

GW National Health Reform Law and Policy Project

Comparing National Health Reform Proposals: The Taxonomy

In comparing national health reform proposals and how well they address the challenges of coverage access, affordability, quality, and financing a relatively lengthy series of questions can arise because of the complex nature of insurance. This complexity is particularly great today not only because insurance contracts are complicated and intended to protect companies from financial risks but because of the nature of modern insurance coverage. Today, nearly all insurance products integrate coverage with health care itself, by encouraging (in the case of more costly plans) or requiring members to receive virtually all covered services through a provider network that has been selected by the insurer and whose practices are overseen by the company.¹ For this reason, whether the network includes the proper number and range of providers and benefit suppliers to make the coverage actually accessible becomes a crucial issue. Similarly, the existence of provider networks means that plans have obligations to focus on the quality of the care that members receive, not just its costs.

Key Elements of Analysis: Basic Approach and Domains

In any comparative analysis of health reform proposals, it is important to consider certain analytic domains covering eligibility, coverage, and the interaction of insurance with the health care system itself. But the analysis actually begins with a threshold question that is meant to focus in on the basic approach offered by the proposal: how would it operate? Understanding the basic approach reflected in any particular proposal is essential, since this basic approach ultimately will affect its functioning.

Once the basic structure is described, the individual domains then become the mechanism by which readers can compare proposals that may be very different in their basic approach. This comparative step allows a reader to understand the similarities and differences among proposals, even proposals that address certain issues only implicitly rather than explicitly. (For example, in a national health reform proposal, the absence of any description of a benefit requirement would signal a desire on the part of Congress to allow private insurers broad discretion in designing a product).

The domains themselves reflect the key operating components of modern health insurance arrangements, beginning with eligibility and enrollment and continuing through consumer safeguards. GW faculty and staff have identified these attributes over many years of analyzing health insurance and coverage arrangements and reviewing reports, studies, judicial case law, and analyses of health insurance. Extensive evidence related to health insurance coverage and payment² -- voluminous studies and reports and thousands of judicial rulings involving

¹ Kaiser Family Foundation, "How Private Health Coverage Works: A Primer," 2008.
<http://www.kff.org/insurance/index.cfm>

² Institute of Medicine, "America's Uninsured Crisis: Consequences for Health and Health Care," 2009. Institute of Medicine, "Coverage Matters: Insurance and Health Care," 2001; Institute of Medicine, "Care Without Coverage: Too Little, Too Late," 2002. The Commonwealth Fund, "The Costs and Consequences of Being Uninsured," 2003; The Commonwealth Fund, "How Many Are Underinsured? Trends Among US Adults, 2003 and 2007," 2008,

challenges to health insurance coverage and payment decisions -- underscore that any one of these domains is essential to insurance performance and the accessibility and quality of care.

Basic Approach

In the current health reform debate, the proposals take three basic forms, each of which raises questions regarding its feasibility and its potential to improve quality and affordability while reducing cost and inefficiency.

- *An Exchange System.* The first and most prominent approach would be to create a government-sponsored health insurance exchange for individuals without access to employer coverage, Medicaid, or another form of group coverage. The exchange would offer subsidized affordable products sold by private insurers, without restrictions tied to health status or other personal characteristic. The key issues include whether one of the insurance options will be a public plan, how affordable the plans will be, and how good the coverage will be in terms of benefits, cost sharing, and plan performance on matters such as provider networks and health care quality. Proponents of a public plan option believe that a public plan is needed to assure that options are available in all communities and to keep pricing and quality competitive.³ Opponents view a public plan as seriously affecting the existence of a private health insurance market and diminishing the potential for health care innovation.⁴
- *A Single Payer System.* A second approach would be to eliminate private health insurance entirely or nearly entirely (people could be allowed to buy supplemental coverage) in favor of a single payer system such as Medicare for all persons.⁵ Proponents underscore the fairness and universality of the approach, as well as the ability to more directly control the cost and quality of care.⁶ Others point to problems with the performance of public insurance systems such as Medicare, with limited payments and low provider participation, the rationing of care, and the need for privately insured persons now covered through employer plans to shift into the new insurance system.⁷
- *A “Health Mart” System.* A third approach would be to eliminate employer coverage in favor of individual private coverage, with choice of plans managed through competing

<http://www.commonwealthfund.org/Publications.aspx>. Kaiser Family Foundation, “Sicker and Poorer: The Consequences of Being Uninsured,” 2002, <http://www.kff.org/uninsured/20020510-index.cfm>.

³ The Commonwealth Fund Commission on a High Performance Health System, “The Path to a High Performance US Health System: A 2020 Vision and the Policies to Pave the Way,” 2009, <http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2009/Feb/The-Path-to-a-High-Performance-US-Health-System.aspx>.

