



Common Sense Affordability Protections: How the Senate Can Deliver Health Reform that Works for Low-Income Families and the Country

People earning less than 200 percent of the federal poverty level (FPL) - or \$36,620 for a family of three - make up nearly two-thirds of the uninsured¹ and well over half of the underinsured². The majority of these uninsured individuals are part of low-wage working families who are not offered coverage through their jobs.³ Making coverage affordable for these working families is vital to the success of health reform, because they are the least able to bear the burden of an individual mandate without adequate affordability protections. Requiring people to purchase insurance that costs too much and covers too little will frustrate the goal of extending coverage to everyone, and risk a political backlash that could unravel health care reform.

Like other bills being considered by Congress⁴, the recently approved Senate Finance Committee (SFC) bill makes coverage substantially more affordable than it is today by expanding Medicaid eligibility to 133 percent FPL (\$24,352 for a family of three) and offering premium subsidies to families up to 400 percent FPL (\$73,240 for a family of three) without employer-sponsored insurance. Despite this progress, the SFC bill still misses the mark for low-income families. It would impose premiums on adults earning just over the federal poverty level, and it would expose low-income families to unmanageable out-of-pocket costs if they faced serious or chronic illness.

Senate leaders are currently merging the SFC and the Health, Education, Labor and Pensions (HELP) Committee bills; this is a critical opportunity to fix the flaws in the SFC bill and bring meaningful coverage within reach of low-income families. We propose two affordability solutions for the merge, and offer five revenue-raising provisions that would more than cover the associated costs.

Affordable Coverage for Low-Income Families Is Two Solutions Away

- 1. Reduce premiums for low-income families by adopting both the larger Medicaid expansion and the more affordable premium subsidies offered in the HELP bill**

The HELP and House bills offer more adequate premium subsidies than the SFC bill.

Despite improvements made during the mark up, the SFC bill still requires low-income people to spend much more on premiums than the other bills (see Table 1).

The HELP bill offers better affordability protections to low-income individuals and families than both SFC and the House bill partly because it expands Medicaid to individuals and families earning up to 150 percent FPL, while the SFC and the House bills expand to only 133 percent FPL. A strengthened Medicaid program is uniquely positioned to ensure access to affordable care for low-income families because it typically protects families below 150 percent FPL from premiums.⁵

But even for those earning 150 percent FPL and above, both the Senate HELP and the House bills offer much better protections against high premiums than SFC. For example, under the SFC subsidy schedule, a family of three earning \$27,465 would pay four-and-a-half times as much as they would under the HELP schedule.

Table 1: Comparison of premium contributions for a low-income family of three receiving subsidies in all Congressional bills

Income		HELP bill* (as passed 07.15.09)		SFC bill (as passed 10.13.09)		House bill passed by the Energy and Commerce Committee*** (as passed 07.31.09)	
% FPL	\$ amount (for a family of three)	\$ amount (for a family of three)	% income	\$ amount (for a family of three)	% income	\$ amount (for a family of three)	% income
133%	\$24,352	0**	0**	\$901	3.7%	\$365	1.5%
150%	\$27,465	\$275	1%	\$1,236	4.5%	\$824	3%
200%	\$36,620	\$1,208	3.3%	\$2,563	7.0%	\$2,014	5.5%

*Assumes premium contributions increase at a constant rate across the income scale. Actual scale would be set by regulation

**The Senate HELP bill expands Medicaid to 150% FPL, so people at 133% FPL will qualify for Medicaid and will not pay premiums.

***The bill as passed by the other two committees of jurisdiction requires slightly lower contributions from families at 200% FPL.

Unaffordable premiums can deter enrollment, result in frequent coverage losses due to small income changes, and cause serious financial stress to low-income families.

Experience from state Medicaid and CHIP programs suggests that even nominal premiums can cause substantial numbers of low-income families to leave public programs.⁶ For example, in 2003 Oregon used a Medicaid waiver to increase premiums for low-income adults to \$6-\$20, depending on their income. These seemingly trivial premium increases had a dramatic effect: enrolment in the Medicaid program dropped by nearly half or roughly 50,000 people.⁷

At what point can families afford to contribute to their premiums? Community Catalyst analyzed the amount an individual or family needs for a minimally adequate living standard, including shelter, food, childcare and transportation in the largest metropolitan area in each state. We found that the cost of living varies widely across the country (see Table 2). However, in the metropolitan area with the median “living wage” before factoring in health care costs, a childless adult would need to earn \$18,456, or 166 percent FPL,⁸ and a family of three living would need at least \$37,087, or 198 percent FPL.⁹

Since the Senate Finance Committee bill requires premiums from families earning just over the poverty level, many low-income people would face a difficult choice. They could remain uninsured and pay a penalty for not purchasing coverage which will only exacerbate their difficult financial circumstances. Or, they could purchase coverage and cut back on other necessities, live in substandard housing, rely on unlicensed childcare, or go into substantial debt to meet basic living expenses while still facing substantial out-of-pocket costs.

