

**ANA POLICY & 2008 PRESIDENTIAL CANDIDATES
-- DEMOCRATIC --**

ANA	BIDEN	DODD	GRAVEL
	Announced health plan 10/23/07	Announced health plan 7/26/07	No date
ACCESS			
1. HC as a human right	Not addressed. Supports universal health care.	Not addressed. Supports universal care.	Not addressed; supports universal health care.
2. Available (geographic; times; alternative sites; disabled; elderly)	Yes, on macro level. Automatically enroll eligible, uninsured children into SCHIP at birth, school registration, or through other income-tested programs, like WIC, reduced price school lunch, or Head Start.	Yes, on a macro level. One Universal HealthMart in tandem with FEHBP available to everyone, unless someone chooses to keep their existing plan. FEHBP and existing plans "available everywhere." Fully portable. Direct enrollment when people file plans or tax returns. Automatic enrollment for those who do not or are unable to enroll directly and choose plans.	Yes. Each individual's entire health history would be on the electronic health record and therefore available to any physicians or medical facility in the country. Permits free choice of doctor and access anywhere.
3. Acceptable (respect autonomy & culture; patient-centered)	Not addressed	Not addressed	Not addressed.
4. Affordable (treatment and followup care; based on ability to pay)	Yes. <i>For children:</i> expand SCHIP to at least 300% FPL; extend coverage to age 21; allow all families to buy into SCHIP on sliding scale based on income. <i>For adults:</i> expand Medicaid eligibility for some parents of low-income children; buy-in to FEHBP-type program on sliding scale based on income; allow people between ages 55-64 to buy into Medicare, w/ subsidy for low-income.	Yes. Expand Medicaid to cover all people under 100% FPL. SCHIP incorporated into Universal HealthMart to guarantee coverage for all children. Consolidated purchasing in FEHBP-like market & benefits for everyone in Universal HealthMart. Sliding scale subsidies to	Yes. Under Gravel's "Universal Single Payer National Voucher Program," all Americans would get a voucher from the government, individually designed to cover a person's health needs (basics + special needs). Modest co-pay and deductible. Paid or by national retail sales tax.

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		<p>supplement premiums for those unable to pay full amount.</p> <p>Subsidies to small business.</p>	
5. All citizens and residents	No. "All Americans"	No. "All Americans."	Unclear; appears to be for Americans.
6. Std. package of essential health services	Allow uninsured to buy into FEHBP-type program + access to reinsurance for catastrophic costs.	Voluntary FEHBP-like market with comprehensive benefits available to everyone.	Yes. Government voucher would cover basics. Plus it would feature individually designed benefits based on a person's own needs.
7. Mental health parity	Yes.	Yes, though not addressed directly; comparable to FEHBP benefits..	Not addressed

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QUALITY			
IOM 2001, <i>Crossing the Quality Chasm</i>" (1st 6 items below)			
1. Safe	Not addressed	Not addressed	Not addressed.
2. Effective	<p>Yes.</p> <p>Increase comparative effectiveness research.</p> <p>Est. Comparative Effectiveness Panel to evaluate treatment protocols, medical devices and new technology and est. best practices for management of chronic conditions.</p>	Not addressed.	Not addressed.
3. Patient-centered	Not addressed.	Not addressed	Not addressed.
4. Timely	Not addressed	Not addressed	Not addressed
5. Efficient	Not addressed	Not addressed	Not addressed.
6. Equitable	Yes.	Yes.	Not addressed

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(eliminate health disparities_	<p>FEHBP buy-in would have age-adjusted “payment” or “bonus” for plans that enroll older and less healthy people to help avoid effects of adverse selection.</p> <p>Insurers that offer indiv. policies could access reinsurance pool if they agree to not turn people away based on pre-existing conditions, or the risk of them.</p> <p>Protect against genetic discrimination by prohibiting employers & insurance cos. From collecting or using genetic info when making decisions re: hiring. Providing health coverage, or discriminating in pricing of a policy.</p>	<p>No adverse risk selection into Universal HealthMart, with “level playing field” for all plans.</p> <p>Eliminates insurance discrimination based on condition.</p>	<p>directly. Universal voucher system meant to create level playing field.</p> <p>No pre-existing conditions.</p>
7. Continuity of care	Not addressed	Yes. Employ management among providers and levels of care, esp. with chronic care management.	Yes. Addressed by universal availability of individuals’ entire health record in electronic form to all providers.
8.Chronic disease management	<p>Yes.</p> <p>Establish chronic disease treatment programs in Medicare and other fed programs to better manage care, esp. when patient has multiple conditions.</p> <p>Support research on best approaches to coordinate chronic care management.</p>	<p>Yes. Implement integrated system of chronic disease management modeled after Veterans Administration. Employ interoperable health IT and</p>	Not addressed.

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9. Disease prevention & health promotion	<p>Yes.</p> <ul style="list-style-type: none"> > Eliminate co-pays for physicals, vaccinations, vision and hearing screenings and preventive dental check-ups for children of any income level. > Increase funding for existing programs that promote awareness and prevention of chronic diseases and obesity. > Require insurers participating in fed programs to cover preventive care. > Waive Medicare co-pay requirements for screenings for cervical, breast and colon cancer, as well as for other high cost chronic diseases. 	Not addressed.	Sees a leadership role for the President in changing the American culture regarding health and personal responsibility (response to question asked by RN at a forum).
10. End of life care	Not addressed	Not addressed	Not addressed

