

SELECTED NATIONAL COVERAGE INITIATIVES

	Federation of American Hospitals	President-Elect Barack Obama	Senator Max Baucus (D-MT)	S. 334 (Senator Ron Wyden, D-OR)*
General Approach	Requires all individuals to have health insurance. Builds on existing employer coverage and reforms individual insurance market. Subsidies to help individuals meet insurance mandate. Public program expansion for indigent adults and children.	Requires all children to have health insurance. Builds on existing employer coverage. Creates a new public program with coverage similar to the federal employee plan and expands Medicaid and SCHIP. Creates a National Health Insurance Exchange through which individuals and small businesses could purchase the new public plan or private coverage, with subsidies available. Requires larger employers to provide coverage or contribute to new public program. Offers tax credits to small business and, to all firms, subsidies for catastrophic costs.	Requires all individuals to have health insurance. Builds on existing employer coverage. Creates a Health Insurance Exchange through which individuals and small businesses could purchase a new Medicare-like public plan or private coverage, with subsidies available. Expands Medicaid and SCHIP and offers temporary Medicare buy-in for pre-Medicare population. Requires larger employers to provide coverage or contribute to new public program, offers employer subsidies based on firm size and income.	Requires all Americans to purchase private coverage, with subsidies available. Ends most employer-based coverage and Medicaid and SCHIP.
Status	Announced February 22, 2007.	Announced May 29, 2007.	Announced November 12, 2008.	Introduced January 18, 2007; referred to Senate Finance Committee.*

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Individual mandate	All legal residents must have coverage.	All children required to have health insurance.	All individuals must have health insurance. Penalty may be enforced through the tax system or another point of contact between individuals and the government.	All citizens over age 19 must enroll along with dependent children. Imposes penalty for not enrolling equal to the amount of the average premium for each uncovered month plus 15%.
Employer mandate	None. However, to qualify for the “Health Coverage Passport” (HCP) subsidy, there is a maintenance of effort requirement for employers to increase payments per employee by at least the Consumer Price Index plus 1.25 percentage points annually.	Larger employers must offer or contribute to coverage or pay a percentage of payroll to help pay for the new national public program. Small businesses exempt.	Large employers would have to offer coverage or contribute to a fund to cover the uninsured. Contribution would likely be based on a percentage of payroll taking into account firm size and revenue. Contributions required for small and mid-sized firms would be less than for larger firms. All but the smallest employers must offer a Section 125 plan to allow employees to pay premiums with pre-tax dollars.	Employers must 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%.

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Public program expansion	Medicaid for adults <100% of FPL; funding for all SCHIP eligible children.	Medicaid and SCHIP to be expanded. Creates a new national public program with coverage similar to that available to federal employees. Open to individuals without access to group coverage and to self-employed and small businesses. Coverage guaranteed regardless of illness or pre-existing conditions. Simplified administrative and enrollment processes to be used.	Medicaid coverage expanded to everyone under 100% of the FPL and SCHIP to cover all children up to 250% of FPL; states could continue existing coverage above 250%. Suggests enhanced federal match may be provided. Offers immediately an option for 55-64 year olds without access to group coverage to buy into Medicare; enrollee premiums would fully fund the buy-in. Provision would expire once the Health Insurance Exchange was established. New public plan option offered through the Health Insurance Exchange. Similar to Medicare, but provider payments could differ. The 2-year waiting	Terminates SCHIP and maintains only a residual Medicaid program to provide benefits that are not covered under a private plan. Children without private coverage must be enrolled in a private plan through a new Healthy Start program.

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			<p>period for Social Security disability beneficiaries to enroll in Medicare would be phased out.</p> <p>Creates temporary RightChoices program to provide prevention services and treatment referral to the uninsured. Free treatment for those under 200% of FPL.</p>	
Subsidy (tax credit/ Medicaid etc.)	<p>HCP sliding scale subsidy credit up to 400% of FPL for those not eligible for Medicaid or SCHIP. Individuals and families with incomes at or below 150% of FPL receive full premium subsidy. New tax deduction for individual insurance premiums not tied to income.</p>	<p>Income-related subsidies available to individuals purchasing public or private coverage through the new National Health Insurance Exchange.</p> <p>Government will reimburse employers for some of the catastrophic costs incurred above a threshold if savings are used to reduce workers' premiums.</p> <p>Refundable tax credit to</p>	<p>Premium subsidies available to individuals and families up to 400% of FPL who purchase coverage through the Health Insurance Exchange. Amount of subsidy to be determined by a new Independent Health Coverage Council (see Benefits discussion below.)</p> <p>Small business tax credit would vary by firm size and per employee earnings, up</p>	<p>Individuals and families with incomes at or below 100% of FPL receive full premium subsidy. For those between 100% and 400% of FPL, premium subsidies are provided on a sliding scale. Premium subsidies tied to lowest cost plan in an area.</p> <p>Eliminates the current tax exclusion for employer-paid health insurance and creates a new health care</p>

