 12, 2008.

The coverage expansion provisions of the two bills share many of the same features including:

- Both bills require all Americans to have coverage;
- They both provide subsidies for the purchase of insurance for people living below 400 percent of the federal poverty level (FPL);
- Both bills would create a national network of “Exchanges” to provide access to a range of affordable health plans;
- The bills would require employers to contribute to the cost of covering their workers;
- Employers would be able to continue providing health insurance;
- Both bills prohibit insurers from declining coverage due to health status;
- Both extend Medicaid benefits to 100 percent of the FPL (although under the HAA, eligible people are given private insurance with Medicaid covering only co-pays and services not covered by the private plan); and
- Both have some form of a public plan option. The Baucus plan creates a national public plan modeled on Medicare, while the HAA allows safety-net providers to offer their own health plans in the exchange, and provides a federal fallback plan if there aren’t at least two private plans in a state or region.

The two proposals have complementary approaches to cost control. A combined proposal could include the extensive cost control and quality improvement provisions of the Baucus plan, most of which would originate within the Medicare program. For the privately insured, the combined proposal could include new price incentives and market competition created under the Wyden/Bennett model. Ultimately, competitive forces would help encourage private insurers to adopt the Medicare payment reforms introduced by Senator Baucus, once proven under the Medicare program.

Because the CBO has found that HAA is fully funded in the first full year, the savings to the government programs under the Baucus initiatives would probably improve the CBO estimate resulting in additional net savings to the Federal Government and other payers in the system.

In this paper we assess the technical feasibility of merging the HAA into the Baucus proposal. The Baucus proposals for cost containment and quality improvement would be included as proposed. For coverage, the process could start with the coverage expansion provisions of the HAA since it already exists in legislative language and has been scored by CBO. One could then modify these provisions to address areas of inconsistency with the Baucus coverage proposals. The result could be a fully funded universal coverage proposal with complementary cost containment strategies for public and private insurance. We present our analysis in the following sections:

- Coverage provisions compared;
- Cost control measures compared;
- Phase-in model for health reform; and
- Conclusions.

## A. Coverage Provisions Compared

In this section we summarize the key coverage expansion features of the two proposals. We then compare these features to identify areas of consistency and potential agreement. *Figure 1* presents a summary of the key coverage features of the two proposals.

### *The Baucus Coverage Proposal*

The Baucus proposal would require all Americans to have health insurance once affordable coverage is available to all. The plan would begin by establishing an “exchange” that makes a selection of affordable health plans available to consumers. Once affordable coverage is available, all individuals would be required to have health insurance. Premium subsidies would be provided through tax credits to assist people in purchasing coverage. Until affordable plans are established, the Baucus plan would take the following steps to expand coverage:

- Americans age 55 to 64 would be permitted to buy-in to the Medicare program;
- The current two-year waiting period for Medicare disability coverage would be eliminated;
- All Americans living below 100 percent of the FPL would be eligible for Medicaid;
- All states would be required to cover children under the State Children’s Health Insurance Program (CHIP) through 250 percent of the FPL;
- Establishes the “Right-Choices” program to provide preventive care, screening and treatment for uninsured people with high cost conditions; and
- Increased funding for the Indian Health Service.

The Baucus plan is designed to strengthen and expand employer provided health insurance. All but the smallest employers would be required to establish a section 125 plan enabling workers to purchase coverage through withholding in pre-tax dollars. Medium and large employers would be required to either provide insurance or contribute to a government fund to help cover those who remain uninsured (contribution is reduced for medium size employers). This model is often referred to as “pay-or-play.” In addition, a new tax credit would be created for the smallest of firms to encourage them to provide health insurance. The tax exclusion for employer provided benefits is retained, but Senator Baucus has expressed interest in limiting the currently unlimited exclusion.

The Baucus plan would establish a network of exchanges throughout the country. Their role would be to organize a selection of affordable health care coverage options, providing comparable information on the premiums and features of the various health plans. Individuals and employers would have the option to purchase health insurance through the exchange. However, participating employers must offer coverage to all of their workers under the exchange. The program also would use risk adjustment mechanisms to adjust for cases where individual health plans cover a disproportionate number of higher-cost individuals.

