

Comparison of Health Reform Proposals

	Obama Campaign Plan	Baucus White Paper	Wyden Healthy Americans Act (110 th Congress)	Durbin-Kind SHOP Act (110 th Congress)
Insurance Market Reforms	<p>Access: All coverage would be guaranteed-issue.</p> <p>Rating: In markets where the insurance business is not competitive, insurers will be required to meet minimum loss ratio requirements.</p> <p>Other: Young adults up to age 25 would be allowed to continue coverage through their parents' plans.</p>	<p>Access: All coverage would be guaranteed-issue</p> <p>Rating: Rules for rating would be specified in statute after consultation with the NAIC, consumer advocates, plans, and others. Use of health status would be prohibited and age rating would be limited. Rules would be national and would apply inside and outside of the Exchange (see below).</p> <p>Other: A new Independent Coverage Council would set standards in a broad range of areas, including:</p> <ul style="list-style-type: none"> • Mandated benefits • Out-of-pocket limits based upon income • Chronic care management • Quality reporting 	<p>Access: All coverage would be guaranteed-issue</p> <p>Rating: States would set their own rules within the parameters set by the legislation:</p> <ul style="list-style-type: none"> • Age, health status, and industry may not be used in setting premiums. • States may permit variation based on geography, smoking status and family size • States must allow insurers to offer premium discounts and other incentives to individuals based upon participation in wellness, chronic disease management, and other programs designed to improve the health of enrollees. <p>Other: Phases out all group health insurance. All coverage would be sold on a non-group basis through state Health Help Agencies</p>	<p>Rating: In the 3rd year after enactment, rating based upon health status would be prohibited nationwide in the small group market. The NAIC would develop rating rules that would apply within the SHOP program. The NAIC would also specify the maximum permissible variance between state rating rules and SHOP rating rules. These rules would take effect in the 5th year after enactment.</p>
Individual Mandate	Requires coverage of all children. Enforcement is not specified.	Proposes an individual mandate to purchase health insurance once "affordable, high-quality, and meaningful health insurance options are available to	All adults and children must be enrolled in a Healthy Americans Private Insurance plan. Uninsured individuals who receive care in emergency departments will be	

		<p>all Americans.”</p> <p>Enforcement: Through the tax code or other point of contact between individuals and the government.</p> <p>Minimum Standards: To be determined by new Independent Health Coverage Council.</p> <p>Affordability Standards: To be determined by new Independent Health Coverage Council.</p> <p>Exemptions: None specified.</p>	<p>automatically enrolled in a plan.</p> <p>Enforcement: A financial penalty of 115% of the average premium for an individual in the person’s coverage class and area.</p> <p>Exemptions: Waivers will be granted to those who are opposed to purchasing insurance for religious reasons. Penalties may be waived in the case of economic hardship.</p>	
Employer Mandate	Employers that do not offer meaningful coverage or make a meaningful contribution to the cost of quality health coverage will be required to contribute a percentage of payroll toward the costs of the national plan. Small businesses will be exempt from the mandate.	<p>Small, mid-size and large businesses would be required to make a contribution to their employees’ health coverage or pay an assessment into a fund to provide care for the uninsured. Required contributions would be calculated as a percentage of payroll and would be based upon firm size and annual earnings.</p> <p>All but the smallest firms would be required to offer Section 125 “cafeteria” plans.</p>	Every employer must make a payment equal to a percentage of the average HAPI plan cost for each employee. The percentage is determined by size and revenue and ranges from 2% for the smallest, lowest earning employers to 25% for the largest, most lucrative employers.	
Purchasing Arrangements	<p><u>National Health Insurance Exchange</u></p> <p>Markets Included: Individual</p> <p>Role of Exchange: To act as a watchdog and help reform the private insurance market by creating rules and standards for participating plans. The Exchange would</p>	<p><u>Health Insurance Exchange</u></p> <p>Markets Included: Individual and small group</p> <p>Role of Exchange: To organize affordable insurance options, create understandable, comparable information about those options, and develop a standard</p>	<p><u>State Health Help Agencies</u></p> <p>Markets Included: The group market would be phased-out and all policies would be individual.</p> <p>Role of Agency: To oversee enrollment in Healthy Americans Private Insurance (HAPI) plans by: providing standardized information on plans, administering open</p>	<p><u>Small Business Health Options Program (SHOP)</u></p> <p>Markets Included: Small group (up to 100 employees) and self-employed</p> <p>Role of SHOP: To contract with insurers to provide coverage to small businesses and self-employed individuals, to facilitate enrollment of businesses and individuals,</p>

