



FOCUS *on Health Reform*

SIDE-BY-SIDE COMPARISON OF MAJOR HEALTH CARE REFORM PROPOSALS

This side-by-side compares the leading comprehensive reform proposals across a number of key characteristics and plan components. Included in this side-by-side are proposals for moving toward universal coverage that have been put forward by the President and Members of Congress. In an effort to capture the most important proposals, we have included those that have been formally introduced as legislation as well as those that have been offered as principles or in White Paper form. This side-by-side will be regularly updated to reflect changes in the proposals and to incorporate major new proposals as they are announced.

| | President Obama Principles for Health Reform | Senate Finance Committee Policy Options | Sen. Max Baucus Call to Action: Health Reform 2009 |
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| Date plan announced | February 26, 2009 | April – May 2009 | November 12, 2008 |
| Overall approach to expanding access to coverage | <p>President Obama outlined eight principles for health care reform in his FY 2010 Budget overview. The President has indicated that comprehensive health reform should:</p> <ul style="list-style-type: none"> • Reduce long-term growth of health care costs for businesses and government. • Protect families from bankruptcy or debt because of health care costs. • Guarantee choice of doctors and health plans. • Invest in prevention and wellness. • Improve patient safety and quality care. • Assure affordable, quality health coverage for all Americans. • Maintain coverage when you change or lose your job. • End barriers to coverage for people with pre-existing medical conditions. | <p>The Senate Finance Committee released a series of papers laying out options for health reform. While not a formal proposal, these papers offer a framework for achieving health reform goals and present the range of options the Committee will consider as it works to draft health reform legislation.</p> <p>Require all individuals to have health insurance. Create a Health Insurance Exchange through which individuals and small businesses can purchase health coverage, with subsidies available to individuals/families with incomes between 100 and 400% of the federal poverty level. Impose new regulations on the non-group and small group insurance markets. Expand Medicaid and CHIP and offer a temporary Medicare buy-in for the pre-Medicare population.</p> | <p>Require all individuals to have health insurance. Create a Health Insurance Exchange through which individuals and small businesses can purchase a new public plan or private coverage, with subsidies available. Expand Medicaid and CHIP and offers temporary Medicare buy-in for the pre-Medicare population. Require larger employers to provide coverage or contribute to a new public program. Provide employer subsidies based on firm size and income.</p> |

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| Individual mandate | <ul style="list-style-type: none"> The plan must put the country on a clear path to cover all Americans. | <ul style="list-style-type: none"> Require all individuals to have insurance that meets minimum coverage standards. Enforced through an excise tax equal to a percentage of the premium for the lowest cost option available through the Health Insurance Exchange in the area where the individual resides. Exemptions will be granted for financial hardship; if the lowest cost plan option exceeds 10% of an individual's income; and if the individual has income below 100% of the poverty level. | <ul style="list-style-type: none"> Require all individuals to have health insurance. Enforced through a tax penalty or other point of contact between individuals and government. |
| Employer requirements | Not specified. | <ul style="list-style-type: none"> Proposed Option A: Require employers with more than \$500,000 in total payroll per year to offer coverage to their employees and contribute at least 50% of the premium or pay an assessment. The employer assessment could be structured in several ways: 1) a set fee per enrollee per month based on total annual payroll; 2) a tiered penalty calculated as a percentage of payroll; or 3) a larger penalty only on firms with annual payroll of more than \$1,500,000. Proposed Option B: No employer "pay or play" requirement. | <ul style="list-style-type: none"> Require large and medium-sized employers to offer coverage or contribute a percentage of payroll to a fund to cover the uninsured. Contribution likely to be based on a percentage of payroll taking into account firm size and revenue, with smaller firms contributing less. All but smallest employers required to offer Section 125 plan to allow employees to pay premiums with pre-tax dollars. |

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| <p>Expansion of public programs</p> | <ul style="list-style-type: none"> As a foundation for health reform, the President signed the Children’s Health Insurance Program Reauthorization Act (CHIPRA), which provides coverage to 11 million children. | <p>Medicaid</p> <ul style="list-style-type: none"> Expand Medicaid to all individuals with incomes up to 115% FPL, with a possible increase in eligibility for parents, pregnant women, and children to a higher level. Coverage could be provided through the current program structure or by enrolling children, pregnant women, parents, and childless adults in the Health Insurance Exchange. Another alternative is to enroll all populations except childless adults in Medicaid. Under this approach, childless adults would not be eligible for Medicaid but would be given tax credits to purchase coverage through the Exchange or to buy-in to Medicaid. <p>Children’s Health Insurance Program</p> <ul style="list-style-type: none"> After September 30, 2013, expand CHIP eligibility to 275% FPL. Once the Health Insurance Exchange is fully operational, CHIP enrollees would obtain coverage through the Exchange and states would be required to continue to provide services not covered by plans in the Exchange, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. <p>Medicare</p> <ul style="list-style-type: none"> Until the Health Insurance Exchange is underway, allow individuals aged 55-64 without coverage to buy-in to Medicare at full-cost. Phase-out or reduce the two-year waiting period for Medicare eligibility for people with disabilities. <p>Public Health Insurance Option</p> <ul style="list-style-type: none"> Proposed Option A: Create a new public plan to be offered through the Exchange that will be subject to the same rating and risk adjustment rules as the private plans. The public plan could be administered by the federal government, by multiple third-party administrators, or by the states. Proposed Option B: Do not create a public plan option. | <ul style="list-style-type: none"> Expand Medicaid to all individuals with incomes up to 100% FPL. Expand CHIP to children with family incomes up to 250% FPL. Eliminate the five-year waiting period for legal immigrants to become eligible for Medicaid and CHIP. Until the Health Insurance Exchange is underway, allow individuals aged 55-64 without coverage to buy-in to Medicare at full-cost. Phase-out the two-year waiting period for Medicare eligibility for people with disabilities. Create a new public plan, similar to Medicare, available to individuals and small businesses. Provide grants to states to create temporary “RightChoices” programs to provide uninsured individuals with immediate access to preventive care and treatment for identified chronic conditions. Increase funding for Indian Health Service. |