**Figure 1**  
**Key Coverage Features of the Baucus Proposal and Healthy Americans Act**

	Baucus Proposal	Healthy Americans Act (HAA)
Individual Mandate	<ul style="list-style-type: none"> <li>▪ Mandate to have coverage once affordable insurance is available</li> </ul>	<ul style="list-style-type: none"> <li>▪ All Americans must have coverage</li> </ul>
Employer Based System	<ul style="list-style-type: none"> <li>▪ Preserved and expanded with small business tax credits</li> </ul>	<ul style="list-style-type: none"> <li>▪ Firms must convert health benefits to wages</li> <li>▪ Employers can continue to provide coverage,</li> <li>▪ But workers can elect to purchase coverage through employer or exchange</li> </ul>
Employer Requirements	<ul style="list-style-type: none"> <li>▪ Medium and large firms must provide coverage or pay a fee (unspecified)</li> <li>▪ All but smallest employers must create section 125 plan</li> </ul>	<ul style="list-style-type: none"> <li>▪ All firms contribute between 2% and 25% of national average premium, depending on firm size and revenues</li> <li>▪ Medium and large employers (10+ workers) must administer plan selection at Open enrollment</li> </ul>
Exchange	<ul style="list-style-type: none"> <li>▪ Establishes national exchange; voluntary participation</li> </ul>	<ul style="list-style-type: none"> <li>▪ Creates local area exchanges</li> <li>▪ All Participate once fully phased-in</li> </ul>
Medicaid/CHIP	<ul style="list-style-type: none"> <li>▪ Expanded to cover all adults below the federal poverty level (FPL) and children below 250% of FPL</li> </ul>	<ul style="list-style-type: none"> <li>▪ Retained and expanded for wrap-around coverage only.</li> <li>▪ Covers co-pays and Medicaid services not covered by HAA</li> <li>▪ People with incomes too low to pay taxes (roughly 100% FPL) become eligible for co-pay coverage</li> <li>▪ Enrolls people when taxes are filed.</li> </ul>
Medicare Eligibility	<ul style="list-style-type: none"> <li>▪ Buy-in to Medicare for 55-64 population</li> <li>▪ Eliminate 2-year waiting period for the disabled</li> </ul>	<ul style="list-style-type: none"> <li>▪ No changes in eligibility</li> </ul>
Insurance Market Reforms	<ul style="list-style-type: none"> <li>▪ Insurers can not deny coverage due to health status</li> <li>▪ Rating reforms that regulate premium variation with age, health status etc.</li> <li>▪ Risk adjustment within exchange</li> </ul>	<ul style="list-style-type: none"> <li>▪ Insurers can not deny coverage due to health status</li> <li>▪ Consumers pay community-rated premium</li> <li>▪ Plans receive risk adjusted payments</li> </ul>
Tax Exclusion for Employer Provided Benefits	<ul style="list-style-type: none"> <li>▪ Retain to promote employer coverage</li> <li>▪ Congress should consider ways of changing it to promote cost control</li> <li>▪ Possible changes: <ul style="list-style-type: none"> <li>- Cap exclusion</li> <li>- Phase-out exclusion</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>▪ Tax exclusion is replaced with a fixed health expense deduction for</li> <li>▪ Deduction: \$6,025 single; \$12,050 couple; \$8,610 one parent; \$15,200 family;</li> <li>▪ Plus \$2,000 per child</li> <li>▪ Phased-out between \$62,500 and \$125,000 income for single; \$125,000-\$250,000 for joint filers</li> </ul>
Prevention	<ul style="list-style-type: none"> <li>▪ Temporary "right choices" program for uninsured <ul style="list-style-type: none"> <li>- Preventive care and screenings</li> <li>- Treats people with costly health conditions</li> <li>- Free below 200% FPL</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>▪ Minimum benefits package covers prevention and other services</li> </ul>

The Baucus plan would prohibit insurers from denying coverage to people with prior health conditions. The plan would establish rules on how premiums are permitted to vary with individual characteristics such as age, tobacco use and previous illness. The rating rules used in the exchange would be the same as those used for insurers operating outside the exchange.

The proposal includes a refundable tax credit for people living below 400 percent of the FPL, who purchase coverage through the exchange. The credit would limit family premium expenses so they do not exceed a specified percentage of income. In addition, the plan includes a new “Independent Health Council” charged with making affordable health options available and setting standards for chronic care management and quality reporting.