	<p>evaluate plans and make the differences among the plans, including the cost of services, transparent.</p> <p>Product Offerings: All plans would be required to be at least as generous as the new public plan and meet the same standards for quality and efficiency.</p> <p>Plan rating: Use of health status in setting premiums would be prohibited. Insurers would be required to justify an above average premium increase to the Exchange.</p>	<p>application for enrollment in a chosen plan.</p> <p>Geographic Scope of Plans: Plans could operate nationally, regionally, statewide, or locally.</p> <p>Product Offerings: Plans would be required to offer products that could be classified as high-, medium-, or low-benefit options. All plans would have to be actuarially equivalent within benefit categories.</p> <p>Plan rating: Differences in premiums would be due to the difference in benefits and not the differences in expected risk. Participating insurers would have to charge the same price for the same products inside and outside the Exchange.</p>	<p>enrollment periods and plan choice changes, establishing a default enrollment process, ensuring enrollment of all individuals, developing standardized language for plan terms and conditions, determine and administer subsidies, and collect premium payments.</p> <p>Geographic Scope of Plans: Plans would be sold on a statewide basis. States that share one or more metropolitan statistical areas may enter into agreements to share responsibilities for administration.</p> <p>Product Offerings: At least two plans that meet the requirements of the Act must be offered in each state. These may be:</p> <ul style="list-style-type: none"> • Plans similar to the FEHBP BCBS Standard Plan • Plans with additional benefits as long as the benefits are priced and displayed separately • Plans that are actuarially equivalent to the standard plan <p>All plans must make available supplemental coverage for abortion services</p> <p>Plan Rating: States may permit variation in premiums due to geography, smoking status, and family size. States shall also permit premium discounts and other incentives based on participation in wellness, chronic disease management, or other programs designed to improve the health of participants.</p>	<p>collect and distribute premiums, compile, produce and distribute information, consider benefit recommendations of the Small Business Health Board, administer a risk adjustment fund.</p> <p>Geographic Scope of Plans: Plans could operate on a statewide or nationwide basis.</p> <p>Product Offerings: Statewide plans would follow state mandated-benefit laws. Nationwide plans would be required to meet minimum benefit requirements to be determined by the Institute of Medicine.</p> <p>Plan Rating: Initially (3rd year after enactment), plans would follow state rating rules, which would no longer include health status rating. Meanwhile the NAIC would develop rating rules for SHOP, which would be voted on by Congress. After approval, these rules would take effect in the 5th year after enactment. Should Congress fail to adopt rating rules, fallback rules would take</p>
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		<p>Risk-adjustment: The Exchange would have authority to implement a risk-adjustment mechanism.</p>		<p>effect. Self-employed individuals in states that do not include them in the small group market and who fail to enroll in their first year of eligibility will be charged an additional premium. Individual Choice: Within SHOP, individual employees will be allowed to choose their own health plan in any state in which rating is not permitted based upon health status and state rating rules allow a maximum age rating variation of 3:1 or less. Risk-adjustment: In the first 3 years after SHOP begins selling plans, if a plan's medical costs exceed 103% of their expected medical costs, the plan will be reimbursed for a portion of their losses. If the plan's costs are below 97% of their expected medical costs, it will be required to pay a portion of their savings to the risk adjustment fund.</p>
<p>Public Plan</p>	<p>A new public plan that will be similar to the FEHBP</p> <p>Eligibility: Americans who neither qualify for Medicaid or SCHIP nor have access to insurance through their employers, as well as to small businesses.</p>	<p>A public plan option, similar to Medicare, would be offered through the Exchange. It would follow the same rules as private plans.</p> <p>Eligibility: To be determined.</p> <p>Provider Payment: Provider payment rates would be determined by "balancing the goals of increasing competition and ensuring access for patients to high-quality health care."</p>		