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| Premium subsidies to individuals | <ul style="list-style-type: none"> The plan must protect families' from bankruptcy or debt because of health care costs. The American Recovery and Reinvestment Act makes coverage more affordable for Americans who lose their jobs and their access to employer-based health coverage by offering a subsidy of 65 percent of the premium costs for COBRA coverage. | <ul style="list-style-type: none"> Provide refundable tax credits to individuals and families with incomes between 100 and 400% FPL to purchase insurance through the Health Insurance Exchange. The level of the premium tax credit could be set as a percentage of income or as a percentage of the premium, with additional limits on cost-sharing. | <ul style="list-style-type: none"> Provide refundable tax credits to individuals and families with incomes below 400% FPL to purchase insurance through the Health Insurance Exchange. |
| Premium subsidies to employers | Not specified. | <ul style="list-style-type: none"> Provide certain small employers that purchase insurance for their employees with a tax credit. The full credit of 50% of the average total premium cost paid by the employer would be available to employers with 10 or fewer employees and whose employees have average annual wages of less than \$20,000. The tax credit would be phased out as firm size and earnings increase. The tax credit would not be payable in advance or refundable. | <ul style="list-style-type: none"> Provide small businesses that purchase coverage for their employees through the New Health Insurance Exchange with a refundable tax credit. The credit would be based on firm's size and earnings per employee and would be phased out as firm size and earnings increased; the smallest firms with the lowest earnings would be eligible for a tax credit of up to 50% of the average premium cost for employer coverage in their state. |
| Tax changes related to health insurance | Not specified. | <ul style="list-style-type: none"> Considers several health insurance-related tax changes affecting the tax preference for employer-sponsored insurance, health savings accounts, flexible spending accounts, and deductions for medical expenses. | <ul style="list-style-type: none"> Calls on Congress to consider changing the tax exclusion for employer-provided insurance by capping the tax exclusion based on the value of the health benefits, income or both; or by making the exclusion available on a sliding scale based on income. |
| Creation of insurance pooling mechanisms | <ul style="list-style-type: none"> The plan should provide portability of coverage and should offer Americans a choice of health plans. | <ul style="list-style-type: none"> Create one national or multiple regional Health Insurance Exchanges through which individuals and small employers can purchase qualified insurance. Require all state-licensed insurers in the non-group and small group markets to participate in the Health Insurance Exchange(s). Require guarantee issue and renewability and allow rating variation based only on age, tobacco use, family composition, and geography (not health status) in the Exchange(s). Require the Exchange(s) to develop a standardized format for presenting insurance options, create a web portal to help consumers find insurance, maintain a call center for customer service, and establish procedures for enrolling individuals and businesses and for determining eligibility for tax credits. | <ul style="list-style-type: none"> Create the Health Insurance Exchange through which individuals and small businesses can purchase the public plan (which is similar to Medicare) or qualified private insurance. Insurers participating in the Exchange can operate nationally, regionally, state-wide, or locally and would be required to offer three different products with high-, medium-, and low-benefit options. Prohibit insurers from denying coverage based on pre-existing conditions and require insurers to conform to rating rules to be developed in consultation with the National Association of Insurance Commissioners. Provide comparable information about the plan options through the Exchange. |

