A Human Rights Assessment of Single Payer Plans

Toward the Human Right to Health Care: The Contributions of Single Payer Proposals

May 2009

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Healthcare is a human right. It is not a political football. I pray we have the strength to do what is right and just, publicly funded and privately delivered healthcare – and do it now – because doing less would not be what we are all about as people. We are better than this.
Donna Smith, California Nurses Association, April 2009[1]

President Obama and congressional leaders have arrived at one early conclusion for health reform: single payer proposals are off the table. Despite single payer bills pending in Congress and state legislatures, and opinion polls showing significant support from the public as well as doctors and nurses,[2] a serious discussion of a single payer model has not taken place. This human rights analysis of single payer plans seeks to encourage such a discussion.

The internationally recognized human right to health care does not prescribe a specific health system but provides principles and standards that enable an in-depth assessment of health reform proposals. To take the health care debate from political expediency to factual analysis, this briefing assesses the substance of four different single payer proposals as well as their particular strengths and weaknesses. Since it also continues our series of human rights assessments, we can compare single payer proposals with market-based plans championed by the President and congressional leaders. Our assessments of the 2008 presidential primaries proposals, followed by an analysis of Senators Obama and McCain's plans prior to the election, found that none of these proposals met human rights standards. While Democrats generally scored better than Republicans, all treated health care as a market commodity and failed to recognize the public obligation to guarantee access to care as a public good.[3]

Single payer proposals, in contrast, meet many key human rights standards. They guarantee comprehensive health coverage for all, are financed in an equitable and cost-effective way, and take important steps toward ensuring universality, equity and accountability. While this assessment also points to some of the proposals' shortcomings, such as their reluctance to fully embrace universality by including undocumented immigrants, these tend to arise from concessions to perceived political realities, rather than from structural flaws of the single payer model. In comparison with market-based reform proposals, it is clear that a single payer approach offers an opportunity for a more sustainable and accountable reform of health care than any of the current alternatives.

Key reform issues	Single Payer proposals[4]	Market-based proposals[5]
What is health care?	A public good that everyone is entitled to share.	A commodity that most people have to buy.
Who gets care?	Everyone (some proposals exclude undocumented immigrants).	Different groups get different coverage, and some may not be covered at all.
What care do people get?	A minimum standard of equal high quality care that is medically necessary and appropriate.	What insurance companies are willing to cover, depending on regulation.
What doctors can people see?	Any doctor they choose.	Doctors that participate in an insurance network or accept public programs.
How is it financed?	Publicly, through our taxes, with no additional premiums or cost-sharing.	Privately, with public subsidies. Patients pay premiums and other fees.
Is it cost effective?	Funds are distributed according to health needs, not profit interests, and derive from a single source, thus reducing administration costs.	Costs depend on what the market incentivizes; costly interventions tend to be profitable.
Who is accountable?	Public agencies and governance boards are accountable to Congress, President and the people.	Insurance companies are accountable to shareholders.

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What is “Single Payer”?

“Single payer” is a national health insurance system which guarantees access to medically necessary services for all by collecting and administering funds through a single public agency. While providers are directly reimbursed through the public agency, the delivery of care through hospitals and doctors may remain largely private.

What are the different single payer bills?

In the U.S. Congress:

Conyers HR 676: Introduced by Representative John Conyers (D-Michigan), this bill would establish a U.S. National Health Care Program for everyone living in the United States and entitle all to a universal, best quality standard of care, financed through taxes and delivered by private doctors and public or non-profit hospitals and clinics.

Sanders S 703 / McDermott HR 1200: Introduced by Senator Bernie Sanders (I-Vermont) and Representative Jim McDermott (D-Washington), these bills would establish an American Health Security Program, administered by the states in accordance with federal standards, that entitles every legal resident to comprehensive health care services. Funds derived from federal taxes would be allocated to each state, and care would be delivered by for-profit, non-profit or public providers. Primary care providers and community health centers would receive special support.

Examples from state legislatures:

States have been active laboratories for universal health care, and many state legislatures have debated single payer bills. Most notably, the California legislature twice approved single payer plans, which were subsequently vetoed by Governor Schwarzenegger. Here we focus on two states, Vermont and Minnesota, where quite different single payer bills have been introduced.

Vermont S 99 / H 100: This state single payer bill introduced in the Vermont House and Senate would establish VermontCare to provide universal access to essential care for all residents, financed through state taxes and other sources, including a potential waiver for using Medicaid funds, while maintaining other federal public health programs. Care delivery through existing private (non-profit) and public providers would be planned and overseen at the community level.