Table 2: Living Wage in Largest Metropolitan area in each state before factoring in health care costs, illustrating the income at which people are able to afford premiums*

State	Single Adult*		Family of Three (2 parents, 1 child)	
	Dollars	FPL	Dollars	FPL
Alaska	\$19,651	113%	\$39,115	171%
Alabama	\$15,317	141%	\$33,045	180%
Arkansas	\$14,543	134%	\$31,613	173%
Arizona	\$17,523	162%	\$34,711	190%
California	\$22,747	210%	\$43,244	236%
Colorado	\$17,844	165%	\$38,346	209%
Connecticut	\$23,269	215%	\$44,683	244%
District of Columbia	\$27,772	256%	\$53,125	290%
Delaware	\$19,810	183%	\$39,334	215%
Florida	\$17,034	157%	\$33,953	185%
Georgia	\$18,579	172%	\$36,308	198%
Hawaii	\$28,950	232%	\$55,388	263%
Iowa	\$18,602	172%	\$37,747	206%
Idaho	\$15,102	139%	\$32,448	177%
Illinois	\$19,343	179%	\$38,627	211%
Indiana	\$17,397	161%	\$34,839	190%
Kansas	\$14,770	136%	\$32,523	178%
Kentucky	\$15,625	144%	\$33,595	183%
Louisiana	\$21,198	196%	\$38,712	211%
Massachusetts	\$27,735	256%	\$53,503	292%
Maryland	\$19,232	178%	\$41,094	224%
Maine	\$21,451	198%	\$41,908	229%
Michigan	\$20,301	187%	\$35,616	195%
Minnesota	\$20,928	193%	\$41,234	225%
Missouri	\$17,446	161%	\$34,551	189%
Mississippi	\$15,069	139%	\$32,385	177%
Montana	\$15,695	145%	\$32,395	177%
North Carolina	\$18,456	170%	\$37,087	203%
North Dakota	\$14,062	130%	\$30,441	166%
Nebraska	\$16,034	148%	\$33,982	186%
New Hampshire	\$21,748	201%	\$42,738	233%
New Jersey	\$21,352	197%	\$42,297	231%
New Mexico	\$16,641	154%	\$34,486	188%
Nevada	\$21,191	196%	\$38,389	210%
New York	\$23,686	219%	\$54,100	295%
Ohio	\$17,934	166%	\$36,336	198%
Oklahoma	\$13,691	126%	\$30,935	169%
Oregon	\$18,771	173%	\$37,840	207%
Pennsylvania	\$20,159	186%	\$43,181	236%
Rhode Island	\$21,630	200%	\$42,712	233%
South Carolina	\$14,678	136%	\$31,790	174%
South Dakota	\$13,984	129%	\$30,268	165%
Tennessee	\$15,550	144%	\$32,758	179%
Texas	\$12,037	111%	\$33,751	184%
Utah	\$16,858	156%	\$34,850	190%
Virginia	\$19,262	178%	\$38,279	209%
Vermont	\$21,182	196%	\$41,824	228%
Washington	\$16,821	155%	\$40,470	221%
Wisconsin	\$19,176	177%	\$38,786	212%
West Virginia	\$14,858	137%	\$31,290	171%
Wyoming	\$13,923	129%	\$31,244	171%
Median	\$18,456	166%FPL	\$37,087	198%FPL

*See appendix for note on Living Wage calculation

To protect low-income families from the financial consequences of unaffordable premiums, Senate leaders should adopt the HELP bill’s Medicaid expansion and subsidy schedule when merging the two Senate bills.

Specifically, the merged bill should: 1) expand Medicaid to 150 percent FPL, and 2) adopt the HELP subsidy schedule for those between 150 and 200 percent FPL. This would more accurately reflect what low-income families can actually afford to spend on their premiums. (See Table 5 for the projected cost of this solution.) The end result will mean more people will be insured and fewer people are likely to face bankruptcy, thereby accomplishing a major goal of health reform.