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| Benefit design | Not specified. | <ul style="list-style-type: none"> • Create four benefit categories (lowest, low, medium, and high). Require all plans to provide a comprehensive set of services and prohibit inclusion of lifetime limits on coverage or annual limits on benefits. • All policies (except certain grandfathered employer-sponsored plans) must comply with one of the four benefit categories, including those offered through the Exchange and those offered outside of the Exchange. | <ul style="list-style-type: none"> • Allow insurers participating in the National Insurance Exchange to offer products that can be categorized as high-, medium-, or low-benefit options. Plans must be actuarially equivalent within benefit categories, but premiums may differ across benefit options. • Create a new Independent Health Coverage Council charged with ensuring that coverage is affordable, clinically appropriate, provides access to necessary health services, and protects enrollees against high health care expenses. |
| Changes to private insurance | <ul style="list-style-type: none"> • The plan must end barriers to coverage for people with pre-existing medical conditions. | <ul style="list-style-type: none"> • Require guarantee issue and renewability and allow rating variation based only on age, tobacco use, family composition, and geography (not health status) in the non-group, micro-group (2-10 employees), and small group markets. Require risk adjustment in all markets. • Require all state-licensed insurers in the non-group and small group markets to participate in the Health Insurance Exchange. • Require all insurers to issue policies in each of the four new benefit categories. • Allow states the option of merging the non-group and small group markets. | <ul style="list-style-type: none"> • Insurers offering coverage through the Exchange must meet requirements and charge the same for products inside and outside the Exchange. • Prohibit insurers from denying coverage based on pre-existing conditions and require insurers to conform to rating rules that will be developed in consultation with the National Association of Insurance Commissioners. |
| State role | Not specified. | <ul style="list-style-type: none"> • Allow states the option of merging the non-group and small group insurance markets. • Require state insurance commissioners to provide oversight of health plans with regard to consumer protections, rate reviews, solvency, reserve fund requirements, and premium taxes and to define rating areas. | <ul style="list-style-type: none"> • Create temporary “RightChoices” programs to provide uninsured individuals with immediate access to preventive care and treatment for identified chronic conditions. States will receive federal grants to finance these programs. |

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| Cost containment | <ul style="list-style-type: none"> • The plan should reduce high administrative costs, unnecessary tests and services, waste, and other inefficiencies that consume money with no added benefit. • The plan must invest in public health measures proven to reduce cost drivers in our system—such as obesity, sedentary lifestyles, and smoking—as well as guarantee access to proven preventive treatments. The American Recovery and Reinvestment Act provides \$1 billion for prevention and wellness. | <ul style="list-style-type: none"> • Encourage adoption and use of health information technology by expanding eligibility for the Medicare HIT incentives in the American Recovery and Reinvestment Act to include additional providers. • Eliminate fraud, waste, and abuse in public programs through more intensive screening of providers, the development of the “One PI database” to capture and share data across federal and state programs, increased penalties for submitting false claims and violating EMTALA, and increase funding for anti-fraud activities. • Restructure payments to Medicare Advantage plans to promote efficiency and quality. • Require drug or device manufacturers to disclose payments and incentives given to providers and any investment interest held by a physician. • Improve transparency of information about skilled nursing facilities. • Allow providers organized as accountable care organizations that voluntarily meet quality thresholds to share in the cost-savings they achieve for the Medicare program. • Improve prevention by covering only proven preventive services in Medicare and Medicaid and providing incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs. | <ul style="list-style-type: none"> • Encourage adoption and use of health information technology by providing financial incentives to providers and assistance in navigating the HIT marketplace. • Eliminate fraud, waste, and abuse in public programs. • Eliminate overpayments to private insurers in the Medicare Advantage program. • Require hospitals and providers to publicly report measures of health care costs and quality and require drug or device makers to disclose payments and incentives given to providers. • Adopt medical malpractice reforms to promote alternatives to civil litigation and the collection of data on medical errors to improve patient safety. • Improve prevention by requiring health plans participating in the Exchange to include certain preventive services in the benefit package. |

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| Improving quality/health system performance | <ul style="list-style-type: none"> • The plan must ensure the implementation of provide patient safety measures and provide incentives for changes in the delivery system to reduce unnecessary variability in patient care. It must support the widespread use of health information technology and the development of data on the effectiveness of medical interventions to improve the quality of care delivered. • To lay the foundation for improving the health care delivery system and quality of care, the American Recovery and Reinvestment Act invests \$19 billion in health information technology, including \$17 billion in incentives to providers to encourage their use of electronic medical records, and provides \$1.1 billion for comparative effectiveness research. | <ul style="list-style-type: none"> • Strengthen primary care and chronic care management by providing bonus payments to certain primary care providers and providing reimbursement for certain care management activities for patients with hospital stays related to a major chronic condition. • Establish a framework to set national priorities for comparative clinical effectiveness research. • Create a Chronic Care Management Innovation Center within CMS to disseminate innovations that foster patient-centered care coordination innovations for high-cost, chronically ill Medicare beneficiaries. • Bundle payments for acute, inpatient hospital services and post-acute care services occurring within 30 days of discharge from a hospital. • Establish a hospital value-based purchasing program to pay hospitals based on performance on quality measures. • Develop a strategy for the development, selection, and implementation of quality measures that involves input from multiple stakeholders. Improve public reporting of quality and performance information that includes making information available on the web. • Require enhanced collection and reporting of data on race, ethnicity, and primary language. Also require collection of access and treatment data for people with disabilities. | <ul style="list-style-type: none"> • Strengthen primary care and chronic care management through improved payments for primary care services and promotion of patient-centered medical homes. • Create an independent institute to guide comparative effectiveness research, including dissemination of research findings. • Encourage care coordination through organizational models that allow for patient care across the treatment spectrum and allowing Medicare to pay bundled payments for an episode of care. • Improve quality through value-based purchasing for hospital and physician services. • Require health plans participating in the Exchange to collect and report data on race, ethnicity, and gender. |