Minnesota SF 118/ HF 135: This state single payer bill introduced in the Minnesota House and Senate would establish the Minnesota Health Plan to provide universal access to care for all residents, funded through sliding scale social insurance premiums and waivers for using existing federal funds. Care delivery through existing private (non-profit) and public providers would be planned in metropolitan and rural health boards.

To enable states to test innovative universal health care solutions, Senator Sanders introduced a bill (S. 898) in April 2009 designed to offer financial grants and legal flexibility to five competitively selected states for implementing a universal health care system. The bill specified that at least one of these grants would have to be earmarked for testing a single payer system. States would be able to obtain waivers permitting the use of federal funds for providing universal comprehensive services and to apply for exemption from federal legal provisions that would otherwise impede the demonstration project. If passed, this legislation would considerably ease a full-fledged implementation of single payer systems in states, and ultimately facilitate a replication of successful examples at national level.

What is a human rights assessment?

Health care reform proposals can be measured against human rights standards, which guarantee a health care system that is universal, equitable and accountable to the people.

Specifically, the human right to health care requires that hospitals, clinics, drugs, and doctor’s services must be accessible for all, available in all areas, appropriate to needs, and of high quality for everyone. Health care must be financed and delivered in a non-discriminatory way that enables the participation of individuals and communities, provides access to information and ensures transparency, and has effective mechanisms to hold both the public and private sector accountable.

Human right to health care principles: how do single payer plans measure up?

Single payer plans treat health care as an essential service – a public good – to be financed and delivered for the purpose of meeting people's fundamental health needs. While the bills analyzed here do not explicitly recognize health care as a right, they do guarantee access to care and confer on everyone an entitlement to comprehensive services. Their goal is to provide universal access to quality care, and to that end they design a simple system with one major financing source that allocates resources based on needs and collects contributions based on ability to pay. This would allow costs and benefits to be shared equitably by all.

The principle of universality, emphasized by all single payer proposals, is compromised in some instances for the sake of political expediency. At least one bill does not extend entitlements to undocumented residents, and thus fails to meet a basic human rights tenet. However, Conyers' HR 676, the overall strongest proposal when measured according to human rights standards, not only guarantees health care for every resident, but also boasts the most equitable way of paying for universal access through a portfolio of progressive taxation measures.

The assessment shows that all single payer proposals would provide more affordable and comprehensive care than market-based plans. They achieve this by eliminating the need for private insurers as middlemen and instead setting up a public fund that would pay providers directly for a comprehensive range of services that are monitored for quality. While some proposals fall short of listing all services integral to a human rights based system, most specify a transparent process by which decisions about the scope of covered services can be reviewed.

All single payer proposals, but in particular the current state-based plans (assuming they were adopted on a national scale), facilitate a more rational, needs based distribution of infrastructure and resources, thus addressing the problem of medically underserved communities and resulting health disparities. They

Human Rights Principles		**Conyers HR 676**	**Sanders S 703/ McDermott HR 1200**	**Vermont S 99 / H 100**	**Minnesota SF118/HF135**
Health care is a right		◒	◒	◒	◒
Universal access to health goods, facilities and services	Universality	●	◒	◒	◒
	Affordability	●	●	●	◒
	Equity	●	◒	◒	◒
	Comprehensiveness	◒	●	○	◒
Availability of health infrastructure and services everywhere		●	●	●	●
Acceptability and dignity of care		◒	◒	**N/A**	◒
Quality of health care		●	●	●	●
Non-discrimination		●	●	**N/A**	**N/A**
Participation		◒	●	●	●
Information and transparency		**N/A**	◒	●	●
Accountability		◒	●	●	●

KEY: ● fully meets human rights standards ◒ partially meets human rights standards ○ fails to meet human rights standards

remove health care from the calculations of a marketplace that delivers care only where enough paying customers can be identified and rations care for rural and poor communities. Under single payer plans, everyone can choose their own health care provider, and because measures are taken to address provider shortages, doctors should be available where they are needed. Vermont's and Minnesota's bills emphasize regional and community-level planning based on needs assessments, and all proposals offer incentives for increasing primary care delivery.

Plans limited to the state level, however, face greater difficulties in meeting other human rights principles. They are significantly constrained by federal laws and regulations, as well as funding mechanisms for existing public health insurance programs. State-based plans are required to maintain national programs (Medicare, Veterans Administration and the Federal Employees Health Benefits Program) and have to apply for waivers to channel Medicaid and Children's Health Insurance Program funding - and the population eligible for these programs - into the single payer plan. Therefore, they cannot offer a truly universal and unified approach, and may be restricted in the financing mechanisms they use.