The exchange would offer a new “public plan” option modeled on Medicare. The plan is intended to foster public-private competition to reduce costs while improving quality. It states that eligibility and provider payment levels would be set at levels designed to balance the goals of increased competition and access to high quality health care.

### *The Healthy Americans Act*

The “Healthy Americans Act” (HAA) establishes a program that provides private health insurance for all Americans except those covered through Medicare or the military. Participants would choose from a selection of private plans offered through newly created regional exchanges called “Health Help Agencies” (HHAs). Workers could also elect to take a health plan offered by their employer. All Americans would have coverage at least as comprehensive as the health coverage now provided to members of Congress and federal workers, although an actuarially equivalent substitution of HMO and Health Savings Account (HSA) plans is permitted.<sup>2</sup>

Medicaid would be retained and expanded to provide “wrap-around” coverage for co-pays and services not covered under the HAA benefits package (for example, there is no deductible for “in-network” ambulatory care under the package). All of those now eligible for Medicaid would be eligible to enroll in private plans through the exchanges. Also, people with incomes too low to be required to pay taxes (roughly equal to the FPL) are eligible for coverage of co-payment amounts under the plan. People could apply to the Medicaid office as under current law, or could be enrolled through tax returns (many low-income people file taxes to obtain refunds) or other income-tested programs such as Food Stamps, WIC or school lunch programs.

Employers would be required to convert the value of their health plans to wages for covered workers. The current tax exemption for employer-provided health benefits is eliminated to strengthen incentives for employees to seek lower cost coverage. However, a new “health premium” tax deduction is created to offset increased taxes on these wage increases. To maintain incentives to control costs, the deduction is fixed and cannot be increased by purchasing more costly coverage, as with the current tax exclusion. The deduction ranges from \$6,025 for individuals to \$15,200 for joint filers with children. Parents get an extra \$2,000 deduction per child.

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<sup>2</sup> The HSA would include a high deductible plan plus a contribution to an HSA such that the combined value of the plan and the contribution is equal to the actuarial value of the HAA benefits package.

An important feature of the program is that employers are permitted to offer a health plan that would be available to their workers as an alternative to the plans offered by the exchange. Workers in insuring firms would be permitted to decline the employer plan and enroll in one of the plans in the exchange. This enables a worker to stay with their existing coverage when they change jobs and would provide access to alternative plan designs that could be lower in cost. Employer-sponsored health plans would receive a risk-adjusted payment equal to the lowest cost premium in the local area exchange for those workers who decide to take the coverage offered by their employer.

All HAA participants would pay premiums through wage withholding and their annual income tax filings. The program would fully subsidize the premium for those below 100 percent of the federal poverty level (FPL), with the premium phasing-in for people living between 100 percent and 400 percent of the FPL. People who do not have enough income to pay taxes are assumed to be eligible for the program with full subsidies, thus eliminating the need to apply separately for assistance as under the current Medicaid program. Employers also would be required to pay an assessment ranging from 2 to 25 percent of the national average premium for the minimum benefits package, depending upon firm size and revenues per worker.

### *Coverage Features Compared*

There are important similarities in the coverage provisions of the two proposals. Both establish shared responsibility for coverage including individuals, employers and the government. In both bills, all individuals are required to take coverage as affordable insurance becomes available. Both create an exchange charged with providing a selection of alternative health plans. Also, they both would reform insurance markets so that insurers cannot decline coverage due to a history of illness.

These proposals also extend Medicaid coverage to all people living below the FPL. However, under the Wyden/Bennett bill, all Americans covered by the HAA would have private insurance as their primary source of coverage, regardless of income or ability to pay. Medicaid would serve as wrap-around coverage for co-pays and Medicaid covered services not covered under the private plan. Both bills would provide premium subsidies for families living below 400 percent of the FPL.

Covering all Americans under private insurance, as under the HAA, is highly consistent with Senator Baucus' stated goal of reducing health disparities across income and other demographic groups. Under today's Medicaid program, many health providers will not treat Medicaid patients because payment levels under the program are so low. For example, Medicaid payments to physicians are only 56 percent of what private insurers are paying for comparable services (*Figure 2*). Covering the Medicaid population under the same private coverage available to others would dramatically increase access to care for the low-income population and reduce these health disparities (the cost of doing so is included in the CBO cost estimate).