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COST/FUNDING			
1. Support single payer as “most desirable option”	<p>No. Plan espouses “4 essential steps” to lay foundation for universal health care:</p> <ul style="list-style-type: none"> > cover all children > access for adults > reinsurance for catastrophic cases > encouraging prevention & modernization 	<p>No. Supports universal coverage, with private insurance provided through employer or individually through a health insurance marketplace (FEHBP-like), called Universal HealthMart.</p>	<p>Close, but not exactly. Gravel's Universal Single Payer National Voucher Program is similar to single payer, with an element of HSAs added. Eliminates employer role in coverage.</p> <p>Everyone receives a federal voucher for basic or “adequate” health care, with added benefits for any special individual condition that person may have. If more coverage is desired, it will be commercially available.</p>
2. Public funding thru Medicare expansion, based on	Supports buy-in to FEHBP-like program, on sliding scale based	Medicare remains intact.	Funded through a retail sales tax; supplemented by

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payroll taxes, general fund revenues; employers play or pay & indivs can buy into system; add'l services purchased thru private insurers	<p>on income. Would create its own insurance pool. Carriers would have to offer plans, but could have access to reinsurance to help with catastrophic cases.</p> <p>Create Medicare buy-in for people aged 55-64, also with sliding scale based on income.</p>	<p>All people under 100% FPL are eligible for Medicaid.</p> <p>Universal HealthMart financed primarily by a combination of employer and individual/family premiums or contributions to buy insurance policies. Other revenue streams anticipated from administrative savings.</p>	modest co-pays and deductibles.
3. Cost of essential services should be borne by private-public partnership	See above.	See above.	Funded through a retail sales tax; supplemented by modest co-pays and deductibles.
4. Protect families from impoverishment from high medical expenses	<p>Yes. Est. federal reinsurance pool to reimburse employers, insurers or associations 75% catastrophic costs (> \$50K per individual) for active and retired employees & families.</p> <p>To participate in rebate program, employers would have to cover all employees and apply best practices for disease management. Private insurers in indiv. mkt. would have to demonstrate that they operate an effective high cost case management system.</p>	Not addressed directly.	Not explicitly addressed.
5. Personal responsibility (beneficiaries pay portion of care)	Not addressed.	Not addressed, other than by way of sliding scale subsidies.	Modest co-pays and deductibles. Individual can purchase more coverage if desired.
6. Rebalance investment in acute vs. primary & preventive care	Yes, indirectly.	Not addressed.	Not addressed
7. Recognize economic value of RNs	Not specifically addressed.	Not addressed	Not addressed
8. Administrative simplification/ Health IT	Yes. Invest in information technology to improve quality of care, improve patient-provider	Medical underwriting prohibited, yielding "substantial administrative savings."	Depends on universally available electronic health records.

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	<p>communications, and reduce duplication of services and treatment.</p> <p>Invest at least \$1 billion per year to move to electronic health records.</p> <p>Provide grants to states to develop electronic medical records & other health IT systems.</p> <p>Assist hospitals, medical facilities and doctors to upgrade to electronic records systems and implement in their practices.</p> <p>Require uniform billing and claims</p>	<p>Create incentives to spread interoperable health information technology among all providers and plans.</p>	<p>Program would permit 5-6 insurance plans, plus a probable public plan. These would be run by a central body – a National Health Care Board, with Regional Boards supporting.</p>
<p>9. Money for HC provider education; R & D</p>	<p>Yes. (see below for RN-specific proposals).</p> <p>Support research on best approaches to coordinate chronic care management.</p>	<p>Not addressed</p>	<p>Not addressed.</p>

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WORKFORCE			
<p>1. Supply – recruitment and retention of RNs; improve RN work environment; increase RN diversity</p>	<p>Yes. Goal to put 100,000 new nurses in the workforce in the next five years.</p> <p>Acknowledges poor working conditions causing nurses to leave profession prematurely.</p>	<p>Not addressed</p>	<p>Not addressed</p>

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2. Education – expand # nursing faculty; create stable RN funding streams for loans and scholarships	<p>Yes.</p> <ul style="list-style-type: none"> - Increase yearly loan amounts available in the Nurse Student Loan program. - Explicitly include accelerated degree nursing students (have undergrad degree in another field & who go back to school for nursing degree) in Nursing student Loan Program. -Provide funds for academic institutions to est. doctoral nursing degree programs in states that currently lack such a program. - Est. doctoral nursing consortia pilot projects to allow academic institutions to share faculty and other resources to better teach nursing students. - Est. pilot projects between health care facilities and academic institutions to allow nurses to stay in their jobs while also attending school to earn a graduate degree and eventually teach. 	Not addressed	Not addressed
3. Distribution – financial and other incentives to bring RNs to rural and underserved areas; National RN Corp funding; distance learning	Not addressed.	Not addressed	Not addressed
4. Utilization – address barriers to practice in current reimbursement system; Scopes of practice; APRNs as primary case mgrs (amend Medicaid)	Not directly. Identifies nurses as playing critical role in quality of patient care. Does address need for more education money for physicians for primary care, geriatrics and emergency care.	Not addressed	Not addressed.

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<p>PRIORITIES OF CANDIDATES THAT ANA DOES NOT CURRENTLY ADDRESS (from candidates' websites)</p>	<p>Focus on educating next generation of public health workforce – funding and employment opportunities.</p> <p>Pledges to convene groups on all sides of debate within first 90 days of his administration to seek 4 goals of his plan.</p> <p>Remove prohibition against fed government negotiating prescription drug prices for Medicare Part D.</p> <p>Close Medicare gap in benefits –the “doughnut hole” -- that occurs once a retiree hits \$2,250 in coverage.</p>	<p>Would phase in plan implementation in 2 years for ages 0-29 and 55-64; 4 years for ages 30-54.</p>	<p>Focus on removing employer from healthcare equation.</p> <p>Does not anticipate that plan could pass Congress; therefore relies on passing a “national ballot initiative” bill that would permit US voters to participate directly in direction for new health plan.</p>