	H alth Security Act (President Clinton) HR 3600 / S 1757 Gephardt / Mitchell	Managed Comp tition Act HR 3222 / S 1579 Cooper / Breaux	Health Equity and Access Reform Today Act HR 3704 / S 1770 Thomas / Chafee	American Health Security Act HR 1200 / S 491 McDermott / Wellstone
Reform Approach	Universal, coverage of all legal residents achieved through employer-based private group health plans administered by the States through regional alliances. Individual mandate exists for non-working persons. Discounts provided to low-income persons and small employers to purchase health insurance.	Voluntary coverage provided through expanded private health insurance achieved through the establishment of purchasing cooperatives. Participation in the cooperative would be mandatory for small employers, optional for large employers (greater than 100 employees). Provides subsidies to low-income persons to assist in purchasing insurance.	Universal, coverage for legal residents achieved through reform of private group health insurance and individual mandate. Vouchers provided to low-income persons to assist in purchase of insurance.	Universal, mandatory coverage of all legal residents achieved through a federally regulated, state-administered health insurance program.
Universal Coverage Achieved (Completed)	1998	Not applicable	2005	1995
Benefits	Comprehensive benefits package with no lifetime limits (specified in bill language). Cost-sharing and deductibles vary based on choice of health plan. No cost-sharing on preventive services. National Health Board could expand but not reduce benefits. Limits out-of-pocket payments.	Benefits package not specified. The Health Care Standards Commission would recommend a uniform set of benefits to Congress for approval in an up or down vote. Commission would also recommend uniform deductibles, cost-sharing and out-of-pocket limits to Congress for approval.	Specifies two benefit packages to be created - standard and catastrophic. Defines categories of items / services to be covered but leaves the specifics to be determined by a Benefits Commission upon enactment. Commission will also specify deductibles, cost-sharing and out-of-pocket limits for the different benefits packages.	Comprehensive benefits package with no lifetime limits (specified in bill language). No cost-sharing or deductibles for acute care or for preventive benefits.

	(President Clinton) HR 3600 / S 1757 Gephardt / Mitchell	Managed Competition Act HR 3222 / S 1579 Cooper / Breaux	Health Equity and Access Reform Today Act HR 3704 / S 1770 Thomas / Chafee	American Health Security Act HR 1200 / S 491 McDermott / Wellstone
Administration: ▸Federal	The National Health Board, an executive branch agency, is responsible for: Establishing standards for participating States; Interpreting and recommending changes to comprehensive benefit package; Certifies State implementation plans and monitors compliance; Oversees quality management system; Oversees development of national health information system for the collection, reporting and dissemination of health care information; Administers premium caps; Develops risk adjustment system;	A health care standards commission, an independent executive branch agency (specified to terminate on 12/31/99), would: Make recommendations to Congress on a uniform benefits package; Register health plans meeting specified standards; Develop process for purchasing cooperatives to risk-adjust premiums among accountable health plans (AHPs); Establish reporting requirements by AHPs to national health data system; Develop survey instrument to evaluate performance of cooperatives and AHPs; Monitor reinsurance market for AHPs.	If a State failed to establish a State program or its program failed to meet federal standards, the federal government would takeover the State program. Secretary of HHS oversees relevant State responsibilities in cases of multistate employer plans. Secretary would also: Monitor the reinsurance market; and Collect information on individuals who choose not to obtain insurance and issue reports on ways to increase coverage.	The American Health Security Standards Board would develop policies, procedures, and guidelines for the program. The board would also establish uniform reporting requirements and standards for a national health care database regarding every facet of the health care delivery system (providers, financing, plans, etc.). The American Health Security Quality Council would oversee quality related activities.
▸States	~~Identify and adopt an overall health care~~ Develop and implement a strategy for achieving universal coverage of all residents by 1/1/98. Establish regional alliances; Assure access to choice of health plans; Certify health plan and assure financial solvency; Assist alliance eligibility verification and collections; Establish complaint review office and procedures; Fund certain alliance cash shortfalls; Establish reinsurance system (if required by the national board); Amend workers' compensation and auto insurance rules.	Must establish by July 1, 1994, a non-profit health plan purchasing cooperative (HPPC) in each HPPC area; Each State would be considered an HPPC area but it may also provide for the State to be subdivided into multiple HPPC areas;	Establish health care coverage areas; Must develop procedures for the establishment and operation of individual and small group purchasing groups; Required to develop and disseminate comparative information on purchasing cooperatives and qualified health plans certified in the State; Provide for annual open enrollment; Meet federal data collection standards and requirements; Offer a similar or actuarially equivalent health benefit plan as the standard benefit package or catastrophic plan.	Submit plans meeting federal standards to national board and must enroll all eligible persons by 1/1/95; Establish State health security budgets and payment methodologies within federal guidelines; State administration expenses could not exceed 3% of total State program costs; Assure freedom of choice in providers; Permitted to join in regional programs; Establish one or more qualified entities to carryout quality reviews; Develop and utilize uniform electronic databases.

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▸Alliances	States authorize creation as non-profit organizations, independent agency or State agency and designate geographic area for each alliance. - Regional alliances may cover entire State; - If more than one in a state, areas may not overlap, must include sufficient population and may not discriminate. - Areas may not cross state lines or split a metropolitan statistical area (within state) - Organize open enrollment - Provide information to consumers on plan choices - Approve health plan advertising - Collect premiums / make payments to plans - Encourage expansion of plans to underserved areas.	States establish non-profit health plan purchasing cooperatives (HPPC). HPPCs must have a minimum of 250,000 persons. HPPCs enter into agreements with accountable health plans (AHP) and small employers; enroll individuals in AHPs; Monitor enrollee satisfaction through surveys; Receive and disseminate individual and small employer premiums and forward to AHP; Conduct open enrollment periods;	The Act does not require the establishment of purchasing groups. If established, purchasing groups would be operated as non-profit entities under state law. Purchasing groups would: Market qualified plans to members in a health care coverage area; Enter into agreements with plans and employers; Enroll individuals in plans; Collect premiums and forward to plans; Conduct open enrollment; Publish and distribute comparative plan information.	Not applicable.
State Flexibility	States have option of forming a single payer system in all or a portion of their State. Must meet federal requirements for: comprehensive benefits package; cost containment; health plan standards (except marketing and solvency); and employer contributions. May include corporate alliance employers and employees (if statewide). directly.	No provisions.	States may choose to establish own system provided it is not a single payor system. Plans are reviewed by HHS and either accepted or rejected within 90 days. Plan must demonstrate State's ability to cover the same percentage of individuals within the same timeframe as the national coverage. State's annual rate of growth in health care spending cannot exceed national annual rate of growth in health care costs. Plan must be budget neutral to the federal government.	No provisions.