<p>Subsidies</p>	<p>Small Business Tax Credit: A credit for small businesses who offer a quality health plan to all their employees, and cover a meaningful share of the cost of employee health premiums. The credit will be refundable, and will cover up to 50% of the premiums paid by the small business.</p> <p>Premium Subsidies: Individuals and families who do not qualify for Medicaid or SCHIP but still need assistance will receive income-related federal subsidies. They can use the subsidy to buy into the new public plan or purchase a private plan.</p>	<p>Small Business Tax Credit: A credit for small businesses purchasing coverage would be initially available only in states with tight rating rules. It would then become available for coverage purchased through the Exchange for small businesses making a meaningful contribution to the cost of coverage. The size of the credit would be based upon firm size and earnings, with the smallest firms receiving a credit of 50% of the average total premium in the state.</p> <p>Premium Subsidies: Premium subsidies would be available for individuals and families below 400% FPL purchasing coverage through the Exchange. The subsidies would make up the difference between a geographically adjusted average premium and an affordability standard to</p>	<p>Premium Subsidies: Individuals and families with income up to 100% FPL will be eligible for a full subsidy. Subsidies will phase out from 100% to 400% FPL.</p>	<p>Small Business Tax Credit: A credit for small businesses and self-employed individuals purchasing coverage within the SHOP program would be based upon number of employees and dependents covered and size of the employer's contribution. The credit would also be available to businesses and self-employed individuals purchasing coverage in the small group market if the state meets the following requirements:</p> <p>1st & 2nd years after enactment:</p> <ul style="list-style-type: none"> • Self-employed included in small group market • Rating on health status prohibited • Rating varies by age (3:1 max), industry (1.15:1 max), geography, family composition, and tobacco <p>3rd & 4th years after enactment:</p> <ul style="list-style-type: none"> • All above requirements • State has established a statewide purchasing pool <p>5th year and following:</p> <ul style="list-style-type: none"> • Self employed included in small group market • Rating rules at least as tight as SHOP's • State has established a statewide purchasing pool
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	<p>Reinsurance: Reimburse employer plans for a portion of catastrophic costs they incur above a threshold if they guarantee such savings will be used to reduce the cost of workers' premiums.</p>	<p>be determined by the Independent Health Coverage Council.</p>	<p>Personal Responsibility Contribution Subsidies: Individuals up to 100% FPL will be eligible for a subsidy equal to the full amount of any personal responsibility contributions. Those above 100% FPL may be eligible for a partial subsidy.</p>	
<p>Role of State Regulators:</p>	<p>State Flexibility: Allows states to continue to experiment with reforms, provided they meet the minimum standards of the national plan.</p>	<p>Exchange Plans: Plans participating in the Exchange would be subject to state oversight with regard to consumer protections (e.g. grievance procedures, external review, oversight of agents, market conduct). Plans would be subject to state regulation related to solvency, reserve requirements, and premium taxes.</p>	<p>HAPI Plans: States must designate or create a Health Help Agency (HHA), ensure HAPI plans are sold through the HHA, develop enrollment and premium collection mechanisms, enforce individual mandate and implement auto-enrollment for those who are not covered and seek care in emergency rooms. States will continue to apply consumer protection and licensure laws.</p> <p>State Flexibility: States may be granted waivers to provide health coverage that is at least as comprehensive as what is required under HAPI plans.</p>	<p>SHOP Plans: States may enforce SHOP rating and mandated benefit requirements that supersede state law.</p> <p>State Flexibility: States may prohibit small group carriers from participating in SHOP if they include self-employed individuals in their small group markets and have in effect small group rating rules that are at least as stringent as those for the SHOP program.</p>
<p>Medicaid</p>	<p>Eligibility: Would expand eligibility.</p>	<p>Eligibility: Would extend Medicaid eligibility to everyone below 100% FPL. Would eliminate the waiting period for legal immigrants.</p> <p>FMAP Payments: Would increase FMAP</p>	<p>Medicaid enrollees would be transitioned into HAPI plans.</p>	

		payments during economic downturns. Enrollment: Would implement uniform and simplified verification and renewal rules.		
SCHIP	Eligibility: Would expand eligibility.	Funding: Would provide additional funds to states for expanded enrollment. Eligibility: Would eliminate the waiting period for legal immigrants.	SCHIP enrollees would be transitioned into HAPI plans.	
Medicare	<p>Medicare Advantage: Eliminate overpayments for MA plans.</p> <p>Prescription Drug Pricing: Repeal ban on direct negotiation with drug companies in Medicare Part D.</p> <p>Provider Payments: Accelerate efforts to develop and disseminate best practices and align reimbursement with provision of high quality health care. Rewards for</p>	<p>Early Retirees: Would allow 55-64 year-olds to buy-in to Medicare until affordable coverage is available under the Exchange. Once this coverage is available, Medicare-enrolled early retirees could choose whether to remain in Medicare or purchase coverage through the Exchange.</p> <p>Medicare Advantage: Would eliminate overpayments for MA plans. Plan payments should reflect plan performance.</p> <p>Prescription Drug Pricing: Extend Medicaid pricing to dual-eligibles in prescription drug plans.</p> <p>Disabled Individuals: Would phase out the 24 month waiting period prior to enrolling in Medicare.</p> <p>Provider Payments: Replace the Sustainable Growth Rate (SGR) formula with a more feasible method of determining provider payments.</p>	<p>Prescription Drug Pricing: Repeals ban on direct negotiation with drug companies in Medicare Part D. Specifies that no uniform formulary or price setting is permitted.</p> <p>Prescription Drug Coverage Gap: Requires Part D plans to allow enrollees to switch to a plan that has no coverage gap when they reach the coverage gap in the plan in which they are currently enrolled.</p>	