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| Other investments | <ul style="list-style-type: none"> As an initial investment in strengthening the health care workforce, the American Recovery and Reinvestment Act provides \$500 million to train the next generation of doctors and nurses. | <ul style="list-style-type: none"> Promote prevention and wellness by providing grants to states to implement innovative approaches to promoting integration of health care services to improve health and wellness outcomes and providing tax credits to small businesses that implement proven wellness programs. Change the Medicaid FMAP formula to include data on a state's poverty level and increase Medicaid FMAP rates during economic downturns to assist states in financing increased Medicaid enrollment. Reform Graduate Medical Education to increase training of primary care providers and promote training in outpatient settings, and ensure the availability of residency programs in rural and underserved areas. Improve the availability of long-term care services by increasing access to home and community based services through changes in Medicaid program requirements and through grants to states. | <ul style="list-style-type: none"> Promote a national focus on wellness by providing grants to states or communities to implement evidence-based prevention and wellness programs and providing tax credits to small businesses that implement proven wellness programs. Reform Graduate Medical Education to increase training of primary care providers and to improve the racial and ethnic diversity of the health care workforce. Increase Medicaid FMAP rates during economic downturns to assist states in financing increased Medicaid enrollment. |
| Financing | President Obama dedicated \$630 billion over ten years toward a Health Reform Reserve Fund in his budget outline released in February 2009 to partially offset the cost of health reform. | Not specified. Considering a range of options for achieving savings and for generating new revenues. | Not specified. Considering cap on exclusion of employer-paid health insurance premiums for income and payroll tax purposes. |
| Sources of information | http://www.whitehouse.gov/omb/budget/ http://www.HealthReform.gov | Go to following link: http://finance.senate.gov/sitepages/baucus.htm then select these items 5-11-09 Baucus, Grassley Policy Options for Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans 4-28-09 Baucus, Grassley Policy Options for Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs | http://finance.senate.gov/healthreform2009/home.html |

| | Sens. Tom Coburn and Richard Burr Reps. Paul Ryan and Devin Nunes Patients' Choice Act of 2009 (S. 1099 and H.R. 2520) | Sens. Ron Wyden and Bob Bennett Healthy Americans Act (S. 391) |
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| Date plan announced | May 20, 2009 | February 5, 2009 |
| Overall approach to expanding access to coverage | Create state-based health insurance exchanges through which private plans offer coverage meeting certain benefit and other standards. Allow employers to continue providing coverage to their employees, but replace the current tax preference for employer-sponsored insurance with a tax credit for individuals and families to provide incentives for insurance coverage. Integrate low-income families into private insurance by providing additional financial support and maintain Medicaid coverage for low-income people with disabilities. | Require most Americans to purchase private coverage (called Healthy Americans Private Insurance or HAPI) meeting certain standards, with federal subsidies available for individuals/families up to 400% of the federal poverty level. State-based Health Help Agencies administer the offering of HAPI plans, which have to meet federal benefit and other standards. Employers can continue to sponsor health plans but many are unlikely to do so because the favorable tax treatment for individuals of employer-paid and insurance is eliminated. |
| Individual mandate | <ul style="list-style-type: none"> • No requirement for individuals to have coverage. | <ul style="list-style-type: none"> • Require all citizens over age 19 to have insurance along with dependent children. Those without coverage are subject to a financial penalty based on the number of uncovered months and the weighted average of HAPI premiums. |
| Employer requirements | Not specified. | <ul style="list-style-type: none"> • Require employers to contribute an amount equal to a percentage of the average premium of their workforce times the number of workers. Percentage of the average premium varies for large and small employers from 2% to 25%. • For the first two years, permit employers previously providing health insurance to increase their workers' wages by the amount of the health insurance premium in lieu of the employer shared responsibility payment described above. • Employers who continue to sponsor health plans must provide information on HAPI plans to employees. • Require employers to deduct individual and family premiums from workers' payroll. |
| Expansion of public programs | <ul style="list-style-type: none"> • Restructure the Medicaid program to provide care only to low-income people with disabilities. Integrate low-income families into private insurance by providing them with a tax credit plus other financial support. • Allow private facilities to compete with Veteran's Administration facilities to provide care to veterans. • Allow eligible American Indians to access medical care outside of Indian Health Service facilities. | <ul style="list-style-type: none"> • Eliminate Medicaid and CHIP as comprehensive coverage programs and instead provide supplemental, wrap-around coverage for low-income beneficiaries. Provides for a modified Medicaid long-term care services program. |
| Premium subsidies to individuals | <ul style="list-style-type: none"> • Provide a tax credit of \$2,300 for individuals and \$5,700 for families to be used to purchase insurance. • Provide additional financial support to low-income families to enable them to afford private insurance. | <ul style="list-style-type: none"> • Provide premium subsidies for individuals and families with incomes between 100 and 400% FPL; those with incomes below 100% FPL would not pay premiums. • Provide a health care standard tax deduction for individuals and families with incomes above 100% FPL; would phase-out at higher income levels. |
| Premium subsidies to employers | Not specified. | No provision. |