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Employer Issues 1) Pooling Arrangements 2) Expenditure caps 3) Part-timers	1) States required to establish 1 or more regional alliances. Alliances oversee health plans and providers. State and federal employees are included in the regional alliances. 2) Caps the States/employers (excluding those in corporate alliances) health care costs at 7.9% of payroll, annually. Small low-wage employers are capped at between 3.5 and 7.9% of payroll. 3) States/employers make pro-rata contributions for part-time employees working 40 hours a month but less than 120 hours.	1) States required to establish mandatory health plan purchasing cooperatives for small employers (up to 100 employees) and individuals. Permits large employers to establish own group purchasing arrangements. 2) No provision. 3) Employers are not required to contribute toward the purchase of any employees' health insurance including accountable health plans.	1) Purchasing groups may be established for individuals and small employer. But, neither are required to purchase insurance through the purchasing group. Large employers (greater than 100 employees) may also establish purchasing groups. 2) No provision. 3) If an employer contributed toward the purchase of a qualified health plan for the part-time employee, the employee would be required to include excess employer contributions into gross income.	1) States will oversee a single, state-wide pool of all residents. 2) No provision. 3) Not applicable.
Retirees	Federal government provides subsidies for early retirees (55-65) to be covered through regional alliances. Employers are assessed a percentage of their retiree health cost for 3 years.	No provision.	No provision.	No provision.
Tax Cap	Beginning in 2004, employees would pay taxes on employer provided benefits in excess of the guaranteed benefits package.	Employers and individuals may only deduct expenses for the lowest-cost plans; any amounts in excess would be taxable.	Caps employer deductibility of cost of providing a federally certified health plan. Employer paid health insurance premiums in excess of tax cap are taxable to the employee. Similar application to individuals. Caps the amount of contributions to medical savings accounts made either by the employer or the individual. Excess amounts are taxable to the employee.	Not applicable.

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Medicaid	Integrated into new regional alliance system. State spending for guaranteed benefits package capped at budgeted rate of growth. For AFDC/SSI recipients, State per capita Medicaid payments to alliances set at 95% of current levels. New federal program will provide wrap-around coverage for services not in guaranteed benefits package for children up to age 18 currently eligible for Medicaid. Coverage for substance abuse and mental health under alliances reduces program costs for States. Repeals DSH program and replaces with vulnerable population adjustment for hospitals serving a large percent of low-income persons. Medicaid community based long-term care remains as is, including current FMAP. Institutional care remains but includes increases in asset limits and living expense allowances for nursing home residents.	Medicaid is repealed; federalizes Medicaid acute care. Recipients will select coverage through purchasing cooperatives. No residual program for wrap-around services. Low-income persons enrolling in accountable health plans eligible for premium assistance and reduced cost-sharing. Federal government would pay premiums for those with incomes below 100% of poverty level; but individuals would pay nominal copayments. Sliding scale subsidies for those with income between 100-200% of poverty.	Medicaid is restructured; States have option to enroll recipients in purchasing cooperatives; managed care plans or other alternative. Federal government makes payments to States on a per capita basis based on historical costs. Phases-out DSH payments by year 2000. Medicaid growth capped for acute care at national health spending level. The expansion of the voucher program to assist low-income persons (beyond 90% of poverty) only takes place if savings occur on schedule.	Folded into new State based system.

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Long-Term Care	Spending for Medicaid long-term care that is transferred to new LTC program is capped at rate of growth. Establishes a new State grant program for home and community based services. Funding for the program includes: new federal funding of $38.3 billion is phased-in over 7 years and $5.8 billion redirected from Federal Medicaid dollars (total spending over 7 years would be $43.533 billion). Provides grants to States for the enforcment of private long-term care insurance standards with authorization of $32.5m over 4 years (and an additional $5m for subsequent fiscal years). Premiums paid for qualified long-term care insurance would deductible as medical expenses (subject to the 7.5% AGI floor) beginning in 1996. Qualified long-term care expenses would deductible as medical expenses (subject to the 7.5% AGI floor) beginning in 1995.	Requires States to assume responsibility for long-term care portion of Medicaid. Provides a "Sense of Congress" that if financing is provided long-term care benefits may be provided on a pay-as-you-go basis.	Provides for long-term care insurance standards. Only policies meeting such standards would receive tax favored treatment. Premiums paid for qualified long-term care insurance would deductible as medical expenses (subject to the 7.5% AGI floor) beginning in 1996. Qualified long-term care expenses would deductible as medical expenses (subject to the 7.5% AGI floor) beginning in 1995.	Long-term care covered under new program for persons with 3 or more ADLs. Individuals eligible for long-term care program pay monthly premium of $65.
Medicare Integration	Program remains and is expanded to include outpatient prescription drugs. Outlaws balanced billing. States have option to integrate Medicare into alliance system once new State program is implemented. Individuals reaching age 65 have option to remain in regional alliance. Medicare workers are covered by alliances. Increases Part B premium for high income beneficiaries. Imposes a 20% copayment on lab services.	Program remains; expands benefits to include some preventive services. Increases Part B premiums for high income individuals.	Remains separate program with same benefits. Permits integration of beneficiaries into qualified health plans after 1 year. Increases Part B coinsurance and means tests the premium. Expands availability of Medicare Select policies to all States. Imposes a 20% copayment on lab and home health services.	Program is repealed. Beneficiaries would be enrolled in new State based program. check