Room for improvement? A comparison of strengths and weaknesses

Conyers HR 676

Among all current health care reform proposals - single payer and market-based - Conyers' bill HR 676 has the strongest provisions for universal, equitable and affordable access to health care. Among its particular strengths is the establishment of a universal entitlement to health care that, unlike any other proposal, includes everyone residing in the United States, independent of their immigration status. It also removes all profit interests that have been found to impede health protection by eliminating both insurance companies and investor-owned hospitals and health maintenance organizations. Instead, health care financing, administration and delivery are non-profit or public to ensure that care can be accessed by everyone as a public good, whenever needed, similar to other public services such as firefighting.

HR 676 also guarantees a comprehensive package of health services that are automatically covered, including dental, vision and mental health care. However, clarification is needed on whether reproductive health services are fully covered, as these are not explicitly listed in the bill.

Compared with other single payer bills, HR 676 is not quite as strong on provisions for accountability, participation, information and transparency, although it marks a significant improvement over market-based proposals which tend to offer no participation opportunities and little accountability. This may partially be due to the bill's level of generality (with 30 pages compared to 172 pages of Sanders' S 703), but it also reflects potential weaknesses of a central administrative structure under the authority of the Health & Human Services Secretary, a political appointee that reports to the President and Congress. There is certainly scope for more shared governance

mechanisms that include greater public participation.

Sanders S 703 / McDermott HR 1200

Sanders' and McDermott's bills establish an entitlement to health care, yet this is restricted to legal residents. Authorities may extend benefits to undocumented immigrants on a discretionary basis, but this haphazard way of addressing the health needs of approximately 12 million people is unacceptable from a human rights perspective. Compared to market-based approaches, S 703/HR 1200 are able to substantially increase equity in the health care system by guaranteeing affordable access to health care through tax-based, public financing that distributes resources according to need. Yet contrary to HR 676, Sanders' and McDermott's state-based approach, which gives states flexibility in planning and administering care, could also lead to considerable

variation in levels of access, services and quality. States may be tempted to adjust provision based on budgetary or political considerations rather than health needs, which could result in perpetuating some of the fragmentation and inequities that characterize the current system. Likewise, the proposal of a flat tax rate, in contrast with HR 676's progressive taxation, places a higher burden on low-income people, although this difference may be considered marginal when compared with the high costs shouldered by people in a market-based system.

A noteworthy strength of Sanders' bill, which exceeds provisions in McDermott's proposal, is its significant support for expanding primary health care, and in particular community health centers and the National Health Service Corps, which receive designated funds under S 703. The bill emphasizes securing access to care for all communities, including rural and inner city populations who currently face a shortage of providers, as well as a recognition of the effectiveness of primary care in protecting the health of the entire population. Another strong point of S 703/ HR 1200 are explicit mechanisms for people to hold those who finance and administer health care accountable. For example, the bills propose to establish independent ombudsman offices in each state to act as people's advocates and address concerns and complaints.

Vermont S99 / H100

The House and Senate single payer bills in Vermont are explicit in their recognition of health care as a public good, and the corresponding obligation on government to be accountable for furthering this public good. Yet the bills, as introduced, also remain vague on some important points. For example, it is unclear who may be excluded by "reasonable residency requirements" that are to be defined at a later stage, and what exact financing mechanisms may be adopted as part of a mix that includes an emphasis on broad-based taxes but also allows donations from corporations. Of particular concern is the question of the type of health care services that will be covered by the plan. Even though the international human rights framework is clear on the range of services that a health care system is obligated to provide to everyone, the Vermont bills fails to provide even minimum standards for the "essential" benefits the plan will cover. Instead, it calls for a public process to define those benefits, without any safeguards for services that may be controversial (reproductive health) or expensive (inpatient hospital services). This misplaced flexibility should be addressed in future versions of these bills.

A particular strength of the Vermont bills is their exemplary attention to the important role of community-based health services, which enable communities to assess their needs jointly, take part in planning and decision-making and build strong relationships with providers in their communities.