**Figure 2**  
**Provider Payment Levels for Major Payers as Percentage of Private Payer Rates for Comparable Services**

Payer Group	Payment Rates as a Percent of Private	
	Hospital Services <sup>a/</sup>	Physician Services
Private	100%	100% <sup>b/</sup>
Medicare	71%	81%
Medicaid	67%	56% <sup>c/</sup>

a/ American Hospital Association, "Trends Affecting Hospitals and Health Systems, TrendWatch Chartbook April 2008.

b/ "Report to Congress: Medicare Payment Policy," Medicare Payment Advisory Commission (MedPAC), March 2008.

c/ State Health Facts, The Kaiser Family Foundations (KFF), 2003 report.

Source: The Lewin Group

Both proposals envision a major role for employers in a reformed health care system. The plan requires medium and large employers to either offer insurance or pay a "contribution" that would be used to help fund coverage for the uninsured. The proposal creates tax credits to help small employers offer coverage and maintains the tax exclusion for employer provided health benefits to retain the existing tax preference for employer-sponsored insurance.

The HAA permits employers to continue to offer health insurance, and requires all employers to pay a percentage of premiums for each worker (2 percent to 25 percent depending on firm size and revenues). Also, medium and large employers are required to administer open enrollment for their workers using materials supplied by the local exchange.

However, both proposals would lead to at least some loss of employer provided health insurance. For example, under the Baucus plan, some employers may decide to discontinue coverage once Medicaid is expanded and tax credits become available for the purchase of non-group coverage. One study estimates that up to 60 percent of children in CHIP would have had private coverage in the absence of the program.<sup>3</sup> Also, many employers would discontinue their private insurance and cover their workers under the new public plan option created under the Baucus proposal.

The HAA expressly permits employers to continue offering coverage and for workers to keep the coverage they have if they chose to do so. However, employers could elect to discontinue their health plans under the Act. Workers may also decline coverage offered by an employer to take an insurance product offered through the exchange. The tax exclusion for employer provided benefits is replaced with a fixed deduction so that workers can take coverage in the exchange without loss of tax benefits. These changes are intended to extend new coverage options to workers through the exchange in addition to the coverage offered by their employer.

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<sup>3</sup> Gruber, J., Simon, K., 2008. Crowd-out 10 Years Later: Have Recent Public Insurance Expansions Crowded out Private Health Insurance? *Journal of Health Economics* 27 (2), 201-217.

The Baucus proposal creates a public plan modeled on the Medicare program. Such a plan would be 20 to 30 percent less costly than comparable private insurance, due to lower provider payment levels and administrative costs under Medicare (see *Figure 2* above).<sup>4</sup> We have estimated that up to 70 percent of the 170 million people now with private health insurance would lose that coverage and enroll in the public plan.<sup>5</sup> However, the Baucus plan appears to envision a less aggressive form of the public plan. His proposal states that “Rates paid to health care providers by this option would be determined by balancing the goals of increasing competition and ensuring access to high quality health care.”

The HAA does not include a public plan at the national level, but does permit local area Medicaid-only health plans to participate in the exchange. In many areas of the country, public plans have formed around public hospitals and clinics at the local level that compete for enrollment under state Medicaid managed care programs. These entities would be permitted to continue as one of the health coverage options offered through the exchange. In addition, the HAA provides a federal fallback plan in any state or region that does not have at least two private plans offering coverage.

## B. Cost Control Measures Compared

Cost containment is a key feature of both proposals. The Baucus proposal provides a roadmap to controlling costs in government programs through payment reforms that reward quality and efficiency. The HAA features a market-based approach to controlling costs for the private sector. Although different, these approaches do not conflict. They both could be implemented in a single reform model resulting in savings for both the public and private sectors.

### *The Baucus Proposal*

The Baucus proposal provides the most extensive cost containment model now before Congress. It begins by requiring coverage for preventive services and chronic care management in all federal programs including Medicare, Medicaid, TRICARE and the Federal Employees Health benefits Program (FEHBP). These requirements would also be made of all plans operating in the newly established exchange. The “Right Choices” program described above would assure access to preventive services and health screening for the uninsured. These steps are designed to increase the emphasis on preventive services throughout the health care system.

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<sup>4</sup> Provider payments are 29 percent lower than private payer rates for hospitals and 19 percent less for physicians. Administration under the public plan would be two-thirds less than in private plans for individuals, and small employers.