	HR 3600 / S 1757 Gephardt / Mitchell	HR 3222 / S 1579 Cooper / Breaux	Health Equity and Access Reform Today Act HR 3704 / S 1770 Thomas / Chafee	American H alth Security Act HR 1200 / S 491 McDermott / Wellstone
Public Health Initiatives	Increases authorization levels for NHSC $950m over five years. Increases authorization levels for CHC/MHC program $600m over 5 years. Provides grants for Community Health Plans and Practice Networks $1.7 billion over 5 years. Authorizes $1.5 billion over 5 years for school related health services; and increases the authorization for school health education by $300m over the same period. Increases the authorization for academic health centers by $27m over 5 years. Mental health and substance abuse (to ensure accesss to services) would have authorizations increased by $1.2 billion over 5 years. The Public Health Service (CDC) receives increased authorizations of $2.7 billion over 5 years to carry out core public health service activities related to strengthening the capacity of State and local health agencies to monitor and protect communities from communicable diseases, identifying and controlling disease outbreaks, and providing information to consumers and providers on preventive health care.	Increases the authorization levels for the NHSC to $150m-'FY95; $175m-FY'96; $200m-FY'97; $225-FY'98; and $250m-FY'99. Authorizes $300m over 4 years for rural development grants. HHS would provide financial assistance to eligible entities (ex. FQHCs) to establish accountable health plans in rural areas. Community health centers would receive increased authorizations of $354m over 4 years; Migrant health centers would see authorization levels increase by $46m over 4 years. Extends funding (1995-1999) for immunizations against vaccine treatable diseases; elimination and control of TB; lead poisoning prevention with out any increase in authorization. PHS preventive measures related to breast and cervical cancer are extended through 1999. Authorizes $100m for FY'94-'96; such sums for FY'97-99. Extends grants for preventive health and health services from 1997-1999 without increased authorization. Extends grants for early intervention for HIV/AIDS from 1995-1999 without increased authorization. Authorizes $10m annually (FY'96-99) for programs in the Office of Smoking and Health. No school based health programs.	No mandatory public health initiatives. Increases funding for NHSC to expand number of primary care providers. Authorizes $120m in FY'95; such sums for FY'96-98. Provides Secretary of HHS with authority to conduct demonstration programs where entities could apply for Medicare / Medicaid waivers to operate rural health networks. Secretary of HHS has authority to award grants to States to target coordinated services to pregnant women and infants. Authorizes such sums for FY'95-98. Dept. of Education would award grants to States to establish local, comprehensive health education/prevention; and early intervention in elementary and secondary schools. Authorizes such sums for FY'95-98.	Increases funding for NHSC. Authorizatior levels not specified. Establishes new program of grants to non-profit CHCs/MHCs and other FQHCs to delive primary care services in underserved areas
Cost Savings	Reduces rate of growth in Medicare spending $123.4 billion over 5 years. Reduces rate of growth in Medicaid spending $65.3 billion over 5 years.	Reductions in Medicare provider fees $6.5 billion. Federalizing Medicaid acute care and requiring States to takeover LTC has estimated savings of $100 billion.	Reduces combined average rate of growth of Medicare and Medicaid from 12% to 7% over six years. **Note:** The expansion of the voucher program to assist low-income persons (beyond 90% of poverty) only takes place if savings occur on schedule.	Not applicable.

	HR 3600 / S 1757 Gephardt / Mitchell	HR 3222 / S 1579 Cooper / Breaux	Reform Today Act HR 3704 / S 1770 Thomas / Chafee	Act HR 1200 / S 491 McDermott / Wellstone
Cost Containment	National lth board establishes per capita baseline target; using this as reference point board calculates a per capita premium target for each alliance, factoring in adjustments for regional spending variations, rates of under/uninsurance; and variations in expenditures for services provided by academic health centers. Premium targets are indexed annually for inflation. Inflation adjustment would be equal to CPI + 1.5% in '96; + 1.0% in '97; + .5% in '98; + 0 in '99-2000. Regional alliances obtain bids from plans by Sept. 1, then submits report to National board on bids. National board determines weighted average accepted bid for each regional alliance. If the regional alliance's weighted average accepted bid exceeds the per capita premium target, the board assigns a reduced weighted average accepted bid to the alliance. The board would then designate non-complying plans and plan and provider payment reductions. States may choose to assume responsibility for achieving expenditure limits. In such case, if the weighted average premium for a State is less than the alliance target, the State's maintenance of effort payment would be reduced. Establishes provider fee schedules for fee-for-service. Malpractice reform Antitrust reform Administrative simplification.	No health spending constraints. Cost containment is achieved primarily through individuals selecting low-cost accountable health plans. Small employers are required to purchase insurance through purchasing cooperatives to ensure favorable tax treatment. Malpractice reforms. Antitrust reform. Administrative simplification.	No health spending constraints. Malpractice reform. Antitrust reform. Administrative simplification.	Health Security Board establishes annual national and state budgets for health car Limits growth in expenditures to GDP. States set physician fees; hospital and nursing home budgets. Provides separate budget for capital expenditures. States would make direct payments to institutions and facilities for operating expenses based on annually negotiated prospective global budgets. Administrative simplification.

	Gephardt / Mitchell	HR 3222 / S 1579 Coop r / Breaux	Reform Today Act HR 3704 / S 1770 Thomas / Chafee	Act HR 1200 / S 491 McDermott / Wellstone
Financing: ▸Employer	All employers are required to contribute 80% of the weighted average premium for the applicable class of enrollment. Premium discounts are available to small, low-wage firms.	Employers are not required to make any contributions toward employee health plans. However, employers may be subject to a tax equal to the product of the top corporate tax rate and the amount of excess health plan expenses. Excess expenses are those incurred by the employer above the cost of providing the lowest-cost plan. Revenue estimate $16 billion.	Employers are not required to make any contributions toward employee health plans. However, employers deductibility of health benefits is capped at the average cost of the lowest priced, 1/2 of the certified health plans offered in the health care coverage area where the individual lives or works. Employer paid premiums in excess of this cap are taxable to the employee.	The sponsors are currently rewriting the financing section of the bill. Employer and employee payroll taxes to be specified.
▸Other	Reduces rate of growth in Medicare spending $123.4 billion over 5 years. Reduces rate of growth in Medicaid spending $65.3 billion over 5 years. Increases revenues on tobacco products $65.3 billion over 5 years. 1% assessment on Corporate alliances $24.1 billion over 5 years.	Reductions in Medicare provider fees $6.5 billion. Phases-out Medicare Part B premium for high income beneficiaries $1.5 billion. Requires prefunding of federal retiree health benefits $1 billion.	Reduces combined average rate of growth of Medicare and Medicaid from 12% to 7% over six years.	It is reported that the new financing will rely on the elimination of Medicare, Medicaid, FEHBP. It will also include taxes on cigarettes and firearms.