Minnesota SF118/ HF135

The Minnesota House and Senate single payer bills are different from the other bills discussed here, as they seek to finance a universal plan through social insurance premiums rather than taxes. Compared to market-based proposals, this would make access to care more equitable and affordable, as it removes the exclusions and costs entailed in private insurance policies. Yet compared to tax-based financing, premium payments pose some barriers for low-income people. The bills do not specify premium levels (as percentage of income) and already indicate the option of raising premiums in light of budget difficulties. A premium-based system is also likely to require means-testing to establish eligibility for subsidies, thus reducing the ability of the system to provide the same access routes for all and to facilitate the cohesiveness on which solidarity is based.

Among the particular strengths of the Minnesota bills is an inclusion of translation and interpretation services among the benefits covered by the plan. This dovetails with an emphasis on meeting health needs and ensuring that patients get the services that are appropriate for them. Covered services explicitly include maternity care but not broader reproductive care - possibly an omission that can be clarified in subsequent bill versions. The Minnesota bills include a strong accountability mechanism through an independent ombudsman office which is tasked with helping residents to secure the care they are entitled to and whose powers include making binding decisions on patient grievances.

How to implement the human right to health care: An assessment of single payer plans' financing strategies

Most single payer plans adopt financing strategies that directly correspond to human rights guidelines for financing a health care system.[6]

Focused on health, with comprehensive services

Single payer plans prioritize health and therefore design financing mechanisms in a way to ensure the highest quality of care for the greatest number of people. They do this by eliminating insurance market incentives, profit motives and other incidental factors that usually take precedence over the primary goal of protecting people's health. Despite this overall approach, the details of some proposals fall short – perhaps due to strategic considerations of the current policy environment – by not explicitly covering all comprehensive health services guaranteed in the international legal framework. For example, the full range of reproductive services is not usually listed among the covered benefits. The Sanders/ McDermott bill package can be commended for including such services, yet it falls short on another ground – by allowing for-profit, investor-owned hospitals and health maintenance organizations (HMOs) to continue, even though such facilities prioritize their shareholders' interests over public goals and evidence has shown that this compromises health outcomes.[7]

Universal and unified

All single payer plans finance health care in a much more unified way than market based plans, by establishing a single source of funding that enables reduced and streamlined administration. State-based bills and those proposing a state-based system (S703/HR1200), however, are unable to achieve a unified financing system that fully eliminates tiers and different access routes. This is due to federal constraints or, in the case of Sanders/McDermott's bills, an emphasis on states' flexibility.

Public

Most single payer plans make the financing and administration of a health care system fully public, thus minimizing the disincentives to providing care that characterize the business model of private insurers. Single payer plans treat health care as a public good, provided by both private and public hospitals and doctors. Only Vermont's bill explicitly allows outsourcing of administration to private parties, including insurance companies. Depending on how this provision is implemented, it could lead to a wasteful use of resources, or even give a third party decision-making power over provider claims or similar processes and thus compromise accountability to the people.

Free at the point of access

Single payer systems are generally free at the point of access, as financing is collective, rather than based on individual utilization. This solidarity principle, which removes barriers to accessing care, is a key human rights guideline. All single payer bills prohibit providers from charging for services already covered by the plan, yet Sanders' bill is not sufficiently clear on whether other forms of cost-sharing may be allowed, and while McDermott's HR 1200 rules out deductibles, copayments and coinsurance, it does require coinsurance for long-term care.

Equitable

Most single payer plans rely on tax-based financing, which is generally recognized as the most equitable financing mechanism for public goods and services. Yet there are differences with regard to how tax burdens can be shared to produce the most equitable outcome. Conyers' HR 676 is exemplary in this regard, as it requires wealthy people to pay more, whereas Sanders/McDermott's bills merely propose a flat tax rate. Vermont's bill does not specify a financing mechanism (it refers to broad-based tax funding but also to corporate donations), and Minnesota's plan is not tax-funded but based on premium payments, which may necessitate means-testing to determine eligibility for subsidies and thus increase access barriers and possibly reduce affordability for lower-income people.

Single payer plans correspond to other human rights guidelines for financing health care in so far as their financing mechanisms include measures for ensuring responsiveness to needs, controlling quality, financial sustainability and cost-effectiveness. They also propose strong accountability mechanisms, although HR 676 remains somewhat vague on what legal protections people enjoy and how they can assess the performance of the plan, which relies heavily on centrally based oversight by Congress and the President.