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| Tax changes related to health insurance | <ul style="list-style-type: none"> • Reform the tax code to eliminate the exclusion of the value of health insurance plans offered by employers from workers' taxable income. • Allow individuals and families purchasing high-deductible health plans that are less than the value of the tax credit to deposit the excess amount into a health savings account. • Change health savings account (HSA) requirements by allowing health insurance premiums to be paid tax-free from an HSA, increasing the allowable contribution amounts for people with chronic conditions, and permitting high-deductible health plans to cover preventive services, maintenance costs of chronic diseases, and concierge-style primary care services. | <ul style="list-style-type: none"> • Reform the tax code to eliminate the exclusion of the value of health insurance plans offered by employers from workers' taxable income (with exceptions, such as for employer-paid retiree health coverage and coverage through a collectively bargained plan). • Provide a new health care standard deduction that phases out for higher income taxpayers. |
| Creation of insurance pooling mechanisms | <ul style="list-style-type: none"> • Partner with states to create State Health Insurance Exchanges through which individuals can purchase qualified private insurance. • Require plans participating in the Exchanges to provide coverage on a guaranteed issue basis and to provide coverage similar to that provided to Members of Congress. • Require risk-adjustment among insurance plans participating in the Exchange. A non-profit, independent board will develop the risk-adjustment methodology. | <ul style="list-style-type: none"> • Create new state-based purchasing pools (Health Help Agencies) that would offer a choice of HAPI plans. • Everyone, except people enrolled in Medicare, retiree benefit plans, or military-related coverage, are required to enroll in plans through the Health Help Agencies. (Note: employers can still sponsor health insurance but would have to inform employees of HAPI plans available through Health Help Agency.) • Participating plans provide coverage similar to that available through FEHBP. • Require insurers to offer HAPI coverage on a guaranteed issue basis and use adjusted community rating principles in setting premiums. |
| Benefit design | <ul style="list-style-type: none"> • Provide coverage that meets the same statutory requirements used for the health benefits for Members of Congress. | <ul style="list-style-type: none"> • Provide benefits through HAPI plans that are actuarially equivalent or greater in value than the benefits offered under the Blue Cross/Blue Shield Standard Plan provided under the Federal Employees Health Benefit Program (FEHBP). • Additionally provide benefits for wellness programs and incentives to promote the use of these programs, coverage for catastrophic medical events for an individual or family if lifetime limits are exhausted, and full parity for mental health benefits. • Create the Healthy America Advisory Committee to issue annual reports recommending modifications to the benefits, items, and services covered by HAPI plans. |
| Changes to private insurance | Not specified. | <ul style="list-style-type: none"> • Require insurers to offer coverage on a guaranteed issue basis and use adjusted community rating principles in setting premiums; prohibit discrimination based on health status. • Require insurers to meet established medical loss ratios. • Require insurers to create an electronic medical record for each covered individual. |

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| State role | <ul style="list-style-type: none"> • Create state Health Insurance Exchanges that meet federal standards. • Form voluntary compacts (at state option) with other state Exchanges to diversify pooling, ease administrative burdens, and increase the availability of innovative insurance products. | <ul style="list-style-type: none"> • Create Health Help Agencies and ensure that participating insurers meet requirements related to solvency and financial standards, consumer protections, and establishment of wellness programs. • Implement mechanisms, such as automatic enrollment, to ensure maximum enrollment of individuals into private insurance. |
| Cost containment | <ul style="list-style-type: none"> • Encourage adoption and use of health information technology by providing incentives to hospitals and individual providers. Create personal health records maintained by an independent health record bank and available to the individual through a card, much like an ATM card. • Emphasize prevention by developing a national strategic prevention plan, creating a web-based prevention tool capable of producing personalized prevention plans, and implementing national science-based media campaigns on health promotion and disease prevention. • Reward seniors who adopt healthier behaviors with lower Medicare premiums. • Allow providers to form accountable care organizations and receive bonuses in Medicare if they improve quality and satisfaction while also lowering costs. • Adopt competitive bidding for private plans in Medicare. • Require higher income Medicare beneficiaries to pay more for Medicare Part B and Part D premiums. • Adopt medical malpractice reforms that create independent expert panels or state "health courts" or both to review cases and render decisions. Parties will still have access to state courts if not satisfied with decisions. | <ul style="list-style-type: none"> • Promote prevention by providing premium discounts (including for Medicare Part B premiums) for participation in approved wellness and chronic disease management programs. • Adopt payment policies that reward providers for achieving quality and cost efficiency in prevention, early detection of disease, and chronic care management. • Require insurers to create and implement electronic medical records for each covered individual. • Require insurers to adopt uniform billing and claims forms. • Encourage more rigorous study of new drugs and devices by granting additional exclusivity and patent protections to those subjected to comparative effectiveness reviews. Disallow tax deductions for pharmaceutical manufacturers for direct to consumer advertising for most new drugs. • Require insurers and providers to publicly report data on medical outcomes, health care quality and costs. • Provide bonuses to states that enact medical malpractice reforms. |
| Improving quality/health system performance | <ul style="list-style-type: none"> • Create a new Health Care Services Commission to establish uniform measures for reporting price and quality information. The HSC, managed by five commissioners from the private sector appointed by the President, will issue a report containing guidelines regulating the publication and dissemination of health care information and will be authorized to enforce these standards. | <ul style="list-style-type: none"> • Encourage chronic care programs • Require hospitals to demonstrate improvements in quality control, including rapid response teams, heart attack treatments, procedures that reduce medication errors, infection prevention, procedures that reduce the incidence of ventilator-related illnesses. • Provide enhanced Medicare payments to primary care providers and require Medicare to develop a chronic disease management program. • Establish a website for sharing evidence-based best practices and develop a program for incorporating these best practices into medical school curricula. • Provide for improvements in end-of-life care. |