Comparison of Major Health Care Reform Proposals

The Clinton Proposal
The Senate Republican Health Equity and Access Reform Today (HEART) Proposal
The Conservative Democratic Forum Proposal

and the Blue Cross and Blue Shield Association Position on Universal Health Care Reform

October 25, 1993

Comparison of Major Health Care Reform Proposals and the BCBSA Position		
	Clinton Proposal	**HEART Proposal (Senators Chafee & Dole)**
Coverage	All Americans and legal residents.	All Americans (individual mandate).
Design	Would create single, mandatory health alliances in a region, with competing health plans (limited by a global budget) to provide coverage with employer mandated contributions, but greatly diminishes employers health benefits responsibilities.	Would create one or more voluntary insurance purchasing cooperatives in a region to make coverage more affordable for small businesses and individuals; would retain much of employers traditional health benefits role.
Implementation Date	Universal coverage by 1997; states could begin by 1995.	Universal coverage phased-in with vouchers from 1995 to 2000.
Employer Responsibility	Required to pay 80% of the average price plan offered through their regional or corporate alliance. Employers' mandatory contribution capped at 7.9% of payroll; small employers (fewer than 50 employees) capped at a lower level based on the average wage of the firm.	Small employers (1 to 100 employees) could join a purchasing cooperative or offer the standard benefit package through a qualified health plan. Where there are multiple, competing cooperatives, the employer would choose the cooperative. Employers not required to contribute; would collect and send premiums and any operating fees to the purchasing cooperative or health plan on behalf of employees.
Retiree Benefits	Employer no longer be fully responsible to pay for retired workers aged 55 to 65 (government would pay 80% of premium).	Not addressed.
Individual Responsibility	All individuals would be required to enroll in a health plan and would pay the difference between employer contribution (80% of the average plan) and the cost of plan chosen. Subsidies available for those with incomes below 150% of poverty. Individuals who have failed to enroll would be automatically enrolled when they seek health services.	All individuals would be required to obtain health insurance coverage (phased-in, based on ability to purchase standard plan). Could be met through enrollment in Medicare, Medicaid, VA or CHAMPUS. Vouchers would be available to ensure affordability for low-income individuals (phased-in from 90% of poverty in 1995 to 240% in 2000). Penalty on individuals for non-compliance would equal 120% of the average yearly premium in the local area.
Benefit Package	Standard benefit package includes: hospital, emergency, physician and other provider services, prescription drugs, clinical preventive services, approved investigational treatments, some dental and vision care. Mental health and substance abuse to be fully phased-in by 2001. Expansion of home/community based long-term care. Supplemental coverage allowed for both benefits and cost-sharing would be allowed.	Standard plan includes: medical and surgical services and equipment, prescription drugs and biologicals, preventive health services, rehabilitation and home health related to an acute episode, substance abuse and severe mental health services. Alternative catastrophic plan includes: medical expense account or income-related deductible; same benefit parameters as above; high cost sharing, including deductibles. Supplemental coverage not addressed.

Comparison of Major Health Care Reform Proposals		
	Conservative Democratic Forum Proposal	**Blue Cross and Blue Shield Association**
Coverage	Eventual coverage for all Americans	All Americans
Design	Would offer coverage through a single health plan purchasing cooperative (HPPC) in each state or area for small employers (100 or fewer employees), individuals and former Medicaid eligibles. Would require large employers to offer coverage under a qualified health plan.	Comprehensive insurance market reform to foster true price competition. Universal coverage through required employer contribution and required individual acceptance with subsidies for small employers (2 to 50 employees) and low income individuals.
Implementation Date	HPPCs would be established by 7/1/94. Medicaid and COBRA repeal and tax changes would be effective 1/1/95.	
Employer Responsibility	Employers would be required to offer, but not contribute to, coverage for employees. Small employers would be required to contract with the HPPC in its area, offer enrollment in an AHP and provide payroll for deduction. Large employers would contract directly with accountable health plans, and make payroll deductions of premiums if requested by employees. COBRA Continuation Requirements would be repealed; unemployed individuals could purchase coverage through a HPPC.	Employers would be required contribute to the cost of basic benefits for employees and dependents, with special provisions to ease the financial burden for small employers.
Retiree Benefits	Not addressed.	Not addressed.
Individual Responsibility	There would be no individual mandate. Individuals could purchase coverage from an AHP through their employer, or directly, if not employed. Individuals, not employers, will choose their AHP from among those offered through the HPPC (for small employers/individuals) or through their employer (large employers). Low income individuals would receive subsidies for premiums/cost sharing (see Medicaid, below).	Individuals would be required to accept coverage offered by employers. Subsidies would be provided for individuals not covered by employer insurance and low-income families/individuals to buy coverage.
Benefit Package	Set of uniform benefits: would be defined by the national Health Care Standards Commission and approved by Congress. Supplemental benefits would be allowed if they did not duplicate the uniform benefits package and were priced separately.	Multiple, standard benefit packages would be offered by carriers. Each of the packages would have to include the basic level of coverage guaranteed to everyone. The design of the basic benefit packages should allow maximum flexibility for cost-sharing.