<sup>5</sup> This estimate includes 157 million people with employer coverage and 13 million people with non-group coverage. See: John Sheils and Randy Haught, “The Cost and Coverage Impacts of a Public Plan: Alternative Design Options,” Staff Working Paper #4, April 8, 2009.

The Baucus program would strengthen the role of primary care and chronic care management. It is estimated that about 75 percent of all health spending is associated with the treatment of chronic illness.<sup>6</sup> Yet only about 59 percent of people with chronic conditions receive the recommended primary and preventive care services.<sup>7</sup> Improving primary care and chronic care for these populations could reduce the cost of treating preventable complications. The proposal includes the following initiatives:

- **Ensure accurate payments for primary care services:** Medicare physician fee schedules would be revised to increase payments for primary care services while reducing payments for other services considered to be overvalued in the current fee schedule;
- **Additional payments for primary care providers:** Payments for primary care services under Medicare would be increased. Increases would be offset by budget neutral payment reductions for other types of physician services;
- **Patient centered medical home:** Under this model, patients establish a medical home with individual primary care providers who would provide coordination of care and preventive services. The proposal contemplates changes in patient co-payments to encourage participation; and
- **Community health centers and rural health clinics:** Adopt prospective payment system for federally funded clinics modeled on the approach used under Medicaid. It requires reporting of quality data and investment in the infrastructure required to qualify as a medical home.

The Baucus proposal calls for a gradual transition to payment systems that reward providers for good health outcomes and high quality care. He proposes to focus on quality-based reimbursement for hospital care, physician care, home health services and long-term care. CMS would also explore pay-for-performance models for Medicare Advantage plans. These initiatives include:

- **Hospital quality reporting and next-generation quality-based payment reforms:** The Baucus proposal includes a gradual transition to hospital pay-for-performance programs that include financial rewards for improved performance and alignment of hospital and physician quality goals;
- **Physician quality reporting initiative:** The plan would improve existing reporting models and eventually include payment penalties for physicians that do not participate in data reporting;
- **Provider feedback program and episode groupers:** Promote the use of episode grouper technology that can be used to identify inappropriate care patterns;

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<sup>6</sup> Thorpe (2007), "Potential Savings Under the Advamed Plan Associated with Health Reforms Focusing on Chronic Care Management, Prevention and Health Information Technology" found at: <http://www.advamed.org/NR/rdonlyres/03AE0ADD-3472-4F29-BC58-32EC0575AB67/0/healthreformsavingsthorpeFINAL.pdf>

<sup>7</sup> Their, et al., "In Chronic Disease, Nationwide Data Show Poor Adherence by Patients to Medication and by Physicians to Guidelines", *Managed Care*, February 2008.

- **Quality improvement for other providers and private plans:** The proposal would explore approaches to measuring quality for other services (i.e., other than hospitals and physicians) through a newly-established Independent Health Council;
- **Reforming the sustainable growth rate formula:** Physician payment updates for Medicare would be changed through a payment system that rewards high-value care.

The Baucus proposal would develop new incentives for providers to work together to improve quality of care. These include innovative new payment systems that reduce costs and improve quality such as bundled payments and gainsharing models. These approaches include:

- **Reducing hospital readmissions:** CMS would provide confidential feedback to hospitals and physicians on resource use for themselves and their peers. It would also reduce payments to hospitals for readmissions in excess of benchmarks.
- **Bundle payments:** The proposal would develop and test alternative bundled payment methods that include a single payment for selected treatments such as cardiac bypass graft surgery covering related services before, during and after surgery;
- **Physician group demonstration and Accountable Care Organizations (ACOs):** Under these systems, providers who meet quality targets and achieve cost reductions share in the savings to the Medicare program. The plan would also fund demonstrations of incentive payment systems directed at integrated delivery systems called Accountable Care Organizations; and
- **Gainsharing:** This model permits groups of providers, such as hospitals and physician partners to share in savings that result from improved quality and efficiency.

The Baucus proposal would make investments in the healthcare infrastructure that improve our understanding of the clinical value of alternative treatment methods and health information technology (HIT) that can improve efficiency and the quality of medical decision making. These include:

- **Comparative effectiveness research:** Funding would be provided to conduct and compile research on the effectiveness of alternative medical treatments. These studies could be used to develop evidenced-based medical practice guidelines designed to improve outcomes and reduce unnecessary spending. The recent economic stimulus package includes about \$1.0 billion in funding for such research;
- **Health Information Technology (HIT):** The proposal includes three strategies to encourage adoption and use of HIT including: financial incentives; assistance to providers in navigating the HIT market and systems; and promoting information sharing among providers; and
- **Health care workforce:** The proposal calls for a reevaluation of federal policy on medical education to reflect current and emerging demand for medical professionals.