⁴ The Heritage Foundation, “The Real Price of a Public Health Plan: Less Innovation and Lower Quality,” 2009, <http://www.heritage.org/Research/HealthCare/bg2263.cfm>

⁵ Woolhandler S, Himmelstein D, Angell M, Young Q. “Proposal of the physicians’ working group for single-payer national health insurance,” *JAMA*, 2003; 290(6)798-805.

⁶ Himmelstein D, Woolhandler S, Wolfe S. “Administrative waste in the US health care system in 2003: the cost to the nation, the states, and the District of Columbia, with state-specific estimates of potential savings,” *Int J Health Serv*, 2004; 34(1)79-86.

⁷ The Heritage Foundation, “Single Payer: Why Government-Run Health Care Will Harm Both Patients and Doctors,” 2009.

market brokers, much in the way other goods and services are offered through competing private sellers.⁸ Proponents believe that this model will bring cost, quality, and value through the use of markets, the dynamic that shapes the rest of the U.S. economy. Others question whether health care truly is a market good, particularly for people who are sick, and whether the approach can create accountability and prevent problems in access, cost, and quality among populations that have little market clout.

Regardless of basic approach, each proposal can be compared across ten domains (identified by numbers) included in the GW taxonomy, each of which has a series of sub-domains (identified by letters).

Health Reform Legislation Taxonomy

1. Health Insurance Accessibility and Affordability

A. Access to health insurance

- How does the proposal change the current health insurance market (e.g., does the proposal create a health insurance exchange, single payer system, health mart or other structure)?
- Who has access?

B. Pre-existing condition exclusions and waiting periods

- How does the proposal treat insurer practices involving the use of pre-existing condition exclusions to bar coverage of certain conditions entirely or impose waiting periods before coverage begins?

C. Age and gender

- How does the proposal address insurer practices involving the use of higher premiums based on an applicant's age or gender?

D. Health status

- How does the proposal address insurer practices related to higher charges based on health status or possible limitations on coverage?

E. Residence and legal status

- How does the proposal address issues of state residence and U. S. legal status as conditions of qualifying for coverage?

⁸ Kaiser Family Foundation, "Explaining Health Care Reform: What Are Health Insurance Exchanges?" 2009, <http://www.kff.org/healthreform/7908.cfm>.

F. Premium affordability in relation to family income and health need

- What provisions does the proposal contain to assure that premiums are affordable, and how is affordability measured?
- What factors can be used as rating factors (e.g., community vs. experience) and are there limitations on variance in premiums?
- In setting the premium, does the proposal adjust the cost not only for family income but also in relation to the presence of other needs experienced by persons who may be seriously ill that increase the cost of living (e.g., additional travel, transportation and nutrition costs that may arise among people who are undergoing extensive cancer treatment)?

G. Subsidies

- Does the proposal offer subsidies (e.g., premium subsidies or other subsidies such as limits on cost-sharing or special tax treatment for high expenses)?
- If subsidies are available, what factors are considered in calculating whether a plan is affordable and the subsidies for which people will be eligible?
- If subsidies are offered through taxes, are they deductions or credits? Can they be negative payments? To whom are they paid (insurer or individual)?

H. Affordability for the currently insured

- In the case of exchange-style plans, does the proposal guarantee that persons with current coverage will pay no more for that coverage than they would pay if they were to enroll in coverage through the exchange taking into consideration group size (e.g., individual, small group, etc.)?

2. Choice of Coverage, Enrollment, and Marketing

A. Choice of coverage or plans

- Does the proposal specify a choice of coverage or plans where choice of coverage or plans is a relevant consideration (e.g., in an exchange or health mart approach)?
- Does the proposal include a public plan option or requirement in exchange or health mart types of proposals?
- How might the choice of coverage or plan vary depending on whether a subsidy is provided?
- In the case of exchange-style plans, does the proposal guarantee that persons with current coverage may keep that same coverage?

B. Enrollment

- How does the proposal address enrollment overall?
- Is enrollment required (e.g. mandated or optional)?
- If there is an enrollment mandate, for whom – individuals, children, both?
- If there is an enrollment mandate, are there hardship waivers?
- If there is an enrollment mandate, how is enrollment enforced?
- If enrollment is optional, are there incentives to encourage enrollment?

C. Enrollment process and marketing

- How does the proposal address enrollment procedures?
- Does the proposal offer a mechanism for assisting in the plan enrollment process, such as a government sponsored exchange or a health insurance marketing mechanism?
- Does the proposal specify marketing rules and information requirements, including minimum information about coverage, network members, and locations that must be made available to prospective enrollees and the forms and languages that such information must take?