	Clinton Proposal	HEART Proposal (Senators Chafee & Dole)
Regulation and Market Reform	Guaranteed issue and renewability Community rating in regional alliances (groups of 1 to 4,999), adjusted only for family size. No preexisting condition limitations Solvency standards (includes guaranty funds) Regional alliances must and corporate alliances may use a risk adjustment (demographics, health status, certain access barriers), under federal guidelines.	Guaranteed issue and renewability Adjusted community rating for individuals and small businesses (1 to 100 employees) who purchase through a cooperative. Community rating for individuals and small businesses who do not purchase through a cooperative. Rules for larger employers are unclear. No preexisting condition limitations Solvency standards States would be responsible for required risk adjustment between all plans in a geographic region, using federal guidelines.
Health Plans	Would be qualified by the state (based on quality, financial stability and capacity) to provide coverage through health alliances and comply with requirements on: underserved areas, risk adjustment, administrative and insurance market reforms; solvency/guaranty fund, grievance procedures, confidentiality, credentialing of providers, quality standards, and utilization management.	Would be certified by the state in which they are offered to: deliver full range of services in the standard benefit plan; comply with requirements on underserved areas, risk adjustment, administrative and insurance market reforms, solvency; and establish a provider risk management program.
Alliances/ Purchasing Cooperatives	Regional and corporate (> 5000 employees) health alliances would enroll all individuals in their geographic area. Would: negotiate/collect premiums and pay plans, approve plans' marketing materials and disseminate consumer information. Could require plans to contract with designated specialty providers and community providers. Could decertify a plan for service/quality problems, regulate premiums to avoid exceeding budget target, and refuse to contract with plans whose premium levels might cause the alliance to exceed its budget target. Alliances must remain within a given state; contiguous states may coordinate the operation of their alliances.	Purchasing cooperatives would be limited within their region to employees in small (1 to 100 employees) businesses and to individuals not enrolled in employer health plans. Would: collect premiums from members to forward to plans; charge members a limited operating expense fee; and distribute information to members on prices, outcomes, enrollee satisfaction. Could require plans to contract with designated specialty providers and community providers. Interstate agreements would be allowed.

	Conservative Democratic Forum Proposal	Blue Cross and Blue Shield Association
Regulation and Market Reform	Guaranteed issue and renewability within a HPPC. "Open" AHPs would offer benefits on an open enrollment basis; "closed" AHPs would not be required to provide open enrollment to individuals not eligible for their plans. Community rating: each "open" AHP would establish a community rate (adjusted for age and family size not to exceed 2:1 in a family category) for each HPPC area in which it offered coverage. Preexisting condition limitations would not exceed 6 months from the date of coverage, with credit for time served under previous continuos coverage with that AHP Solvency standards HPPCs would administer a risk adjustment.	Guaranteed issue and renewability Community rating in the small group market (2 to 50 employees), with adjustments for demographic characteristics No pre-existing conditions limitations Solvency standards Risk adjustment would be administered by states.
Health Plans	Would be registered with the Health Care Standards Commission; required to offer only the uniform set of effective benefits (and additional benefits that did not duplicate the uniform set only if priced separately); only offer reduced cost-sharing for low-income individuals; meet quality, solvency and grievance procedure requirements; pay 1% of gross premiums to the National Medical Education Fund; and provide information to HPPCs/Commission on enrollee characteristics, treatments and outcomes. "Open" AHPs would be available to all individuals/ employers; "Closed" AHPs would be limited to one or more large employers and Taft-Hartley plans with more than 100 employees.	Would be certified by the state in which they are offered to: deliver full range of services in the standard benefit plan and comply with requirements on market reforms, administrative simplification, solvency, fraud and abuse. Physicians and hospitals should be allowed to contract with more than one AHP in their area in order to maintain a competitive environment -- especially in medically underserved areas.
Alliances/ Purchasing Cooperatives	HPPCs would be required to contract with all small employers (100 or fewer employees), with administrative expenses to be funded by a small (<1%) surcharge. Would: be not-for-profit corporations governed by their members; contract with and offer coverage through AHPs; distribute information on AHP price, outcomes and enrollee satisfaction; manage enrollment process; collect premiums; establish/maintain grievance process for AHPs/HPPC; forward risk-adjusted premiums to AHPs. Would not assume risk or regulate provider rates, premiums or AHP compliance. Could require an AHP to serve an underserved area, with funding available during a transition period. One or more HPPCs would be established per state, provided that metropolitan areas were not split and the number of eligibles was not less than 250,000. One or more contiguous states also could set up a HPPC in adjoining areas.	Voluntary alliances should be allowed for small employers (2 to 50 employees). Mandatory health alliances are not necessary for price competition, universal coverage, market reforms or to provide purchasing power to small employers. Economic incentives instituted by insurance reform, tax limitations on the deductibility of employer contributions for health benefits and benefit standardization would control costs. Health alliances would not reduce administrative costs for small employers. Rather, they would increase administrative costs by duplicating many functions now performed by health plans.

	Clinton Proposal	HEART Proposal (Senators Chafee & Dole)
Cost Containment Features	Fostering price competition through insurance reforms and establishing a limit on the tax deductibility of health plans to the cost of the standard package National and alliance-specific health spending budget targets Insurance premium caps Limits on Medicaid/Medicare spending Malpractice and administrative reforms Cost sharing, except on preventive care Drug price rebates for Medicaid and Medicare NHB recommendations on capital/technology spending	Fostering price competition through insurance reforms and establishing a limit on the tax deductibility of health plans to the cost of the "tax cap" (see Taxation of Health Care Benefits, below) Incorporation of Medicaid/Medicare into purchasing cooperatives Adjustments to Medicaid/Medicare spending Malpractice and administrative reforms Cost sharing, except on preventive care
Federal Oversight	National Health Board (appointed by President with advice and consent of Senate). Would: regulate/update the nationally guaranteed benefit package, establish requirements for health plans' monitoring and compliance, develop/publish performance indicators for health plans, investigate drug pricing, implement/enforce a national health care budget, develop standard supplemental cost-sharing policies, develop market conduct standards, and annually evaluate the national health care system.	Benefits Commission (appointed by President and Majority and Minority leadership in House and Senate). Would: clarify benefit plan within six months, recommend changes to the package annually, and approve plans requests for coverage decisions. Would be prohibited from specifying providers/provider services and required to treat severe mental health the same as physical health services.
State Responsibilities	Would: submit implementation plan to the NHB, ensure access to the guaranteed benefit package, establish one or more alliances, qualify health plans, ensure that the risk adjuster meets federal standards, create financial incentives for enrolling disadvantaged groups, establish capital standards for plans, and operate a guaranty fund. States would have option to establish single-payer and all-payer systems.	Would: establish geographic areas for cooperatives, authorize one or more cooperatives in an area, certify health plans, and make risk adjustments, according to federal guidelines. States would have option of establishing their own health care system (including single-payer) provided that the same percentage of individuals would be covered and health care spending would not exceed national rate.
Global Budget	Target set by National Health Board; to be used as a "backstop" if an alliance exceeds its budget. National per capita premium target would be based on the estimated first year cost of the guaranteed benefits package, adjusted for expected utilization increases from the uninsured and under-insured and to recapture uncompensated care costs. The annual rate of increase thereafter would be trended forward by a national inflation factor based on annual CPI with population adjustments.	None