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| Other investments | <ul style="list-style-type: none"> • Make changes to Medicaid long-term care services to provide states with a defined allotment for Medicaid long-term care services in exchange for having the Medicare program assume responsibility for the premiums, cost-sharing, and deductibles for low-income Medicare beneficiaries and ensure choice between institutionalized and home-based long-term care services. | <ul style="list-style-type: none"> • Provide grants to school districts and communities to increase access to school-based clinics. • Permit states to create State Choices for Long-term Care Programs through their Medicaid programs to provide institutional and home and community-based long-term care for eligible individuals. • Create new long-term care insurance plans that meet standards developed by NAIC or by federal regulations. |
| Financing | Not specified, but claims proposal is revenue and budget neutral. | <p>In 2008, CBO scored an amended version of the bill which is very similar to this year's version. In that CBO estimate, Federal costs would be offset by revenues and savings in first year of full implementation, Thereafter, the bill would be more than self-financing because of indexing growth in the value of the health insurance deduction and the subsidized benefits.</p> <p>Financing will come from combination of individual premiums, employer assessments, state and federal savings in Medicaid, elimination of most Medicare and Medicaid disproportionate share hospital (DSH) payments, and changes in tax treatment of insurance.</p> |
| Sources of information | http://coburn.senate.gov/public/index.cfm?FuseAction=HealthCareReform.Home&ContentRecord_id=5e3b30a4-802a-23ad-4b44-14f0219114c6 | http://wyden.senate.gov/issues/Legislation/Healthy_Americans_Act.cfm http://wyden.senate.gov/issues/Health_Care.cfm http://www.cbo.gov/ftpdocs/91xx/doc9184/05-01-HealthCare-Letter.pdf |

| | Rep. Pete Stark AmeriCare Health Care Act of 2009 (H.R. 193) | Rep. John Dingell National Health Insurance Act (H.R. 15) | Rep. John Conyers U.S. National Health Care Act (H.R. 676) |
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| Date plan announced | January 6, 2009 | January 6, 2009 (Has introduced similar legislation in each Congressional session since 1957) | January 26, 2009 |
| Overall approach to expanding access to coverage | Create a new public plan, modeled on Medicare, as default coverage for all Americans. Individuals in a qualified group plan or Medicare may opt out of AmeriCare. Require employers and individuals to contribute toward the cost of the plan, with federal premium subsidies available for individuals below 300% FPL. Use Medicare's administrative structure to govern the plan. Financed by premium contributions from employers and individuals, state maintenance of effort payments, and from general revenue. | Create a national health insurance program for individuals meeting eligibility requirements. Require states to administer the program and provide for equivalent care for "needy" individuals who do not meet eligibility requirements. A National Health Insurance Board determines allotments for the classes of covered services. Financed by a value-added tax imposed on certain transactions. | Create a public health insurance program for all U.S. residents. Replace employer coverage and eliminate the Medicare, Medicaid and CHIP programs. Individuals are not required to pay premiums or cost-sharing. Require conversion to a non-profit health care system. Provide for global budgets for hospitals and negotiate annual reimbursement rates with physicians and other non-institutional providers. Finance program by redirecting current federal and state health care spending, impose an employer/employee payroll tax, and leverage additional taxes. |
| Individual mandate | <ul style="list-style-type: none"> All U.S. residents are entitled to coverage under AmeriCare. Individuals may choose not to enroll in the AmeriCare plan if they have coverage under a group health plan. | <ul style="list-style-type: none"> Individuals meeting certain requirements are entitled to benefits under the National Health Insurance Program. | <ul style="list-style-type: none"> All individuals residing in the US are covered under the United States National Health Care Act (USNHC). |
| Employer requirements | <ul style="list-style-type: none"> Require employers to contribute at least 80% of the AmeriCare premiums for employees or at least 80% of the cost of the group plan if the employer provides qualifying employee coverage. Employers with fewer than 100 employees will be given an additional three years to come into compliance with this provision. A surcharge may be imposed on employers to prevent adverse selection. | No provision. | No provision. |

