

## SELECTED NATIONAL COVERAGE INITIATIVES

	<b>America's Health Insurance Plans</b>	<b>Federation of American Hospitals</b>	<b>Health Coverage Coalition for the Uninsured</b>	<b>Former Senator John Edwards (D-NC)</b>	<b>S. 334 (Senator Ron Wyden, D-OR)</b>
<b>General Approach</b>	Combination of public program expansions, tax changes to support purchase of private insurance and state grants to promote coverage of all children and adults in the state within 10 years.	Subsidies to help individuals meet insurance mandate; build on employer-based system and reform individual insurance market; public program expansion for indigent adults and children.	Public program expansions and tax subsidies for private coverage, with "Kids First" as Phase I.	Requires employers to contribute to employee coverage, provides new tax credits, expands public programs, reforms insurance laws, creates purchasing pools (regional Health Markets), and eventually requires all individuals to have coverage.	Requires all Americans to purchase private coverage. Ends most employer-based coverage and Medicaid and SCHIP.
<b>Status</b>	Proposal announced on November 13, 2006	Announced February 22, 2007.	Announced January 18, 2007.	Announced February 5, 2007.	Introduced January 18, 2007; referred to Senate Finance Committee.
<b>Target population</b>	Uninsured individuals with a priority for children in low-income families and low-income adults.	All uninsured Americans.	Children (Phase I) and adults (Phase II).	All uninsured Americans.	All uninsured Americans.

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<b>Individual mandate</b>	No individual mandate. However, under the state performance grant program, states permitted to impose a coverage mandate on individuals and their dependent children.	All legal residents must have coverage.	None.	Once other reforms are in place, all Americans will be required to obtain health coverage. Special exemptions in the case of extreme financial hardship or religious beliefs.	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%.
<b>Employer mandate</b>	No employer mandate. However, under the state performance grant program, states permitted to require employers to offer and contribute to the costs of coverage.	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.	None.	Employers must provide comprehensive coverage or contribute to cost of coverage through new purchasing pools called Health Markets.	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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<b>Public program expansion</b>	Expand SCHIP to cover all uninsured children in families with annual incomes <200% of FPL. Expand Medicaid to cover all adults with incomes <100% of FPL.	Medicaid for adults <100% of FPL; funding for all SCHIP eligible children.	Phase I funding to enroll all children eligible for Medicaid and SCHIP. Phase II expands Medicaid to adults <100% of FPL.	Expand Medicaid and SCHIP to serve all adults <100% of FPL and all children and parents <250% of FPL.	Terminates SCHIP and maintains only a residual Medicaid program for wrap-around 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.
<b>Subsidy (tax credit/ Medicaid etc.)</b>	A new child health tax credit equal to \$200 per child with a family maximum of \$500 for families with incomes <300% of FPL and not eligible for public programs. Establishes a Universal Health Account for adults at <300% of FPL for pre-tax payment of premiums and medical expenses	HCP sliding scale subsidy credit up to 400% of FPL for those not eligible for Medicaid or SCHIP. New tax deduction for individual insurance premiums not tied to income.	Phase I sliding scale tax credit for families up to 300% of FPL. Phase II tax credits for individuals 100%-300% of FPL.	Tax credit to subsidize purchase of coverage through Health Markets. Credit available on a sliding scale to middle class families and refundable to help families without income tax liability.	Individuals and families with incomes below FPL receive full premium subsidy. For those between 100% and 400% of FPL, premium subsidies are provided on a sliding scale.

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	with a 50% (or 25% for those between 300 & 400% of FPL) federal match of individual contributions up to a maximum of \$1,000/\$2,000 for individuals/families. States and employers could also contribute to accounts.				
<b>Benefits</b>	Under the state performance grant program, eligibility for grants would be limited to states that either offer targeted coverage (e.g., for primary care, preventive care, acute episodic care, or hospital & emergency care); or coverage actuarially equivalent to minimum federal standards for Health Savings Accounts	For HCP subsidy, in general, minimum actuarial value set at SCHIP benchmark and maintenance of effort required for current employer plans. For tax deduction, 85% of SCHIP benchmark actuarial value.	Not specified.	Plans sold through regional Health Markets must have comprehensive benefits, including full mental health benefits. Primary and preventive services to be offered with minimal cost sharing. Plans encouraged to monitor patients with chronic diseases.	Includes plan similar to the FEHBP Blue Cross Standard plan and actuarially equivalent plans. Plans with additional benefits priced separately. Must provide coverage of wellness programs, stop-loss protection, a ‘health home,’ care coordination. No cost sharing for preventive care.