2. Reduce out-of-pocket costs for low-income families by adopting lower cost-sharing offered in the HELP bill and even smaller annual out-of-pocket caps than either HELP or SFC currently offer.

The HELP and House bills offer more reasonable cost-sharing and cap annual out-of-pocket costs at lower levels for low-income families than the SFC bill.

First, the HELP bill would provide better out-of-pocket cost protections to low-income families because it would expand Medicaid to those earning up to 150 percent FPL, while in the SFC and the House bills Medicaid would only cover people up to 133 percent FPL. The Medicaid program protects low-income families because it typically imposes only very minimal out-of-pocket costs (i.e. \$0.50 to \$3 per service)¹⁰.

Second, the HELP bill and the House bill would require much lower out-of-pocket costs for typical families earning 150 - 200 percent FPL, because they offer subsidized plans with much higher “actuarial values” than the SFC bill (see Table 3). The term “actuarial value” is used to identify what percentage of the cost of covered services that the plan will assume for the typical enrollee. For example, a policy with an actuarial value of 85 percent is expected to cover 85 percent of the cost of the typical enrollees’ care. Under the SFC bill a typical family of three earning \$27,465 would pay for about 20 percent of the costs of the health care they require, whereas they would pay only seven percent of those costs under the House or HELP bills (see Table 3).

Table 3: Comparison of actuarial values for a low-income family of three receiving subsidies in all Congressional bills

Income		HELP bill (as passed 07.15.09)	SFC bill (as passed 10.13.09)	Bills passed by the three House Committees
% FPL	\$ amount (for a family of three)	Actuarial Value	Actuarial Value	Actuarial Value
133%	\$24,352	n/a*	90%	97%
150%	\$27,465	93%	80%	93%
200%	\$36,620	93%	70%	85%

*The Senate HELP expands Medicaid to 150% FPL, so people at 133% FPL will qualify for Medicaid, which typically has an actuarial value in the high nineties.

Third, the HELP and House bills better protect families between 150 - 200 percent FPL from health care expenses that could lead to financial ruin because they cap annual out-of-pocket costs at much lower levels than the SFC bill (see Table 4). Under the SFC bill, families of three earning \$27,465 with a catastrophic or a chronic illness could spend up to 14 percent of their income on out-of-pocket costs. But that same family would only pay up to 5 percent or 8 percent of their income in total out-of-pocket costs under the House bill or the HELP bill respectively (see Table 4).

Table 4: Comparison of out-of-pocket maximums for a low-income family of three in the three current Congressional bills.

Income		HELP bill (as passed 07.15.09)		SFC bill (as passed 10.13.09)		Bills passed by the three House Committees	
% FPL	\$ amount (for a family of three)	\$ amount	% income (for a family of three)	\$ amount	% income (for a family of three)	\$ amount**	% income (for a family of three)
133%	\$24,352	n/a*	n/a*	\$3,867	16%	\$900	4%
150%	\$27,465	\$2,320	8%	\$3,867	14%	\$1,450	5%
200%	\$36,620	\$2,320	6%	\$5,800	16%	\$4,400	12%

*The Senate HELP expands Medicaid to 150% FPL, so people at 133% FPL will qualify for Medicaid.

**As estimated by House Ways and Means, July 31, 2009, available at <http://www.kaiserhealthnews.org/Stories/2009/September/04/House-Bill-Premiums.aspx>

Out-of-pocket costs can cause low-income people to delay or avoid necessary medical care and leave them with unmanageable financial obligations

Experience from state Medicaid and CHIP programs suggests that moderate out-of-pocket costs can lead these families to significantly delay needed care, and to experience financial hardship.¹¹

Research from the Commonwealth Fund found that low-income people (earning below 200 percent FPL) who incurred out-of-pocket costs that exceeded 5 percent of their income experienced many of the same consequences as the uninsured. They were more than twice as likely as those with adequate insurance to forgo needed specialist care, and to skip tests, medical treatments, or follow-up care recommended by a doctor.¹² They were also significantly more likely than the fully insured to have problems paying medical bills, change their way of life or be contacted by a collection agency regarding medical bills.¹³

The literature is clear: high cost-sharing and high out-of-pocket caps will lead to medical debt that low-income families will be unable to pay. This will not only devastate the financial stability of these working families, but will also affect finances of hospitals because they will be left with most of that bad debt. Both the SFC bill and the House bills¹⁴ also propose reducing payments that help recompense hospitals for uncompensated care.