	Conservative Democratic Forum Proposal	Blue Cross and Blue Shield Association
Cost Containment Features	Fostering price competition through insurance reforms and establishing a limit on the tax deductibility of health plans to the cost of the lowest cost plan offered by each regional HPPC. Malpractice and administrative reforms Cost sharing, except on preventive care	Fostering price competition through insurance reforms and establishing a limit on the tax deductibility of health plans to the cost of a cost-effective plan. Malpractice and administrative reforms Cost sharing, except on preventive care
Federal Oversight	Health Care Standards Commission (appointed by President) would: establish the uniform benefits package and cost sharing; register AHPs; develop risk adjustment factors; establish a health data system and standards for reporting prices, health outcomes and consumer satisfaction; submit benefits package to Congress for approval; report HPPC information annually and study/report to Congress by 1/1/97 on those remaining uninsured and methods to increase access to coverage. Would be prohibited from establishing/enforcing any price controls.	Would establish market standards that would be enforced by the states. Would establish the standardized benefit packages, set standards for market conduct and administrative simplification, administer subsidies for small employers, set tax limits and enforce mandate.
State Responsibilities	Would no longer be responsible for Medicaid, but would gradually assume responsibility for long-term care for low income individuals. State mandates on benefits and managed care restrictions would be pre-empted. Would have flexibility to increase the defined size of employers who could use a HPPC, so long as not more than half of all employees in the state purchase through the HPPC.	Would certify health plans and oversee the system.
Global Budget	None	None

	Clinton Proposal	HEART Proposal (Senators Chafee & Dole)
Taxation of Health Care Benefits	Employer premium contributions for the guaranteed benefits package would be fully deductible to employers (including self-employed) and not counted as income to employees. Benefits beyond the guaranteed benefits package would be taxable to the employee after a 10 year phase-in period. Employees could no longer use Section 125 plans (i.e., cafeteria plans) to make pre-tax contributions to pay for health expenses.	Employers (including self-employed) could fully deduct the cost of providing the standard plan, up to the amount of the "tax cap" (the average cost of the lowest priced one-third of certified health insurance plans offered in the purchasing cooperative area). Employer-paid premiums would also be deductible to the employee, up to the amount of the tax cap, as would premiums paid by individuals regardless of their employment status. Other health care costs would only be deductible to the extent they exceed 7.5% of Adjusted Gross Income. Medical Savings Account (MSA): tax-favored up to the amount of the tax cap; would be available for those electing the catastrophic plan.
Financing	Premium contributions from individuals/families and employers Medicaid/Medicare savings Cigarette taxes Increased corporate income taxes due to lower health care costs Additional dedicated premium assessments.	Premium contributions from individuals/families and employers Immediate funding from Medicaid/Medicare savings Additional funding from savings from all reforms implemented by the proposal, as certified annually by CBO.
Administrative Simplification	Standardized claims form, electronic reporting, data exchange. Nationally-linked health care information database. Streamlining of coordination of benefits Coordination of licensing and certification Health Security Card	Standardized claims form, electronic reporting, data exchange. Nationally-linked health care information database.
Malpractice Reforms	Alternative dispute resolution system (non-binding) Periodic payment of awards Reduction of awards by any collateral recoveries Limits on attorneys' fees Enterprise liability demonstration project Practice guideline standards pilot project	Alternative dispute resolution system (non-binding) Periodic payment of awards Reduction of awards by any collateral recoveries Product liability reform Joint and several liability reform 50% of punitive damages awarded to the state Statute of limitations: two years or up to 12 years of age for minors Non-economic damages capped at $250,000 Practice guideline rebuttable presumption
Anti-trust laws	Creation of "safety zones" to protect mergers of small hospitals, hospitals entering into joint ventures or purchasing arrangements, and physicians forming networks, if they assume risk. McCarron-Ferguson exemption for health insurers repealed.	Competition guidelines and "safe harbors" for state-licensed health care providers and for qualified health plans and buying cooperatives.

	Conservative Democratic Forum Proposal	Blue Cross and Blue Shield Association
Taxation of Health Care Benefits	Tax deductions for employer or individuals who pay all or part of an AHP premium would be limited to the cost of the lowest-price qualified AHP available through each regional HPPC. Tax deductibility for self-employeds would be increased to 100% of the AHP premium.	Tax-deductible employer and employee contributions would be limited to the cost of a cost-effective AHP in an area. Contributions above this amount would be taxed.
Financing	Premium contributions from individuals/families and employers Current Medicaid spending would be redirected into this program, plus an additional $25 billion from: Tax cap on deductibility of benefits; Limiting the growth for non-primary care physician fees under Medicare; Imposing a tax on Medicare Part B premium subsidy for high income individuals; Establishing a hospital outpatient prospective payment system under Medicare; Phasing out Medicare hospital disproportionate share adjustments.	Premium contributions from individuals/families and employers Tax cap on deductibility of benefits
Administrative Simplification	Standardized claims form, electronic reporting, data exchange. Streamlining of coordination of benefits	Standardized claims form, electronic reporting, data exchange. Streamlining of coordination of benefits
Malpractice Reforms	Grants for states to evaluate alternative dispute resolution A commission would determine limits on non-economic/punitive damage awards. Liability for non-economic damages would be several only; punitive damages would be paid to the state with a two-year statute of limitations. Grants to develop practice guidelines	Appropriate reform of the medical malpractice industry should include changes in the methods of establishing liability and calculating awards.
Anti-trust laws	Certificate of public advantage to exempt health care joint ventures which increase quality/access/cost efficiency and involve substantial integration or risk sharing.	Would retain existing anti-trust law as providing sufficient flexibility for physicians and hospitals to form joint ventures.