	meeting performance thresholds on physician-validated outcome measures.	Bundled Payments: Develop and test other payment models using bundled or global payments for all services provided during hospitalization and for some period of time after discharge.		
Safety Net		RightChoices Program Temporary program would give the uninsured access to preventive services, such as health risk assessments, physical exams, immunizations, and cancer screenings. Common, costly conditions identified at screenings would be treated for individuals who are not Medicare- or Medicaid-eligible. Program would be eliminated when affordable coverage is available through the Exchange.		
Cost Containment	<p>Disease Management: Plans participating in the new public plan, Medicare, or the FEHBP will be required to utilize disease management programs.</p> <p>Cost Disclosure: Hospitals and providers will be required to collect and report cost data. Health plans will be required to report medical loss ratios.</p> <p>Medical Malpractice: Strengthen antitrust laws to prevent insurers from overcharging physicians for their malpractice insurance. Promote new models for addressing physician errors.</p>	<p>Medical Malpractice: Provide grants to states to create alternatives to current tort litigation. States would have flexibility in developing alternatives to civil litigation, with three specific models outlined:</p> <ul style="list-style-type: none"> • Early disclosure and compensation • Administrative determination of compensation • Health courts 	<p>Medical Malpractice: Provides funds to states that:</p> <ul style="list-style-type: none"> • Requires review of malpractice claims by a panel prior to filing; • Permit voluntary non-binding mediation; • Impose sanctions against plaintiff's attorneys who file frivolous lawsuits; <p>or</p>	

		<p>Physician-Industry Relationships: Require disclosure of gifts made by drug and device companies to physicians and other health care professionals.</p> <p>Physician Self-Referral: Increase disclosure of physician’s financial interests in hospitals.</p>	<ul style="list-style-type: none"> Prohibit attorneys who file 3 or more frivolous medical malpractice suits from filing cases for 10 years 	
Quality Improvement	<p>Cost and quality reporting: Hospitals and providers will be required to collect and publicly report health care cost and quality measures.</p> <p>Patient-Centered Medical Home: Support providers to put in place care management programs and encourage team care through implementation of medical home type models.</p> <p>Comparative Effectiveness: Establish an independent institute to guide reviews and research on comparative effectiveness.</p>	<p>Pay-for Performance: Phase-in value based purchasing in Medicare for hospitals, building upon the current hospital quality reporting program. Improve physician reporting by penalizing physicians who fail to participate in the Physician Quality Reporting Initiative.</p> <p>Patient-Centered Medical Home: Expand the medical home model by requiring collaboration between Medicare and ongoing demonstration sites in order to align incentives provided by the disparate models. Test other primary care models that promote comprehensive care management and coordination.</p> <p>Care Coordination: Use payment incentives to drive more collaboration among physicians, hospitals, and other providers.</p>		
Prevention and Wellness		<p>Coverage of Prevention: Eliminate co-payments for recommended preventive services under Medicare, Medicaid, and</p>		

		<p>SCHIP</p> <p>State and Local Wellness Promotion: Provide grants to states to implement wellness and prevention programs at the local level. Provide subsidies to small businesses for wellness programs.</p>		
Long-Term Care			<p>Requests the NAIC to develop a model limiting packages of benefits that may be offered in long-term care insurance policies and prescribing uniform language and definitions and a uniform policy format. Would limit the number of benefit packages to 10. Adds additional consumer protections from NAIC models.</p>	
Tax Policy		<p>Employer-Sponsored Coverage: Consider reforming the tax treatment of health benefits to reduce the distortions these subsidies create in the marketplace.</p>	<p>Employer Contributions: Employer payments will not be considered taxable income to employees.</p> <p>Health Care Standard Deduction: Individuals will be able to claim a standard deduction, which increases with family size. It phases in from 100%-400% FPL and phases out beginning at \$62,500 for a single filer and \$125,000 for a joint return. It is fully phased out at \$125,000 for a single filer and \$250,000 for a joint return.</p>	