D. Safeguards against involuntary loss of enrollment

- Does the proposal offer safeguards so that in cases of involuntary disenrollment (e.g., losing or changing employment, losing Medicaid in the case of an exchange system, or moving to another state in the case of proposals that are state- based) coverage is not interrupted?

3. Health Insurance Coverage and Access to High Quality Covered Treatments and Services

A. Benefits

- How does the proposal address benefits?
- Are minimum benefit classes specified? If not, who decides?
- Does the proposal speak to particular conditions or covered treatments, and if so, which ones?
- Does the proposal provide a definition of medical necessity?
- Does the proposal specify coverage parity?
- Does the proposal create a public authority to develop publicly detailed standards regarding covered treatments?
- Does the proposal address the question of investigational treatments?
- Does the proposal set out standards for the design of certain critical coverage features such as prescription drug formularies, mental health, long term care, preventive care, physical therapy, etc.?

B. Benefit restrictions

- How does the proposal address benefit restrictions (e.g., exclusion of coverage in certain health care settings such as schools or workplace)?

C. Preventive services and wellness

- How does the proposal address issues of preventive services and wellness in terms of coverage or additional treatments and services in certain settings such as the workplace or incentives for preventive or wellness care?

D. Cost-sharing

- Does the proposal contain affordability tests for patient cost-sharing (e.g., limits on cost-sharing related to percentage of income)?
- Are deductibles, copayments, and coinsurance subject to controls? If so, who has discretion to impose controls?
- Is there an annual or lifetime limit on the amount of out-of-pocket costs that an insured person can incur for covered benefits?
- Does the proposal address the use of tiered cost-sharing for more costly drugs and treatments?
- How does the proposal address the discretion of insurers to place annual or lifetime maximums on the amount of covered care they will pay for? Are they required to be based on information that integrates cost-sharing rules and benefits exclusions with standardized levels of utilization?

E. Provider networks and access to out of network care

- How does the proposal address the adequacy and availability of provider networks?
- Are both primary care and specialty care addressed?
- Does the proposal address circumstances in which access will be granted to out-of-network providers (e.g., centers of clinical excellence) for certain conditions and treatments?

F. Actuarial tests of reasonableness

- How does the proposal address insurer investments in coverage and care?
- Are minimum actuarial values established to assure that premiums are invested in care?

G. Paying for health care coverage

- How does the proposal address provider payment?
- Are payment standards established for one or more types of providers?
- Are health plans and/or providers expected to develop, implement, or accept payment innovations that encourage clinical integration or reward quality and efficiency, such as global payments for episodes of care or value-based payment adjustments?
- Are there special payment rules for providers that treat a disproportionate number of uninsured patients who may be ineligible for premium subsidies (e.g., safety net providers)?
- Are payment methodologies and levels public or proprietary?

4. *Consumer Protections*

A. Information about plan performance

- How does the proposal address the provision of information to consumers and plan members about terms of coverage and plan performance?
- Are plans expected to report (to plan members and/or publicly) on quality and access to their provider network?

B. Utilization management, grievances, and appeals

- In the case of proposals that create new insurance arrangements, how does the proposal address the utilization management review process and provide members with access to information essential to filing and appealing a claim?
- Does the proposal address grievances and appeals including an appeal to an external independent review authority?
- Does the proposal provide a right of judicial review for people whose claims have been denied?
- Is there an expedited appeals process for people with urgent health needs?

C. Choice of provider

- How does the proposal address choice of provider?
- In what circumstances is choice guaranteed, if any?

D. Remedies for injuries

- How does the proposal address remedies in the event that individual members experience injury as a result of the negligent or bad faith denial of a claim for benefits?

E. Medical malpractice

- Does the proposal address medical malpractice?

5. *Treatment of Populations and Communities at Risk of Disparities in Health and Health Care*

A. Investments in primary care for medically underserved populations and communities

- How does the proposal address the need for investments in health care in medically underserved communities?

B. Language access

- How does the proposal address the obligations of health plans to assure access to care among patients who experience language access barriers?

C. Provider obligations to treat members who are residents of medically underserved communities

- How does the proposal address the relationship between provider networks and enrolled populations, including the obligation, if any, on the part of network providers to treat all enrolled members?

D. Data collection and reporting on health care access and quality by race, ethnicity, and language and other factors such as health status or disability?

- How does the proposal address, within its data collection and reporting provisions (if any) the obligation to collect data and/or report (confidentially or publicly) on treatment access and outcomes by race, ethnicity, and language?
- Is data collection and/or reporting (confidentially or publicly) on care and outcomes for special needs populations (e.g., persons with underlying health conditions that can complicate health status) a requirement?