	Clinton Proposal	HEART Proposal (Senators Chafee & Dole)
Worker's Compensation/ Automobile Insurance	Health plans would provide treatment for work/auto-related injuries and be reimbursed by worker's compensation/automobile insurers, based on a fee schedule or negotiated arrangement.	Not addressed.
Federal Programs	Medicaid: Non-cash recipients would be enrolled in health alliances, with premiums paid by their employers or premium discounts if they are not employed and have low incomes. Medicaid would make capitated payments for cash-eligible recipients, who would continue to receive traditional Medicaid supplemental benefits beyond the standard package. (Subsidies available for those below 150% of poverty.) Medicare: Individuals over 65 would have the option to choose traditional Medicare or an alliance; however, states would have option of integrating beneficiaries into their alliance system. Prescription drug coverage would be added. FEHBP: would be fully integrated into new system.	Medicaid: States could provide coverage to recipients through a private purchasing cooperative, managed care plan, or other alternative, provided that the per capita rate would be limited to that of the national average. Medicare: DHHS to study/report on the phase-in of current enrollees into regionally-based purchasing cooperatives. Medicare risk contract would be expanded to experiment with new model of service for the elderly. FEHBP: OPM would have option of allowing some federal employees in some areas to join purchasing cooperatives and of forming cooperatives with small businesses.

	Conservative Democratic Forum Proposal	Blue Cross and Blue Shield Association
Worker's Compensation/ Automobile Insurance	Not addressed.	Not addressed.
Federal Programs	Medicaid: Would be abolished and replaced with a new program covering all individuals/families with incomes below 200% of poverty. Those under 100% could enroll in an AHP with no premium cost to them and nominal cost sharing (and could receive assistance for some items not under the uniform benefits package). Those between 100% and 200% would pay premiums based on a sliding scale. Medicare: "Open" AHPs would have to either enter in to a risk-sharing contract under Medicare or pay the Commission a Medicare adjustment that would put them in the same financial position as if they had been risk-sharing. Medicare Select (Medigap PPOs) would be extended to all states. Preventive services would be expanded. FEHBP: "Open" AHPs would be required to offer coverage under FEHBP under the same conditions as it offers coverage through HPPCs for eligible employers/individuals, except for premiums. (All FEHBP plans also would have to be AHPs.) The federal FEHBP premium contribution would be the same for all AHPs in a HPPC area and could not exceed the lowest cost uniform benefit package offered by an AHP in the HPPC area. Aggregate government contributions to the FEHBP would not change.	Would include coverage of all individuals with incomes up to the federal poverty level, regardless of family status, and permit such individuals to purchase private coverage by fully subsidizing the cost of such coverage. Medicare: Would provide incentives for beneficiaries to enroll in managed care plans at full cost. FEHBP: Would retain separate federal program.

COMPARISON OF COMMITTEE HEALTH CARE REFORM MARKUP DOCUMENTS
103RD CONGRESS
BASED ON WOMEN'S HEALTH CRITERIA*

WOMEN'S HEALTH CRITERIA	HOUSE EDUCATION & LABOR COMMITTEE (FORD)	HOUSE WAYS & MEANS COMMITTEE (GIBBONS)	HOUSE ENERGY & COMMERCE COMMITTEE (DINGELL)	SENATE LABOR & HUMAN RESOURCES COMMITTEE (KENNEDY)	SENATE FINANCE COMMITTEE (MOYNIHAN) (Based on draft outline of markup document)
Universal Access/ Coverage	**Universal Access/ Coverage**	**Universal Access/ Coverage**	**Universal Access/ Coverage**	**Universal Access/ Coverage**	**Universal Access/ Coverage**
Every individual guaranteed coverage through either employment-based or other scheme.	**OK**	Guaranteed coverage through private work-based insurance for some, but perpetuates a two-tiered system by creating a new public program - Medicare Part C.	**MARKUP DOCUMENT NOT YET RELEASED**	Exempts employers with five or fewer employees & average annual wages lower than $24,000.	Exempts employers with 20 or fewer employees, with a mandate to take effect if 97% coverage not achieved by 1998 or 98.5% in 2000.
Premium assistance for poor and near poor individuals.	Sliding-scale premium subsidies up to 200% of poverty level, so that no family pays more than 3.9% of income. **OK**	Sliding-scale premium subsidies expanded to 240% of poverty level, but on a phased-in basis.		Sliding-scale premium subsidies up to 200% of poverty level, so that no family pays more than 3.9% of income. **OK**	Sliding-scale premium assistance up to 150% of poverty (premium expense capped at 5% of income for this group).
Affordable cost-sharing scheme that covers preventive services at no cost and provides low-income assistance with other copayments & deductibles.	No cost-sharing for preventive services, including family planning. 100% discounts on copayments for Medicaid recipients & individuals up to 100% of poverty.	Requires copayments & deductibles for services, even most preventive care. Copayments waived for Medicaid recipients & individuals up to 100% of poverty.		No cost-sharing for preventive services, including family planning. Copayment discounts of 80% for up to 150% of poverty, 60% for 150 to 200% of poverty.	No cost-sharing for preventive services. (Information not available on cost-sharing assistance.)

*This comparison of major health care proposals before the 103rd Congress is based upon the five criteria, developed by AAUW and the Campaign for Women's Health,** for evaluating each plan's capacity for addressing women's health care concerns. The five criteria are: 1.) universal access/coverage; 2.) defined comprehensive benefits, including the full range of reproductive health services, an emphasis on primary and preventive care, and long-term care (at least to be phased in); 3.) a full range of providers and settings; 4.) guaranteed accountability; and 5.) increased attention to women's health care needs in the national research agenda.

American Association of University Women/Campaign for Women's Health
June 14, 1994

**The Campaign for Women's Health is a broad-based coalition of 92 organizations, representing more than 8 million women, dedicated to ensuring that women's health care concerns are fully addressed in the health care reform debate.