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	(HSAs).				Also mental health parity, reconstructive breast surgery & protections for mothers & newborns.
<b>Financing</b>	Not specified.	Not specified.	Not specified.	Eliminate tax cuts for individuals making >\$200,000 a year. Collection of unpaid capital gains taxes and other revenue otherwise owed.	Combination of individual premiums, employer assessments, state and federal savings in Medicaid, cuts in Medicare and Medicaid DSH, and changes in tax treatment of insurance.
<b>Provider taxes</b>	None.	None.	None.	None.	None.
<b>Medicaid provider payments</b>	None.	None.	None.	None.	None.
<b>Provider loss ratio</b>	None.	None.	None.	None.	None.
<b>Private insurance reforms</b>	No insurance market reforms but as a condition of eligibility for state performance grants,	Require health plans to guarantee issue at community rates.	Not specified, but under Phase II, states certify availability of non-group coverage.	Guarantee issue and community rating requirements. Federal help for states and groups of	Requires community rating or adjusted community rating based on

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	states must have high risk pools or other mechanism to guarantee access for uninsurable individuals with broad-based funding for costs of high risk pools.			states to form nonprofit regional Health Markets that offer competing health plans, including one public plan modeled on Medicare. Health Markets to negotiate benefits and premiums and take steps to reduce administrative costs.	geography, smoking status, and family size. Products must be guaranteed issue and renewable. Premium discounts for participation in wellness programs, & chronic disease management.
<b>Coverage of undocumented immigrants</b>	No provision.	Increases funds for emergency care of undocumented immigrants.	No provision.	No provision.	No subsidies for adult illegal immigrants. Visa for legal residents will be revoked if premiums or penalties not paid.
<b>Cost</b>	Estimated federal costs are \$300 billion over 10 years.	Federal cost of \$115.2 billion with state and local savings of \$13.8 billion (2007).	\$45 billion over 5 years for Phase I children's coverage.	\$90-\$120 billion a year when fully implemented.	10-year federal costs of \$812 billion. Total system savings of \$4.5 billion over 10 years. (Lewin estimates)

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<b>Other hospital-related provisions</b>	None.	None.	None.	Report card on hospital effectiveness in treating injuries and diseases. Support for health care safety net, including public hospitals, clinics and community health centers. Federal partnerships with academic medical centers, other steps to promote evidence-based, high-quality medicine. Resources for information technology to improve patient safety and hospital efficiency.	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.

Note: Based on information available as of February 7, 2007. Level of available detail varies among plans.

## SELECTED STATE COVERAGE INITIATIVES

	<b>California</b>	<b>Massachusetts</b>	<b>Pennsylvania</b>
<b>General Approach</b>	Public program expansions and a subsidized state purchasing pool, with individual and employer mandates.	Medicaid expansions and a subsidized state purchasing pool, with individual and employer mandates.	Individual and employer subsidies for private coverage with employer mandate and phased-in individual mandate.
<b>Status</b>	Proposed by Governor Schwarzenegger on January 8, 2007. Most provisions require approval by legislature.	Enacted in April 2006 and is now being implemented.	Proposed by Governor Rendell January 17, 2007. Most provisions require approval by legislature.
<b>Target population</b>	All Californians.	All uninsured state residents.	All uninsured state residents. Eligible businesses for premium subsidies are those with fewer than 50 low-wage employees.
<b>Individual mandate</b>	All Californians must have a minimum level of coverage.	In 2007, state residents must have health insurance or lose personal exemption on state income taxes unless affordable policies not available. In subsequent years, penalty will include a fine for each month without coverage equaling 50% of the monthly cost of health insurance.	Phased-in mandate for health insurance for individuals whose incomes are more than 300% of FPL. Also would require all full time, four-year college and graduate students to be insured as condition of admission.
<b>Employer mandate</b>	Non-offering employers with 10+ workers must pay 4% of payroll to state. All employers must establish "Section 125" arrangements that permit workers to buy health insurance with pre-tax dollars.	Employers with > 10 employees must offer arrangements that permit workers to buy health insurance with pre-tax dollars. Those that do not contribute to employee insurance premiums must pay the state a per-worker contribution, capped at \$295 per year. Surcharges assessed when employees receive free care.	A "Fair Share" assessment of 3% of payroll would be charged to employers who fail to provide coverage, with smaller firms (< 50 employees) exempt for the first year. Thereafter, Fair Share assessment phased-in by size of employer.