Human rights financing guidelines	HR 676	S 703/ HR 1200	Vermont S99 / H100	Minnesota SF118/ HF135
Focused on health, with comprehensive services	◒	◒	◒	◒
Universal and unified	●	◒	◒	◒
Public	●	●	◒	●
Free at the point of access	●	◒	●	●
Equitable	●	◒	◒	◒
Centered on care	●	●	●	●
Responsive to needs	●	●	●	●
Rewarding quality	●	●	●	●
Cost-effective	●	●	●	●
Accountable	◒	●	●	●

KEY: ● fully meets human rights standards ◒ partially meets human rights standards ○ fails to meet human rights standards

A national health plan for all: realizing the human right to health care

This analysis has shown that if health care reformers are serious about developing a system that is universal, equitable and accountable, they have to give careful consideration to single payer proposals, which are well-placed to meet these principles. All single payer bills reviewed in this briefing are solidly grounded in health policy evidence, entail feasible transition and implementation measures, and are guided by the goal of health protection for the whole of society.

Based on our series of assessments, the single payer plans analyzed here proved to be far superior to market-based proposals evaluated in previous reports. While they do not meet all human rights standards, single payer plans would, if implemented, ensure vastly increased access to quality care for all individuals and communities, improve the care delivery system's responsiveness to health needs, and secure long-term financial sustainability.

The best single payer plans propose giving everyone an entitlement to equal high quality care and treating this care as a public good to which people contribute according to their ability and which they access according to their needs. It is time that this proposal be taken seriously in the United States.

References

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2 See, for example, "Support for National Health Insurance Among U.S. Physicians: 5 Years Later," in: *Annals of Internal Medicine*, Vol. 148, No. 7, April 2008; and The Associated Press - Yahoo Poll, December 2007 (http://news.yahoo.com/page/election-2008-political-pulse-voter-worries).

3 See NESRI / NHeLP, *Human Right to Health Care: Nominees Plans Lag Behind Public Demands*, August 2008; and *Pursuing a New Vision for Health Care: A Human Rights Assessment of the Presidential Candidates Proposals*, February 2008. Available at www.nesri.org.

4 See analysis tables in the appendix starting on page 9.

5 See previous assessments, *supra* note 3.

6 See NESRI / NHeLP, *Human Rights Principles for Financing Health Care*, March 2009. Available at www.nesri.org.

7 See, for example, Woolhandler/ Himmelstein, "When Money is the Mission - The High Costs of Investor-Owned Care," *New England Journal of Medicine*, August 5, 1999; and Landon/ Normand/ Lessler/ O'Malley/ Schmaltz/ Loeb/ McNeil, "Quality of Care for the Treatment of Acute Medical Conditions in US Hospitals", *Archives of Internal Medicine*, Vol. 166, 11/25, 2006.

The Human Right to Health Program, run jointly by the National Economic and Social Rights Initiative (NESRI) and the National Health Law Program (NHeLP), develops human rights tools to support organizations and advocates in their efforts to advance the human right to health care in the United States. Special thanks to the U.S. Human Rights Fund, the Moriah Fund and the Herb Block Foundation for their support.

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ACCESS

Access to care must be **universal**, and protect everyone's health on an **equitable** basis. Facilities, goods, and services must be **affordable** and **comprehensive** for all, and physically accessible where and when needed.

Universal

Health care must be equally accessible to every person living in the United States, guaranteed and continuous throughout people's lives.

Conyers HR 676	Sanders S 703/ McDermott HR 1200	Vermont S99 / H100	Minnesota SF118/ HF135
• Establishes the U.S. National Health Care Program for all individuals residing in the U.S. • Establishes an entitlement to a universal, best quality standard of care. • Presumes eligibility, but requires an initial application to receive an insurance card. • Benefits are continuous and portable. • Eliminates existing federal programs, except for the IHS (to be integrated after 5 years) and the VA (which may be integrated after 10 years based on a congressional review).	• Establishes the American Health Security Program, administered by the states in accordance with federal standards. • Establishes an entitlement to health care services in one's state of residence. • Includes citizens and legal aliens, but leaves to discretion of governing board whether benefits can be extended to other individuals. • Provides for automatic enrollment • Provides for continuous access even for those moving from one state to another or visiting another state. • Eliminates existing federal programs except VA and Indian Health Service.	• Establishes VermontCare to provide universal access, ensured by the state, because health care is recognized as a public good essential to human well-being. • Imposes "reasonable residency requirements," to be defined by the board, which could exclude undocumented and non-resident immigrants. • Provides continuous, responsive and seamless coverage • Provides for automatic enrollment • Maintains Medicare, Veterans Administration, and federal employee's benefit plan • May request a Medicaid waiver	• Establishes the Minnesota Health Plan to provide universal access through social insurance. • Establishes eligibility for all residents. Non-residents employed in the state may be considered eligible. • Requires an initial application and offers only limited presumptive eligibility. • Aims to obtain waiver for federally funded state health programs so that federal money can be used for the plan

Equitable

Health care facilities, goods, and services must be distributed equitably, with resources allocated and accessed according to needs and health risks.