WOMEN'S HEALTH CRITERIA	HOUSE EDUCATION & LABOR COMMITTEE (FORD)	HOUSE WAYS & MEANS COMMITTEE (GIBBONS)	HOUSE ENERGY & COMMERCE COMMITTEE (DINGELL)	SENATE LABOR & HUMAN RESOURCES COMMITTEE (KENNEDY)	SENATE FINANCE COMMITTEE (MOYNIHAN) (Based on draft outline of markup document)
Annual out-of-pocket expenditures capped at an amount that does not inhibit access to care.	**OK** ($1,500 for individuals, $3,000 for families)	$5,500 per individual beginning in 2003; $1,000 for prescription drugs.	**MARKUP DOCUMENT NOT YET RELEASED**	**OK** ($2,500 for individuals, $3,000 for families)	Information not currently available.
Community rating for establishment of premiums to prevent discrimination based on risk category.	**OK**	Only requires community rating within each of 5 different categories, so insurers could choose not to cover a pool with a large proportion of high risk individuals.		Employers with 1,000 or more employees are required to purchase insurance outside the community-rating pool.	Modified community rating that permits variations in premiums based on family size, geography, & age, but requires that highest premium be no more than twice lowest.
Coverage for part-time, seasonal, temporary workers.	**OK**	Employers not required to offer private coverage except in very limited cases.		**OK**	Information not available.
Prohibition on exclusions based on health status, including pre-existing conditions.	**OK**	Transitional limits, not prohibited until January 1, 1998.		**OK**	**OK**
Defined Benefits	**Defined Benefits**	**Defined Benefits**	**Defined Benefits**	**Defined Benefits**	**Defined Benefits**
Guaranteed comprehensive benefits package defined in the legislation.	**OK**	Benefits package defined, but limited by Medicare "medically necessary" standard, which is an illness & injury standard; preventive & reproductive services covered as add-ons.		**OK**	**OK**

WOMEN'S HEALTH CRITERIA	HOUSE EDUCATION & LABOR COMMITTEE (FORD)	HOUSE WAYS & MEANS COMMITTEE (GIBBONS)	HOUSE ENERGY & COMMERCE COMMITTEE (DINGELL)	SENATE LABOR & HUMAN RESOURCES COMMITTEE (KENNEDY)	SENATE FINANCE COMMITTEE (MOYNIHAN) (Based on draft outline of markup document)
Benefits must include comprehensive preventive, diagnostic, and treatment services.	**OK**	**OK**	**MARKUP DOCUMENT NOT YET RELEASED**	**OK**	**OK**
Preventive screening schedule in keeping with most up-to-date scientific research.	Covers as preventive care: annual mammograms for women over 50, every 2 years for women 40-49; annual pap smears for women of childbearing age.	Covers as preventive care: mammograms every 2 years for women 40-49 & 65+, annually for 50-64; annual pap smears for women without 3 consecutive negative tests or in high-risk groups.		Covers as preventive care: annual mammograms for women over 50, every 2 years for women 40-49; annual pap smears for women without 3 consecutive negative tests or in high-risk groups.	Information not available.
Benefits package includes full range of reproductive health services -- family planning, maternity care, and abortion services.	**OK**	Services for pregnant women are covered, but services other than pre- & post-natal care are subject to copayments and deductibles.		**OK**	Services for pregnant women are covered but are subject to cost-sharing.
Long-term care services covered, at least to be phased in.	Committee does not have juisdiction over long-term care provisions.	Limited coverage for individuals with severe disabilities through new home & community-based long term care program.		Creates new home and community-based program to be phased in over first seven-year period.	Maintains Medicaid long-term care program & provides tax credits for certain long-term care expenses.
Providers & Settings	**Providers & Settings**	**Providers & Settings**	**Providers & Settings**	**Providers & Settings**	**Providers & Settings**
Services should be available through a broad range of providers that includes licensed & certified non-physician providers and in a variety of community-based settings.	**OK**	Requires plans to contract with all essential community providers in the service area, but does not include Title X clinics in this group. Because employer, not employee, chooses two plans to offer, employee's choice of providers is limited.		Requires plans to contract with all essential community providers in the service area, but does not include Title X clinics in this group.	Information not available.

WOMEN'S HEALTH CRITERIA	HOUSE EDUCATION & LABOR COMMITTEE (FORD)	HOUSE WAYS & MEANS COMMITTEE (GIBBONS)	HOUSE ENERGY & COMMERCE COMMITTEE (DINGELL)	SENATE LABOR & HUMAN RESOURCES COMMITTEE (KENNEDY)	SENATE FINANCE COMMITTEE (MOYNIHAN) (Based on draft outline of markup document)
Public health initiatives to improve access to care for underserved areas and populations.	**OK** (Also assures uninterrupted coverage for victims of domestic violence and runaway & homeless youth.)	Addresses access in rural and urban underserved areas.	**MARKUP DOCUMENT NOT YET RELEASED**	**OK**	Limited initiatives to fund new facilities & infrastructure; tax incentives to providers who locate in designated urban & rural areas.
Accountability	**Accountability**	**Accountability**	**Accountability**	**Accountability**	**Accountability**
Broad anti-discrimination provision that prohibits actors in the reformed system from discriminating on the basis of race, national origin, sex, religion, language, socio-economic status, age, disability, sexual orientation, health status, or anticipated need for health services.	Several anti-discrimination provisions addressing most actors. Lacks a general prohibition against sex discrimination in federally-funded health programs.	**OK**		Several anti-discrimination provisions addressing most actors. Lacks a general prohibition on sex discrimination in federally-funded health programs.	Does not address.
Women's Health Research	**Women's Health Research**	**Women's Health Research**	**Women's Health Research**	**Women's Health Research**	**Women's Health Research**
Increased attention to women's health in the national research agenda.	**OK**	Does not include research provisions on women's health.		**OK**	Information not available.

AMERICAN
ASSOCIATION OF
UNIVERSITY
WOMEN

NANCY ZIRKIN
ASSISTANT DIRECTOR
FOR GOVERNMENT RELATIONS
PROGRAM & POLICY DEPARTMENT

1111 SIXTEENTH STREET N.W.
WASHINGTON, DC 20036-4873
202/785-7720

FAX: 202/872-1425
TDD: 202/785-7777