E. Civil rights laws

- How does the proposal interact with existing civil rights laws prohibiting discrimination on the basis of race, sex, national origin, disability, age, or religion?

6. *Treatment of Other Forms of Health Insurance and Health Care Arrangements*

A. Medicaid and CHIP

- How does the proposal address Medicaid and CHIP?

B. Medicare

- How does the proposal address Medicare?

C. Employee health benefits

- How does the proposal address employee health benefits and the role and responsibilities of employers?

D. Indian Health Service

- How does the proposal address the IHS?

E. Veterans and Military health care

- How does the proposal address veterans and military health care?

F. Other non-group arrangements (e.g., individual arrangements)

- How does the proposal address other non-group arrangements?

7. *Integration with Public Health and Public Health Investments*

A. Integration with public health

- Does the proposal address mechanisms for assuring that health plans and participating providers coordinate their services and activities with public health agencies, such as through the sharing of information, the coordination of coverage and treatment with community services such as health or nutritional education, or the reduction of public health risks?

B. Investment in public health

- How does the proposal address public health investments such as funds to conduct surveillance, develop registries, engage in planning, or develop community public health resources such as safe schools and neighborhoods?

C. Public health emergencies

- How does the proposal address investments in public health emergency infrastructure?

8. *Administering the New System and Assuring Accountability*

A. Administration of the system

- Does the proposal address the role of state governments and the federal government in system administration, including enrollment, subsidies, plan certification and plan oversight?

B. Enforcement tools

- What enforcement tools are given to exclude or sanction poor performing plans and/or providers?
- Which governmental entities are in charge of assuring that one or more elements of the new system work properly?

C. Preemption

- How does the proposal address the question of whether state law safeguards may be preempted by new federal standards? What role does state regulation of insurance play, if any?

D. Fraud and abuse

- Does the proposal address reducing fraud and abuse?

9. Improving Quality and Efficiency of the Health Care System

A. Efficiency and quality investments

- How does the proposal address measuring and improving system efficiency and quality, such as investments in health information technology and clinical integration?
- Does the proposal remove any barriers to fostering greater use of health information technology or clinical integration?
- Does the proposal contain provisions linking implementation to previous investments (under the American Recovery and Reinvestment Act) in HIT?

B. Promoting clinical quality of care and efficient resource use

- How does the proposal address provider quality and resource use?
- Are health plans or others required to review and report (to plan members, providers, or publicly) on the clinical quality and/or resource use for one or more types of care, settings, and/or providers?
- Is provider payment conditioned on reporting quality and resource use information and/or performance on specific quality or resource use metrics? If so, who determines which metrics are used? Are payments in the form of incentives? Shared savings programs?
- How does the proposal address direct investments in clinical quality improvement, such as the education and training of health professionals?
- Does the proposal address efforts to strengthen, integrate, and coordinate the clinical quality of care within institutions and delivery systems (e.g., disease management, end-of-life care, Medical Homes)?

C. Investing in research and innovation

- How does the proposal address certain types of research investments, such as clinical effectiveness research or health services research aimed at finding more effective ways to treat and manage conditions?
- How does the proposal address investments related to treatment and practice innovation?
- Does the proposal include any parameters or requirements for implementation?

D. Data collection and reporting, privacy and security

- How does the proposal address the issue of data collection and measuring and reporting provider, plan, population and/or system level performance (quality and resource use) information (confidentially or publicly)?
- Does the proposal address reporting of both the quality of care and the comparative cost of care by different providers, different plans, in different settings, different parts of the country, or in different health systems?
- Does the proposal address privacy and security requirements for data collection and exchange and reporting (confidentially or publicly)?

E. System performance

- How does the proposal address the issue of health system performance?
- Does the proposal create one or more bodies charged with developing measures of performance both overall and in relation to specific populations?

10. Paying for Health Reform

A. General approach to financing

- Does the proposal address how its reforms will be financed (e.g., reductions in federal spending in Medicare or Medicaid, new taxes or added revenue from reducing current tax deductions or exclusions such as employer-sponsored health insurance, program integrity ([fraud and abuse], or efforts to advance system reform [reducing geographic variation in spending, global payments, medical home pilots])?

B. Pay or play

- How does the proposal address the issue of pay or play, if the employer system is retained?
- Are contributions by employers that do not offer plans required?
- Are there incentives to encourage employer contributions (e.g., tax deductions or credits, other)?

C. Keeping health care affordable

- How does the proposal address the need to hold down the cost of care?
- Does the proposal anticipate direct interventions in the cost of care or more indirect interventions, such as restraining the growth of premium subsidies?

D. Changes to the tax code

- How does the proposal address changes to the tax code?