| | Rep. Pete Stark AmeriCare Health Care Act of 2009 (H.R. 193) | Rep. John Dingell National Health Insurance Act (H.R. 15) | Rep. John Conyers U.S. National Health Care Act (H.R. 676) |
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| Expansion of public programs | <ul style="list-style-type: none"> • Create a new public plan, modeled on Medicare, as default coverage for all Americans. • AmeriCare plan enrollees are subject to deductibles (\$350 individual/\$500 family) and coinsurance of 20% until limits on out-of-pocket (OOP) expenses are met. The OOP limits are \$2,500 per individual and \$4,000 per family. Deductibles and limits are indexed to inflation. • Prohibit coverage under state Medicaid and CHIP programs for benefits covered by AmeriCare plans. | <ul style="list-style-type: none"> • Create a new public plan, covering medical, dental, podiatric, home-nursing, hospital, and auxiliary services. A National Health Insurance Board, in consultation with a National Advisory Medical Council determines the scope of benefits consistent with the statute. • Continue Medicare, but enrollees may be transferred into the new program in the future. Medicare beneficiaries are covered under the new program for services that are not covered by Medicare. • Require states to provide equivalent services to those not eligible under the new plan. Current federal Medicaid funds and other federal funds provided to states under the Social Security Act are available for this purpose. | <ul style="list-style-type: none"> • Create a new public plan, the USNHC program, that provides coverage for a comprehensive set of benefits, including long-term care services, to all US residents. • Eliminate the Medicare, Medicaid, and CHIP programs as beneficiaries of these programs are eligible for the USNHC program. • VA health programs will remain independent for 10 years after which they will either remain independent or be integrated into the USNHC program. The Indian Health Service will remain independent for 5 years after which it will be integrated into the USNHC program. |
| Subsidies to individuals | <ul style="list-style-type: none"> • Low-income individuals (family income <200% FPL) are not required to pay premiums and are not subject to deductibles and co-insurance. • Provide premium subsidies and reduced deductibles for individuals with family incomes between 200% and 300% FPL. • Limit OOP costs for deductibles and coinsurance to 5% of income for those between 200 and 300% FPL, and 7.5% of income for those between 300 and 500% FPL. • No deductibles and coinsurance for pregnancy-related services and covered benefits provided to children (up to age 24). | <ul style="list-style-type: none"> • Individuals are not required to pay premiums to obtain coverage. | <ul style="list-style-type: none"> • Individuals are not required to pay premiums to obtain coverage nor are they charged copayments or coinsurance for covered benefits. |
| Subsidies to employers | No provision. | No provision. | No provision. |
| Tax changes related to health insurance | <ul style="list-style-type: none"> • Individual premium payments for AmeriCare coverage are considered a tax and subject to withholding. | No provision. | No provision. |
| Creation of insurance pooling mechanisms | No provision other than pooling achieved through AmeriCare. | No provision other than pooling achieved through new public program. | No provision other than pooling achieved through USNHC. |

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| Benefit design | <ul style="list-style-type: none"> • Provide the same benefits available through Medicare, with the addition of benefits, such as well-child visits, early and periodic screening, diagnostic, and treatment (EPSDT) services for children, prenatal and obstetric care, and family planning services to reflect the needs of a younger population. | <ul style="list-style-type: none"> • Provide the following classes of personal health services: <ul style="list-style-type: none"> – Medical services including primary and specialty care; – Dental services; – Podiatric services; – Home-nursing services; – Hospital services, for a maximum of 60 days in a benefit year; – Auxiliary services including diagnostic laboratory services, X-ray and related therapy, physiotherapy, optometry services, prescription drugs, and eyeglasses. | <ul style="list-style-type: none"> • Provide coverage for all medically necessary services, including primary care and prevention; inpatient care; outpatient care; emergency care; prescription drugs; durable medical equipment; long-term care; palliative care; mental health services; dental services; chiropractic services; basic vision correction; hearing services; and podiatric care. |
| Changes to private insurance | <ul style="list-style-type: none"> • Allow AmeriCare supplemental policies to be offered that meet minimum federal standards, including standardized benefits, limitations on sales commissions, and the following: <ul style="list-style-type: none"> • Require insurers that offer AmeriCare supplemental policies to do so on a guarantee issue and renewability basis and prohibit them from charging higher premiums based on health status. • Require insurers offering AmeriCare supplemental policies to meet minimum medical loss ratios (85% for group policies; 75% for individual policies). | No provision. | <ul style="list-style-type: none"> • Prohibit insurers from duplicating USNHC benefits but they may offer coverage for benefits not covered by the USNHC program. |
| State role | <ul style="list-style-type: none"> • Require states to make maintenance of effort payments in the amount of the state share of Medicaid and CHIP spending for benefits replaced by the AmeriCare plan. • Allow states to impose more stringent requirements on entities offering AmeriCare supplemental policies than specified by the Secretary. | <ul style="list-style-type: none"> • Assume responsibility for administration of the program. States must submit a state plan of operations that designates a state agency for administering the program benefits; creates, among other things, an advisory committee; establishes local health service areas to further decentralize program administration; and provides a plan for ensuring that benefits will be provided efficiently and to all areas of the state. | No provision. |