To protect low-income families from burdensome out-of-pocket costs and underinsurance, Senate leaders should adopt the lower cost-sharing offered in the HELP bill, and smaller annual out-of-pocket caps than either HELP or SFC currently offer.

First, Senate leaders should offer subsidized plans with the same actuarial values as those in the HELP bill. Second, they should cap out-of-pocket costs at no more than 5 percent of family

income. This standard goes further than either SFC or HELP does, but it would protect families from underinsurance if they face a catastrophic or chronic illness (See Table 5 for the projected cost of this solution).

Cost-Saving and Revenue-Raising Provisions Are Available that Would Provide Sufficient Funds to Make Coverage Affordable for Low-Income Families

The above section suggested two provisions for the merged Senate bill that would make coverage affordable for low-income families and contribute to the overall success of comprehensive health care reform. Not only are these improvements critical to making reform effective, they can be accomplished in a fiscally responsible manner through the health care savings and revenues described below. According to estimates by MIT economist Jonathan Gruber¹⁵, these two fixes would cost \$142.5 billion altogether over ten years (see Table 5).

Table 5: Estimates for the cost of improving the affordability of coverage in the Senate Finance Bill

Improvement to SFC	Cost Estimate Over Ten Years*
Premiums: Expanding Medicaid to 150% FPL and adopting the HELP subsidy schedule for those between 150% and 200% FPL	\$60.8 billion
Cost-sharing: Improving the actuarial value of subsidized plans so they meet the HELP values**	\$19 billion
Both Improvements	\$142.5 billion***

*Estimates were generated by MIT Economist Jonathan Gruber.

**Gruber did not give us cost-estimates for lowering out-of-pocket caps to protect families from underinsurance. That is because lowering out-of-pocket caps, while leaving actuarial values the same, will not cost the federal government any money. We therefore assume that change is revenue-neutral.

***The total cost of the two affordability improvements does not equal the sum of the two amendments taken separately due to the interaction between the two provisions.

The following potential amendments could raise more than the costs necessary to make the two proposed affordability fixes (see Table 6):

- **Introducing a public plan option that results in health care savings:** The SFC bill currently does not include a public option. If the merged Senate bill included a national public option that negotiates rates directly with providers – something similar to what is currently included in the HELP bill – the merged bill would generate \$25 billion in savings over ten years. If the merged Senate bill included a national public option that had the power to set provider rates based on Medicare rates, the bill would generate \$110 billion in savings over ten years.¹⁶
- **Requiring drug companies to pay the Medicaid rebate for “dual-eligibles”:** The Medicaid Drug Rebate Program requires drug manufacturers to offer rebates to state governments for prescription drugs purchased for Medicaid beneficiaries. This rebate program, however, does not apply to “dual-eligibles” – Medicare-recipients who are poor enough to also qualify for Medicaid. The Senate Finance Committee considered, but rejected, an amendment that would require drug manufacturers to pay Medicaid drug rebates to the federal government for drugs provided to “dual-eligibles.” This amendment was intended to raise money to fill the Medicare Part D donut hole, the provision requiring seniors to cover the full cost of their drugs after they surpass the prescription drug coverage limit but before

they hit catastrophic levels. Even after filling the donut hole, this amendment would have a net \$50 billion remaining over ten years to pay for other improvements in the bill.¹⁷

- **Requiring employers to pay their fair share:** The SFC bill does not include an employer mandate. Rather, it requires employers who do not offer coverage to their employees to pay only a fixed fee per employee who takes up subsidies in the Exchange. However, the HELP bill and the House bill require employers that do not cover their employees to pay a fixed penalty for each uninsured employee or a percentage of total payroll, respectively. These mandates would raise more than the SFC bill. If the merged Senate bill included the HELP employer mandate language it would raise \$29 billion more than the current SFC employer requirements over ten years.¹⁸ If the merged Senate bill included the House employer mandate language, it would raise \$140 billion more than current SFC employer requirements over ten years.¹⁹
- **Adding the Community Living Assistance Services and Supports (CLASS) program in from the HELP bill:** The HELP bill's CLASS program is a national voluntary insurance program to help cover services and support for people with disabilities living at home or in a residential setting. People would be automatically enrolled through their employer, unless they opt out, and would pay fixed premiums throughout their lives. Participants in the program who become disabled would receive cash benefits for non-medical services, such as personal care attendants, counseling and other help to maintain independent. The CBO estimates that this program would save the Federal government \$58 billion over ten years, partially from savings to Medicaid and Medicare.²⁰
- **Freezing the value of itemized deductions for people in the top two income tax brackets:** As analyzed by the Center on Budget and Policy Priorities, "the federal government subsidizes the itemized deductions of people at the top of the income scale at a higher rate than people in the middle because the former are in higher tax brackets. (Put another way, the government does more to help a banker than a teacher to buy a house.) This inequity is scheduled to worsen in 2011 when the top two rates increase from 33 and 35 percent to 35 and 39.6 percent, respectively. Holding the value of itemized deductions at their current rates of 33 and 35 percent for people in the top two tax brackets would raise between \$68 billion and \$89 billion between 2010 and 2019 while still providing high-income taxpayers with the *same tax incentives they receive today* to buy a house, contribute to a charity, or incur other deductible expenses."²¹