HR 676	S 703/ HR 1200	Vermont S99 / H100	Minnesota SF118/ HF135
• Enables access to health care on the basis of need. • Requires wealthier people to pay more in taxes. • Removes tiers and equalizes access for everyone. • Seeks to reduce health disparities by race, ethnicity, income and geographic region, and to provide high quality, cost-effective, culturally appropriate care to all individuals regardless of race, ethnicity, sexual orientation, or language.	• Enables access to health care on the basis of need (for residents). • Proposes a flat-rate tax. • Removes tiers but retains some fragmentation through state-based administration and delivery. The level of access to care may to some extent depend on the state of residence. • Requires an annual report with data on differences in the health status of the populations of the different states, taking into account income and race. • Does not equalize access to health care for undocumented immigrants.	• Enables access to health care on the basis of need (for residents). • Commits to equitable financing but does not propose a specific mechanism. • Leaves some tiers in place due to constraints imposed by federal programs and policies, i.e. not everyone can join VermontCare. • May define residency requirements in a way that does not give equal access to undocumented and non-resident immigrants.	• Enables access to health care on the basis of need (for residents). • Establishes social insurance premiums, not taxes, which may require means-testing for subsidies and may be less flexible in adjusting to people's ability to pay. • Requires wealthier people to pay more. • Leaves some tiers in place due to constraints imposed by federal programs and policies, i.e. not everyone can join the Minnesota Health Plan.

Affordable

Health care must always be affordable for everyone, with charges based on the ability to pay, regardless of how health care delivery is financed.

Conyers HR 676	Sanders S 703/ McDermott HR 1200	Vermont S99 / H100	Minnesota SF118/ HF135
• Financed through taxation and transfers from discontinued federal health care programs. Taxes include increased income tax on the top 5%, a "modest and progressive excise tax" on payroll and self-employment income, and a small tax on stock and bond transactions. • Free of cost-sharing, co-payments, deductibles, or coinsurance for covered benefits. • Eliminates sale of private insurance plans for all covered services. • Requires health care providers to be non-profit (private or public). • Pays a global budget to institutional providers (separates capital and operational budgets) and a negotiated fee for service to individual practitioners. • Negotiates prices for drugs (on a formulary) and devices.	• Financed through taxation and transfers from discontinued federal programs. Taxes include a 8.7% employer payroll tax and a 2.2% income tax for all earners, without a progressive sliding scale. • Providers cannot impose charges for covered services, but S.703 is unclear on other forms of cost-sharing. HR1200 prohibits cost-sharing except for coinsurance for long-term care. • Eliminates sale of private insurance plans for all covered services. • Allows for-profit provider facilities to continue and pays them in a way that allows a return on investment. • Pays each state a capitation amount (based on state profile, risk adjustment, average individual costs), and 81% to 91% federal contribution. States submit budgets. • Pays a global budget to hospitals (without separating capital and operational budgets); a negotiated fee for service to individual practitioners (states can develop alternative payment methods for individuals). • Negotiates prices for drugs and devices (both on a formulary).	• Seeks to make financing equitable, through "broad-based" taxes (incl. from employers). Exact financing mechanism remains to be decided. Fundraising from third parties (including corporations) is allowed. • Free of charges for covered services. • Eliminates sale of private insurance plans for all covered services. • May subcontract administration of VermontCare to an insurance company or other private party • Pays a global budget to hospitals; can use a variety of payment methods for individual practitioners. • Negotiates prices for drugs (on a formulary).	• Seeks to make access equitable and affordable, though a social insurance premium structure that is progressive, based on the ability to pay, and capped at a maximum premium amount. Financed also through health tax for businesses; collection from collateral sources (e.g. insurance policies and employer plans) or waivers to incorporate collateral sources into a fund. • Board may increase insurance premiums when necessary. • Free of cost-sharing, co-payments, deductibles, or coinsurance for covered benefits. • Eliminates sale of private insurance plans for all covered services. • Pays a global budget to institutional providers, separates capital and operational expenditures and renders the former subject to approval. Pays a negotiated fee schedule to individual practitioners. • Determines covered drugs through formulary or by board decision; does not pay for drugs directly marketed to public.