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| Cost containment | <ul style="list-style-type: none"> • Generally apply Medicare payment mechanisms, adjusted to reflect the AmeriCare population. • Limit payments to private plans offered through AmeriCare (similar to Medicare Advantage) to average per capita costs under AmeriCare. • Require AmeriCare to develop a fee schedule for outpatient drugs and biologics, to negotiate directly with drug companies for the purchase price of those drugs and biologics, and to encourage greater use of generics and lower cost alternatives. • Require AmeriCare contractors to submit electronic claims. • Apply Medicare provisions relating to fraud and abuse and administrative simplification to AmeriCare plans. | <ul style="list-style-type: none"> • Require the National Health Insurance Board to establish allotments for each of five classes of services to be provided under the program (medical services, dental services, home-nursing services, hospital services, and auxiliary services). Allotments are made to the states based on population, medical professionals and facilities, and cost of services. • Require a study of cost control mechanisms, including an analysis of the impact on medical malpractice claims and liability insurance on health care costs. | <ul style="list-style-type: none"> • Establish annual budgets for health care professional staffing, capital expenditures, reimbursement for providers, and health professional education. • Pay institutional providers, including hospitals, nursing homes, community or migrant health centers, home care agencies, and other institutional and prepaid group practices, a monthly lump sum to cover operating expenses. • Pay physicians and other non-institutional providers based on a simplified fee scheduled or as a salaried employee in an institution receiving a global budget or in a group practice or HMO receiving capitation payments. • Establish a uniform electronic billing system and create an electronic patient record system. • Allow only public or not-for-profit institutions to participate in USNHC. Private physicians, clinics, and other participating providers may not be investor owned. • Require USNHC program to negotiate annually prices for drugs, medical supplies, and assistive equipment. • Establish a prescription drug formulary that encourages best practices in prescribing and promotes use of generics and other lower cost alternatives. |
| Improving quality/health system performance | <ul style="list-style-type: none"> • Apply Medicare provisions relating to outcomes research and quality to AmeriCare. | <ul style="list-style-type: none"> • Require state and local administration to: <ul style="list-style-type: none"> – Promote coordination among providers, between providers and public health centers and educational and research institutions. – Emphasize prevention of disease, disability, and premature death. – Insure the provision of efficient, high quality services. | <ul style="list-style-type: none"> • Require participating providers to meet state quality and licensing guidelines. • Create a National Board of Universal Quality and Access to address issues, such as access to care, quality improvement, administrative efficiency, budget adequacy, reimbursement levels, capital needs, long term care, and staffing levels. • Establish a universal standard of care relating to appropriate staffing levels; appropriate medical technology; scope of work in the workplace; best practices; salary levels for medical professional and support staff. |

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| Other investments | No provision. | <ul style="list-style-type: none"> • Provide grants for training and education of professional and technical personnel needed to provide or administer benefits. Makes available \$5 million in 2010 and 2011; and up to one half of one percent of benefit payments annually thereafter. | <ul style="list-style-type: none"> • Establish regional budgets to cover the full array of long-term care services covered by the USNHC program. • Establish a USNHC Employment Transition Fund to assist people who lose their jobs as a result of the transition to the new national system. • Create a mechanism to facilitate the conversion of for-profit providers of care to not-for-profit status and provide compensation for the financial losses associated with the conversion. |
| Financing | Plan will be financed through an AmeriCare Trust Fund. The trust fund will be financed with employer and individual premium payments, state maintenance of effort payments, and general revenue for premium subsidies. | Program will be financed through a National Health Care Trust Fund. The trust fund will be funded with a value-added tax of 5 percent imposed on certain transactions. | The USNHC program will be funded through the USNHC Trust Fund. Funding for the Trust Fund will come from redirecting existing federal payments for health care; increasing the income tax for the top 5% of earners, instituting a modest and progressive payroll tax, and imposing a tax on stock and bond transactions. |
| Sources of information | http://www.stark.house.gov/index.php?option=com_content&task=view&id=1081&Itemid=103 http://www.stark.house.gov/index.php?option=com_content&task=view&id=1238&Itemid=84 | http://www.house.gov/dingell/issue_healthcare.shtml | http://conyers.house.gov/index.cfm?FuseAction=Issues.Home&Issue_id=063b74a4-19b9-b4b1-126b-f67f60e05f8c |

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