With the exception of the CLASS program, each of these provisions has generated opposition from powerful interest groups such as the drug industry or insurers. Therefore Senate leaders must make a choice in producing a single unified bill: either they can defer to powerful interest groups and saddle low-income people with premiums and out-of-pocket costs they cannot afford, or they can confront those interest groups in order to raise enough revenue make health insurance and health care truly affordable, assuring the success of health care reform that truly meets its goals.

Table 6: Revenue projections from various cost-saving provisions

Provision	Revenue Estimate Over Ten Years*
1. Introduce a national public plan	\$110B for a public plan that can set provider rates at Medicare levels \$25B for a public plan that negotiates provider rates
2. Require drug companies to pay the Medicaid rebate for “dual-eligibles”	\$50B (the total revenue from this provision is \$106B, but only \$50B would be left over after paying to fill Medicare Part D donut hole)
3. Replace the “free-rider surcharge” with a genuine pay-or-play provision	\$140B net savings for replacing the employer-responsibility requirements in SFC with the pay-or-play as set in the House bill \$29B net savings for replacing the employer-responsibility requirements in SFC with the pay-or-play as set in the HELP bill
4. Create a CLASS program, like that in the HELP bill	\$58B
5. Freeze the value of itemized deductions for those in the top two income tax brackets	\$68 billion - \$89 billion
Total	\$230B - \$447B

*** Sources:**

Kasie Hunt and Billy House, Nationaljournal.com, “CBO Estimates Show Public Plan With Higher Savings Rate”, Sept 25 2009, http://www.nationaljournal.com/congressdaily/cda_20090925_6347.php;

Website of Senator Bill Nelson, “Measure to offer seniors full Medicare drug coverage blocked”, Sept 24 2009, <http://billnelson.senate.gov/news/details.cfm?id=318232&>;

Congressional Budget Office, letter to Senator Max Baucus, October 7 2009, http://www.cbo.gov/ftpdocs/106xx/doc10642/10-7-Baucus_letter.pdf;

Congressional Budget Office, letter to Senator Edward Kennedy, July 2 2009, <http://www.cbo.gov/ftpdocs/104xx/doc10431/07-02-HELPltr.pdf>;

Congressional Budget Office, letter to Congressman Charles Rangel, July 14 2009, http://www.cbo.gov/ftpdocs/104xx/doc10430/House_Tri-Committee-Rangel.pdf;

Tax Policy Center, “Alternatives to the Administration’s 28-Percent Limitation on Itemized Deductions Impact on Tax Revenue”, June 4 2009, <http://www.taxpolicycenter.org/numbers/displayatab.cfm?DocID=2401>

Conclusion

Current Congressional bills would do a great deal to make health coverage more affordable to all Americans. However, the SFC bill could subject low-income families premiums and out-of-pocket cost requirements they could not financially manage, jeopardizing the success of health care reform. Improving affordability during the merge of the two Senate bills will not be cheap, but there are at least five credible revenue-raising provisions that would generate more than enough funds to cover the costs. If Congressional leaders are willing to confront the powerful and wealthy special interests that oppose these revenue-raising provisions, affordable health care for low-income Americans can become a reality.

Appendix: Table 4 Methodology

Table 4 presents estimates of the amount of money someone would need to meet a bare-bones budget in the largest city in each state and Washington D.C. The data is drawn from two sources:

1. The Economic Policy Institute's (EPI) living budget analysis calculates the amount of money a family needs to afford adequate shelter, food, transportation, childcare, and other necessities based on geographic areas.²² The housing allowance is limited to a one or two bedroom rental unit at the 40th percentile in a particular geographic area depending on family size.
2. Wider Opportunities for Women produce "self-sufficiency standards" for many states, which also calculate how much money working adults need to meet their basic needs without subsidies of any kind using similar data sources.²³

The family data comes directly from EPI, factoring out the allowance made for health care spending. The EPI data exists for all 50 states and is updated annually, however it does not calculate a living budget for households without children. Wider Opportunities for Women does not cover all 50 states nor is it updated every year, yet they include individuals as well as families in their analysis. We extrapolated the single adult results by combining data from both sources.