Comprehensive

Everyone must get all screening, treatments, therapies, drugs, and services needed to protect their health.

Conyers HR 676	Sanders S 703/ McDermott HR 1200	Vermont S99 / H100	Minnesota SF118/ HF135
• Covers all medically necessary services, including mental, dental and vision care, and prescription drugs. • Does not explicitly include reproductive health services.	• Covers all medically necessary or appropriate services, including mental, dental and vision care, family planning, and prescription drugs. • Allows each state to provide additional benefits.	• Covers "essential" health services, but leaves definition of those entirely to a board-directed process (criteria include costs and "values"). • Defines primary care without explicitly including ob/gyn services.	• Covers medically necessary services, including dental, mental and vision care, maternity care, prescription drugs, and translation. • Does not explicitly include family planning services.

AVAILABILITY

Adequate health care infrastructure (e.g. hospitals, community health facilities, trained health care professionals), goods (e.g. drugs, equipment), and services (e.g. primary care, mental health care) must be available in all geographical areas and to all communities.

Conyers HR 676	Sanders S 703/ McDermott HR 1200	Vermont S99 / H100	Minnesota SF118/ HF135
• Requires state directors to submit an annual state health care needs assessment report, based consultation with public health officials, clinicians, patients and patient advocates. • Requires state physician practice review boards to assure adequate access to needed care and fair reimbursements for services. • Requires state directors to plan services and placement of facilities. • Gives patients free choice of participating providers.	• Incentivizes states to develop regional planning mechanisms to ensure rational distribution of resources. • Incentivizes primary care practitioners by adjusting payment rates. • May pay additional amounts to community-based primary care providers and those providing transportation and translation services. • Establishes budget set-asides and grants for primary health care delivery, including for expanding capacity in urban and rural areas. • Requires states to give patients free choice of participating providers.	• Delivers care through community-based systems that focus on meeting community needs and matching capacity to needs. Community health boards will assess and prioritize community health needs and recommend allocation of resources. • Seeks to compensate and distribute primary care adequately and appropriately. • Requires board to ensure that plan provides a choice of services and providers.	• Requires Office of Health Quality and Planning to assess access to care and adequacy of funding. • Establishes metropolitan and rural health planning regions and require regional planning boards to prepare budgets, recommend goals and guidelines. • Requires an analysis of workforce shortages. • May pay individual providers based on geographic location to address provider shortages. • Gives patients free choice of participating providers.

ACCEPTABILITY and DIGNITY

Health care institutions and providers must respect dignity, provide culturally appropriate care, be responsive to needs based on gender, age, culture, language, and different ways of life and abilities. They must respect medical ethics and protect patient confidentiality and privacy rights.

HR 676	S 703/ HR 1200	Vermont S99 / H100	Minnesota SF118/ HF135
• Seeks to provide culturally appropriate care. • Gives patients the option of keeping any portion of their medical records separate from their electronic medical record.	• Requires providers of school-based services to tackle access barriers, including those resulting from an area's physical characteristics, its economic, social and cultural grouping, and available transportation. If such providers serve a substantial proportion of people with limited English proficiency, their needs should be met in the language and cultural context most appropriate to the individuals.	• Not addressed.	• Seeks to ensure that everyone receives linguistically and culturally competent care. • Mandates that covered services include language interpretation and translation, including sign language and Braille.

QUALITY

All health care must be medically appropriate and of good quality, guided by quality standards and control mechanisms, and provided in a timely, continuous, safe, and patient-centered manner.

Conyers HR 676	Sanders S 703/ McDermott HR 1200	Vermont S99 / H100	Minnesota SF118/ HF135
• Requires providers to meet quality standards. • Requires federal Office of Quality Control to issue annual reports and recommendations. • Requires state physician practice review boards to assure quality. • Requires state directors establish a quality assurance mechanism. • Seeks to establish a universal, best quality standard of care through a National Board of Universal Quality and Access.	• Requires providers to meet national qualifications and performance standards, including patient satisfaction. • Requires quality reviews of providers. • Establishes a national quality council to assure the quality of health services provided, as well as state-based quality review programs which must meet federal standards. • Uses health outcomes as a key measurement.	• Places emphasis on using health outcomes and public health indicators to measure progress. • Requires the board to ensure that quality of care and health outcomes are improved. • Establishes a health care quality unit that is responsible for policies, procedures and oversight to ensure quality of care and patient safety. • Seeks to integrate delivery of care and provide a coordinated continuum of services through community-based mechanisms.	• Establishes quality assurance procedures and seeks to ensure continuum of high quality services to all. • Requires Office of Health Quality and Planning to assess quality. • Encourages care coordination and medical homes.