The Baucus proposal includes several provisions designed to foster a more efficient health care system. These include initiatives to: reduce fraud, waste and abuse; provide public reporting of provider costs and quality of care; and malpractice reform. The plan also proposes that

Congress explore certain limits to the tax exclusion for employer provided health benefits designed to encourage more efficient health care spending.

### *The Healthy Americans Act (HAA)*

The HAA is designed to use competition to limit the growth in health spending. The Act requires employers to convert the amount of their spending for health benefits to wages for covered workers, even if the employer continues to offer a plan. All HAA covered Americans would then choose from a selection of health plans offered through the newly created network of local area exchanges. People would pay the entire amount of the premium, which is adjusted by ability to pay. Thus, consumers retain the full amount of any savings by electing a lower-cost health plan. The HAA also modifies the tax code so that it no-longer favors purchases of higher cost health coverage.

The conversion to wages is intended to be cost neutral to both the employer and the worker. That is, total employer spending for wages under the Act would be the same as what wages plus health benefits expenses would have been in the absence of the Act. Employers are required to continue to pay that amount for 2 years. Also, changes in tax policy would be phased-in over a period of 3 to 4 years so that workers can adjust to the new system and gain confidence in the conversion of benefits to wages.

All HAA covered Americans would choose from a selection of private health insurance options. These would include options ranging from integrated delivery systems such as HMOs, to less tightly managed health plans such as fee-for-service (FFS) and preferred provider networks (PPOs). The exchange could offer HSAs as well. Workers would also have the option of taking coverage offered by their employer in cases where the employer chooses to continue offering a health plan.

The HAA replaces the current tax exemption for employer provided health benefits to a fixed deduction to strengthen incentives for families to seek lower cost coverage. The new “health premium” tax deduction is designed to assure that increased income due to the conversion of health benefits to wages does not result in a general increase in federal personal income tax payments. To maintain incentives to control costs, the deduction is fixed and cannot be increased by purchasing more costly coverage. Thus, unlike the unlimited employer tax exclusion of today, workers would be able to select a lower cost health plan without forfeiting tax benefits.

The Wyden/Bennett plan includes other provisions designed to encourage cost containment. These include:

- **Wellness incentives:** Individuals who participate in approved wellness programs are eligible for a discounted premium;
- **Adjust Medicare Part B premium to reward positive behavior:** The Secretary is required to adjust the Part-B premium amount to reflect participation in positive health behavior such as weight management, exercise or designating a “health home”;

- **Primary care services management payment:** Creates a new care management payment under Medicare for providers who are designated as the health home for Medicare beneficiaries; and
- **Chronic care disease management:** Requires Medicare to establish a chronic care disease management program.

### *Compatibility of Cost Containment Features*

The cost containment features of the HAA would complement the cost savings initiatives already included in the Baucus plan. Although the Baucus plan includes provisions designed to reduce spending throughout the health care system, most of the proposal's payment reform and quality initiatives would originate in Medicare. We expect many private plans to adopt these payment models once proven in Medicare. However, this may take a number of years to materialize and may do little to address cost growth for the privately insured, which is the group at risk of losing coverage due to rising premiums.

The HAA uses a market-based approach to control costs for the privately insured non-Medicare population. As discussed above, the program is designed to give consumers strong financial incentives to seek-out cost efficient coverage alternatives, while also making a broader array of insurance products available to all of the HAA population. This approach could be implemented at the same time the Baucus provisions are introduced.

For example, the additional funding for comparative effectiveness research and HIT development proposed by Baucus could be implemented at the same time the HAA model is taking effect. These investments would ultimately benefit both the Medicare and non-Medicare populations. The Baucus payment reforms under Medicare also could be implemented simultaneously with the HAA coverage provisions for the non-Medicare population, as could the Baucus requirement for federal programs to emphasize primary and preventive care for the chronically ill.

The HAA is also compatible with the new "Independent Health Council" proposed by Senator Baucus. The Council could be used to develop standards and procedures for the exchange and for participating health plans. It would also be suitable for setting standards for chronic care management and quality reporting.