¹ Kaiser Family Foundation, Fast Facts, "Distribution of the Uninsured by Poverty Level and Age", <http://facts.kff.org/chart.aspx?ch=984>, accessed October 10, 2009.

² Cathy Schoen and others, "How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007", *Health Affairs* 27 (2008) 298-309.

³ Kaiser Family Foundation, "The Uninsured: A Primer", <http://www.kff.org/uninsured/upload/7451-05.pdf>, accessed October 11, 2009.

⁴ The Health Education Labor and Pension (HELP) Committee bill as passed July 15th, and the House bill as passed by the three committees of jurisdiction (Energy & Commerce on July 31, 2009; Education & Labor on July 17, 2009; and Ways & Means on July 17, 2009.)

⁵ CMS, "Deficit Reduction Act Important Facts for State Policymakers", February 21 2008, available at <http://www.cms.hhs.gov/DeficitReductionAct/Downloads/Costsharing.pdf>

⁶ Samantha Artiga and Molly O'Malley, Kaiser Family Foundation, "Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences"

<http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=53261>

⁷ Samantha Artiga and Molly O'Malley, Kaiser Family Foundation, "Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences"

<http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=53261>

⁸ Due to variation in Alaska and Hawaii federal poverty levels, the median income and the median federal poverty level in these calculations are not equivalent.

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¹⁰ Samantha Artiga and Molly O'Malley, Kaiser Family Foundation, "Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences"

<http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=53261>

¹¹ Samantha Artiga and Molly O'Malley, Kaiser Family Foundation, "Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences"

<http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=53261>

¹² Cathy Schoen and others, "How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007", *Health Affairs* 27 (2008) 298-309.

¹³ Cathy Schoen and others, “How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007”, Health Affairs 27 (2008) 298-309.

¹⁴ The HELP Committee does not have jurisdiction over these payments to hospitals.

¹⁵ Gruber modeled the costs of the proposed affordability fixes in this paper, but he did not conduct any other analysis included in this paper. He does not necessarily endorse the opinions and recommendations included in this paper.

¹⁶ Kasie Hunt and Billy House, Nationaljournal.com, “CBO Estimates Show Public Plan With Higher Savings Rate”, Sept 25 2009, http://www.nationaljournal.com/congressdaily/cda_20090925_6347.php

¹⁷ Website of Senator Bill Nelson, “Measure to offer seniors full Medicare drug coverage blocked”, Sept 24 2009, <http://billnelson.senate.gov/news/details.cfm?id=318232&>

¹⁸ Congressional Budget Office, letter to Senator Max Baucus, October 7 2009,

http://www.cbo.gov/ftpdocs/106xx/doc10642/10-7-Baucus_letter.pdf; Congressional Budget Office, letter to Senator Edward Kennedy, July 2 2009, <http://www.cbo.gov/ftpdocs/104xx/doc10431/07-02-HELPltr.pdf>

¹⁹ Congressional Budget Office, letter to Senator Max Baucus, October 7 2009,

http://www.cbo.gov/ftpdocs/106xx/doc10642/10-7-Baucus_letter.pdf; Congressional Budget Office, letter to Congressman Charles Rangel, July 14 2009, http://www.cbo.gov/ftpdocs/104xx/doc10430/House_Tri-Committee-Rangel.pdf

²⁰ Congressional Budget Office, letter to Senator Edward Kennedy, July 2 2009,

<http://www.cbo.gov/ftpdocs/104xx/doc10431/07-02-HELPltr.pdf>

²¹ Chuck Marr and Paul N. Van de Water, Center on Budget and Policy Priorities, “Tax Offsets in Baucus Health Plan Are Sound But Can Be Improved”, Sept 18 2009, <http://www.cbpp.org/cms/index.cfm?fa=view&id=2924>

²² Economic Policy Institute, Basic Family Budget Calculator, http://www.epi.org/content/budget_calculator/

²³ Wider Opportunities for Women, Six Strategies for Economic Self-Sufficiency, “Self-Sufficiency Standard”, <http://www.sixstrategies.org/includes/productlistinclude.cfm?strProductType=resource&searchType=type&strType=self-sufficiency%20standard>