Non-Discrimination

Health care must be provided and accessible without discrimination (in intent or effect) based on health status, race, ethnicity, age, sex, sexuality, disability, language, religion, national origin, income, or social status.

Conyers HR 676	Sanders S 703/ McDermott HR 1200	Vermont S99 / H100	Minnesota SF118/ HF135
• Seeks to provide high quality, culturally appropriate care to all individuals regardless of race, ethnicity, sexual orientation, or language.	• Requires providers to deliver services in a non-discriminatory way, and makes compliance subject to quality reviews. • Seeks to ensure that members of governing bodies reflect the racial, ethnic and gender composition of the population. • Requires reporting on differences in health status based on state of residence, income and race.	• Not addressed.	• Not addressed.

Information & Transparency

Health information must be easily accessible for everyone, enabling people to protect their health and claim quality health services. Institutions that organize, finance or deliver health care must operate in a transparent way.

Conyers HR 676	Sanders S 703/ McDermott HR 1200	Vermont S99 / H100	Minnesota SF118/ HF135
• Not addressed.	• Requires governance bodies to publish annual reports on access, quality, costs, needs and outcomes. • Develops a public system for the collection, analysis and dissemination of information on primary care and prevention research. • Offers support to community organizations in applying for public health program funds.	• Establishes community health boards whose role includes communicating with the public and providing information on costs, quality, outcomes, and patient satisfaction.	• Requires regional board to collaborate with local agencies to educate “consumers” and providers on public health. • Requires ombudsman to develop and disseminate informational guides describing “consumer” rights and responsibilities. • Gives ombudsman unlimited access to all nonconfidential and all nonprivileged board documents. • Provides a website with public information on the Plan, including on Board planning meetings.

Participation

Individuals and communities must be able to take an active role in decisions that affect their health, including in the organization and implementation of health care services.

Conyers HR 676	Sanders S 703/ McDermott HR 1200	Vermont S99 / H100	Minnesota SF118/ HF135
• Requires National Board of Universal Quality and Access (with advisory function) to include citizen patient advocates, unions, health care advocacy groups and providers. • Gives patients the right to petition for drugs to be included on or removed from drug formulary.	• Requires governance board to include members representing “consumer” interests. • Establishes an advisory council to the board with a majority of “consumer” representatives and requires states to do the same. • Seeks to develop “consumer” and peer reviews of drug utilization and quality of services. • Requires board to consult with private entities, such as professional societies, national associations, academic health centers, “consumer” groups, and labor and business organizations in the formulation of guidelines, regulations and policy to assure broad public input.	• Requires a mechanism to ensure public input into implementation and administration of VermontCare. • Provides for community health boards in each region, consisting of health care institutions, providers and community members.	• Requires governance board to include one “consumer” member and five providers. • Seeks to establish a process to receive concerns and opinions of the public regarding all aspects of the Minnesota Health Plan and the means of addressing those concerns.

Accountability

Private companies and public agencies must be held accountable for protecting the right to health care through enforceable standards, regulations, and independent compliance monitoring.

Conyers HR 676	Sanders S 703/ McDermott HR 1200	Vermont S99 / H100	Minnesota SF118/ HF135
• Administered through the U.S. Department of Health and Human Services (the Secretary and an appointed Director), and through regional offices established by the Director, utilizing the Medicare infrastructure. • Advised by a national board which reports twice a year to the Secretary, the Director, Congress and the President.	• Requires board to collect reports from states and report to Congress, including on health outcomes. • Requires board to approve whether state plans meet federal requirements, including with regard to free choice of practitioners, participation in planning, and prioritizing shortages and maldistributions. • Places any state program that fails to comply under the jurisdiction of the federal board. • Requires states to establish independent ombudsman for "consumer" complaints.	• Issues guidelines that mandate accountability. • Seeks to ensure that governance furthers the public good. • Requires annual reports and evaluations to elected officials. • Requires community health boards to exercise oversight and carry out evaluations. • Provides redress through complaints and appeals to board.	• Requires board to submit annual report to the legislature and to carry out evaluations, including consumer surveys. • Makes separate budget available for evaluation and assessments. • Establishes independent Ombudsman Office for Patient Advocacy to represent the interests of "consumers" of health care and to implement a grievance system.