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		small businesses equal to up to 50% of premiums paid on behalf of employees. Must cover quality health plan and pay a meaningful share of the premium.	to 50% of the average employer premium in the state. Initially available in states that provide for certain insurance rating rules; available to all firms that purchase coverage through the Exchange once it is in place.	standard deduction for those with incomes >100% of FPL, indexed to general price inflation.
Benefits	For HCP subsidy, in general, minimum actuarial value set at SCHIP benchmark (e.g., FEHBP Blue Cross Standard plan) and maintenance of effort required for current employer plans. For tax deduction, 85% of SCHIP benchmark actuarial value.	Benefits under the new public plan to be similar to FEHBP.	Benefits for plans offered through the Exchange to be determined by a new Independent Health Coverage Council, appointed by President with Senate confirmation, for set, staggered terms. Council would determine benefits and subsidy levels. Benefits would be determined for low, medium and high-benefit options to be offered through the Exchange. Insurers could offer actuarially equivalent	Minimum value of benefits initially set to equal the value of the FEHBP Blue Cross Standard plan offered in 2011, then indexed to growth in per capita GDP. Plans with additional benefits priced separately.

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			packages within benefit categories.	
Private insurance reforms	Require health plans to guarantee issue at community rates. Discounts available for health behaviors such as smoking cessation and exercise.	A new National Health Insurance Exchange to create rules and standards for participating private plans, including requirements for guaranteed issue and benefits that are at least as generous as new public plan. Premiums may not depend on health status. Quality and efficiency requirements for the new public program to apply to private plans as well those offered through the Exchange. Participating insurers must justify an above-average premium increase, and are required to disclose loss ratios. In insurance markets that are not competitive, minimum loss ratios required. The Exchange would evaluate plans and	Insurers must meet requirements to offer coverage through the Exchange, and the same price must be charged for the same products inside and outside the exchange. Guaranteed issue and prohibition on discrimination based on pre-existing conditions. Rating rules will be specified in statute and age rating would be limited. Rating rules to apply inside and outside the Exchange.	Requires community rating or adjusted community rating based on geography, smoking status, and family size. Products must be guaranteed issue and renewable. Premium discounts for participation in wellness programs, & chronic disease management.

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		<p>make differences transparent.</p> <p>Children up to age 25 permitted to continue coverage under their parents' plans.</p>		
Coverage of undocumented immigrants	Increases funds for emergency care of undocumented immigrants.	No provision.	Eliminates 5-year waiting period for Medicaid coverage of income-eligible legal immigrants.	No subsidies for adult illegal immigrants. Visa for legal residents would be revoked if premiums or penalties not paid.
Cost	When fully implemented in 2010, estimated federal cost of \$131 billion with state and local savings of \$18 billion. Savings to families of \$35 billion and cost to employers of \$5 billion.	Obama campaign estimates federal cost of \$50 - \$65 billion a year when fully implemented. Savings to typical family up to \$2,500 a year.	Not available. States that initial investment would be required for some provisions, but that policies are designed so that after 10 years, national health expenditures would not be increased.	Federal costs offset by revenues and savings in 2014, first year of full implementation, in preliminary estimate by the Congressional Budget Office. After 2014, would be more than self-financing because of indexing growth in the value of the health insurance deduction and the subsidized benefits.

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Financing	Not specified.	Allow tax cuts for those making more than \$250,000 a year to expire, and retain estate tax at 2009 level. Small business tax credit financed by savings from generic biologic drugs and reduced DSH payments.	Not specified. Considering cap on exclusion of employer-paid health insurance premiums for income and payroll tax purposes.	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.
Other hospital-related provisions	None.	Hospitals and providers participating in the new public plan must collect and report data to ensure that program requirements regarding quality, health information technology and administration are met. Hospitals and other providers to collect and publicly report data on costs and quality including preventable medical errors, nurse staffing ratios, hospital acquired infections, disparities in care, and	Establishes a value-based purchasing program for Medicare inpatient hospital payments. Reduces payments to hospitals with readmission rates above a benchmark and provides confidential feedback to hospitals and physicians on readmissions. Tests new models for bundling payments, gainsharing, and accountable care organizations.	Hospitals must have rapid response teams; heart attack treatment plans; medication error reduction programs; infection prevention; and prevention of ventilator-related illnesses. Hospitals must seek to document patient end of life care preferences.

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		<p>costs.</p> <p>Changes to antitrust laws to prevent overcharging by malpractice insurers, and new models for addressing medical errors that reduce the need for malpractice suits.</p> <p>\$10 billion would be invested annually for five years to promote broad adoption of standards-based electronic health information systems.</p> <p>Independent institute would be established to guide reviews and research on comparative effectiveness.</p>	<p>Provides financial incentives for adoption of health information technology, sets a deadline for interoperability standards, and promotes technical assistance and information sharing among providers.</p> <p>Increased accountability for how medical education payments are spent and reexamination of payment levels.</p> <p>Scrutiny on physician self-referral, including specialty hospitals.</p> <p>Grants to states for alternatives to malpractice litigation.</p> <p>Creates independent institute to conduct comparative effectiveness research.</p>	

*Reflects modifications to original bill as described by the Congressional Budget Office analysis of May 1, 2008.

<http://www.cbo.gov/doc.cfm?index=9184>

Sources: <http://origin.barackobama.com/issues/healthcare/> Accessed September 25, 2008

Obama press statement, “Senator Barack Obama Announces Plan to Provide a New Health Care Tax Credit for Small Businesses,” July 2008.

Senator Max Baucus, *Call to Action Health Reform 2009*, November 12, 2008.