	<b>California</b>	<b>Massachusetts</b>	<b>Pennsylvania</b>
<b>Public program expansion</b>	Medi-Cal for adults and children <100% of FPL; Healthy Families (SCHIP) for children 100-300% of FPL.	Expands Medicaid to children up to 300% of FPL. Removes enrollment caps on existing program for adults, extends eligibility to legal aliens, funds outreach, and expands existing employee Medicaid buy-in from 200%-300% of FPL.	No expansions of the state's Medicaid and SCHIP programs. [Note: PA previously implemented a Cover All Kids program providing for sliding scale premiums for low-income children.]
<b>Subsidy (tax credit/ Medicaid etc.)</b>	New state-run purchasing pool subsidized on sliding scale for adults 100-250% of FPL. Subsidy can help with employee share of employer plan if employer also contributes.	Insurance premium subsidies for those <300% of FPL.	Uninsured employees in small firms with household incomes below 300% of FPL would receive a premium discount based on income (up from 200% of FPL under current law).
<b>Benefits</b>	Mandated minimum coverage is \$5,000 deductible and out of pocket limit of \$7,500 (individual) and \$10,000 (family). Purchasing pool plan benefits to be determined. Public and private plans to include rewards and incentives for healthy behavior/prevention.	Unspecified but new insurance authority certifies insurance as high value/good quality. Subsidized plans have no deductibles, and plans must be comprehensive, with no premium and modest copays for individuals below 100% of coverage.	Basic benefit package similar to the state's existing program for adult uninsured persons below 200% of FPL, with prescription drugs and some mental health and substance abuse treatment coverage added. Modest co-pays for most services.
<b>Financing</b>	Federal Medicaid/CHIP matching (\$5.5b); provider contributions (\$3.5b); non-offering employer fee (\$1b); county funds (\$2b).	Combination of new funds (e.g., assessments on employers who fail to provide coverage) and redistribution of existing funds, including Federal Medicaid matching funds and state uncompensated care pool.	Employer and employee premiums; assessment on employers who do not provide insurance; redirection of state funds now financing existing uninsured and uncompensated care programs; federal Medicaid, and tobacco taxes.
<b>Provider taxes</b>	Hospital contribution of 4% of revenue; 2% from physicians	Hospitals continued to be assessed to help finance uncompensated care.	No provision.

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<b>Medicaid provider payments</b>	Increases Medi-Cal provider payments (\$10-\$15 billion est.). Future increases linked to performance measures.	Increases Medicaid provider payments in FY 2007-2009 (subject to quality improvement goals).	Not specified.
<b>Provider loss ratio</b>	Hospitals and health plans must spend 85% of revenue/premiums on health care.	No provision.	No provision.
<b>Private insurance reforms</b>	Health plans must guarantee issue individual coverage and rating limits established.	Commonwealth Health Insurance Connector Authority (a pooling arrangement) certifies and offers insurance policies for individuals and small businesses (50 or fewer workers). Merges small group and non-group insurance markets for purposes of regulation; retains modified community rating and allows tobacco use as a rating factor.	Requires standard benefit packages for small group and individual policies; adjusted community rating and rate reviews for small group products; such products must return 85% of premiums in payments for health care costs. Only PA Blues required to bid to provide CAP insurance. Other insurers may bid. Uninsured adults with incomes above 300% of FPL could buy into CAP coverage.
<b>Coverage of undocumented immigrants</b>	Care for undocumented immigrants without employer or individual coverage provided or arranged through county and UC hospitals.	Extends Medicaid eligibility to legal aliens.	Not specified.
<b>Cost</b>	\$12 billion (one year)	Estimated cost \$1.2 billion over 3 years	Not available.
<b>Other hospital related provisions</b>	New federal classification system for hospital construction; new technology assessment process to promote evidence-based care; coordinated state promotion of health information technology including universal e-prescribing	Creates a Health Care Quality and Cost Council to set quality improvement and cost containment goals. Has authority to collect cost and quality data from health care providers, pharmacies, payers and insurers.	State to provide data on quality outcomes and average payments for hospital procedures. Uniform hospital admission criteria and billing procedures. State process for review of large capital investments. Insurers authorized

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	by 2010 and 100% electronic health data exchange in 10 years; increased public access to quality and cost data.	(Non-compliance subject to money penalties.) Council is required to analyze data and publish on its website, including comparative data on hospital costs and quality.	not to reimburse hospitals for costs of treating hospital-caused infections. Establishment of both uniform criteria and amount of community benefit each not-for-profit hospital must provide for its tax exempt status.

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