Adding the HAA to the Baucus plan would create a dual approach to cost containment. The Baucus Medicare initiatives would develop innovative approaches to chronic care management and payment reform within public programs while the HAA coverage model would create new incentives for cost containment within the private sector. Together, these approaches would form an aggressive approach to controlling costs throughout the health care system.

### **C. Phase-in Model for Health Reform**

The Baucus proposal provides a plan for phasing-in health reform. The plan recognizes that it would take at least 2 to 3 years to establish a fully functional network of exchanges throughout the country. In the meantime, the Baucus proposal includes several steps to expand coverage under existing programs. As discussed above, the plan would increase Medicaid/CHIP

eligibility to 100 percent of the FPL for all adults and 250 percent of the FPL for children. Americans age 55 to 64 would be permitted to buy-in to the Medicare program, and the two-year waiting period for the disabled under Medicare would be lifted. His proposal also increases funding for the Indian Health Service.

In addition, the Baucus plan establishes a primary care access program called “Right-Choices.” The program would provide preventive care and screening services to uninsured people who do not qualify for Medicaid, CHIP or other government programs. The program would also provide treatments to people with high-cost diseases. These services would be free for people with incomes below 200 percent of the FPL.

The HAA does not yet include an implementation plan. However, the HAA could be implemented together with the interim coverage steps proposed by Senator Baucus until the nationwide network of exchanges is established. The expansions in Medicaid and CHIP proposed by Senator Baucus could be implemented in a relatively short period of time. The investment in this expansion would not be wasted since the HAA also proposes to provide adults through 100 percent of the FPL with supplemental coverage for co-pays and other services once these people are covered under private health plans.

However, the Medicare buy-in for those 55 to 64 and the elimination of the Medicare waiting period could be made temporary since coverage under the HAA will be more extensive than the Medicare benefits package. The Right Choices program of the Baucus proposal also would be unnecessary once all Americans have health insurance coverage.

Both the Baucus proposal and the HAA would require an implementation plan for the exchange. Under both proposals, the exchange could be organized at the regional, state or local levels. Over time, state- or regional-level exchanges could be spun off into local areas if Congress wishes to do so. Careful planning is required to assure that each exchange can efficiently perform the required tasks. Also, the HAA will require a transition plan to assure worker confidence that health benefits are converted to wages as required under the Act.

A phase-in schedule for a unified Baucus/HHA health reform plan could be as follows:

- Year 1:
  - Begin process of establishing exchanges throughout the country;
  - Implement conversion of the employer tax exclusion to a tax deduction.
  - Implement Right-Choices primary care program for the uninsured;
  - Eliminate disability waiting period; and
  - Any available additional funds could be use to support States’ Medicaid and CHIP programs during the transition.
- Years 2 and 3:
  - Implement exchanges on a voluntary basis until fully demonstrated and debugged;
  - Require all insurers to participate to establish relationships and systems with the exchange; and

- Begin to offer private plan choices for those who wish to transition from public programs.
- Year 4:
  - Make exchanges mandatory for all of the HAA covered population;
  - Employer health benefit is converted to wages;
  - All individuals take coverage through the exchange;
  - Medicaid population shifts to private coverage through the exchange with Medicaid as wrap-around coverage.
  - Insurance market reforms are fully implemented.

In the first year, the process of designing and establishing exchanges would begin throughout the country. Exchanges would be implemented on a voluntary basis and established in years 2 and 3. These exchanges would remain voluntary during that time until it is determined that they are fully functional and capable of handling the demand. In year 4, the exchanges would become mandatory for all of the HAA population (including employer coverage options).

The conversion from the tax exclusion to the tax deduction proposed in the HAA would become effective in the first or second year, even though the program will not be fully implemented until the fourth year. This would require employers to report the value of their health benefits on the W-2 so that individuals can establish a history of employer payments for health benefits and become familiar with the health premium deduction. This is designed to increase worker confidence in the process of converting benefits to wages as required under the Act beginning in the fourth year.

## D. Conclusion

The Baucus proposal and the Wyden/Bennett plans have many important similarities and appear to be fully consistent with the President's stated principles for reform. Together, they could form a bill that achieves universal coverage and controls cost in the public and private sectors, without increasing the federal deficit. We hope that this analysis has offered some useful ideas on how to advance the debate.