SIDE-BY-SIDE COMPARISON OF MAJOR HEALTH CARE REFORM PROPOSALS

This side-by-side compares the leading comprehensive reform proposals across a number of key characteristics and plan components. Included in this side-by-side are proposals for moving toward universal coverage that have been put forward by the President and Members of Congress. In an effort to capture the most important proposals, we have included those that have been formally introduced as legislation as well as those that have been offered as principles or in White Paper form. This side-by-side will be regularly updated to reflect changes in the proposals and to incorporate major new proposals as they are announced. The House Tri-Committee summary incorporates the major amendments to the legislation adopted by the three committees of jurisdiction during their mark-ups of the bill. These amendments are identified using an abbreviation for the House panel that approved it — "E&C" for the Committee on Energy and Commerce; "E&L" for the Committee on Education and Labor; and "W&M" for the Committee on Ways and Means.

	Senate Finance Committee America's Healthy Future Act of 2009	Senate HELP Committee Affordable Health Choices Act (S. 1679)	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)	President Obama Principles for Health Reform
Date plan announced	September 16, 2009 (passed by Committee October 13, 2009)	June 9, 2009 (passed by Committee July 15, 2009)	June 19, 2009	February 26, 2009
Overall approach to expanding access to coverage	Require most U.S. citizens and legal residents to have health insurance. Create state-based health insurance exchanges through which individuals can purchase coverage, with premium and cost-sharing credits available to individuals/families with income between 100-400% of the federal poverty level (the poverty level is $18,310 for a family of three in 2009) and create separate exchanges through which small businesses can purchase coverage. Assess a fee on certain employers that do not offer coverage for each employee who receives a tax credit for health insurance through an exchange, with exceptions for small employers. Impose new regulations on health plans in the exchange and in the individual and small group markets. Expand Medicaid to all individuals with incomes up to 133% of the federal poverty level.	Require individuals to have health insurance. Create state-based American Health Benefit Gateways through which individuals and small businesses can purchase health coverage, with subsidies available to individuals/families with incomes up to 400% of the federal poverty level (or $73,240 for a family of three in 2009). Require employers to provide coverage to their employees or pay an annual fee, with exceptions for small employers, and provide certain small employers a credit to offset the costs of providing coverage. Impose new regulations on the individual and small group insurance markets. Expand Medicaid to all individuals with incomes up to 150% of the federal poverty level.	Require all individuals to have health insurance. Create a Health Insurance Exchange through which individuals and smaller employers can purchase health coverage, with premium and cost-sharing credits available to individuals/families with incomes up to 400% of the federal poverty level (or $73,240 for a family of three in 2009). Require employers to provide coverage to employees or pay into a Health Insurance Exchange Trust Fund, with exceptions for certain small employers, and provide certain small employers a credit to offset the costs of providing coverage. Impose new regulations on plans participating in the Exchange and in the small group insurance market. Expand Medicaid to 133% of the poverty level.	President Obama outlined eight principles for health care reform in his FY 2010 Budget overview. The President has indicated that comprehensive health reform should: • Reduce long-term growth of health care costs for businesses and government. • Protect families from bankruptcy or debt because of health care costs. • Guarantee choice of doctors and health plans. • Invest in prevention and wellness. • Improve patient safety and quality care. • Assure affordable, quality health coverage for all Americans. • Maintain coverage when you change or lose your job. • End barriers to coverage for people with pre-existing medical conditions.

	Senate Finance Committee America's Healthy Future Act of 2009	Senate HELP Committee Affordable Health Choices Act (S. 1679)	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)	President Obama Principles for Health Reform
Individual mandate	• Require U.S. citizens and legal residents to have qualifying health coverage. Enforced through a tax penalty of $750 per adult per year. The penalty will be phased-in according to the following schedule: $0 in 2013; $200 in 2014; $400 in 2015; $600 in 2016; and $750 in 2017. Exemptions will be granted for financial hardship, religious objections, American Indians, and if the lowest cost plan option exceeds 8% of an individual's income or if the individual has income below 133% of the poverty level.	• Require individuals to have qualifying health coverage. Enforced through a minimum tax penalty of $750 per individual per year (maximum penalty per family of 4 times the individual penalty). Exemptions to the individual mandate will be granted to residents of states that do not establish an American Health Benefit Gateway, members of Indian tribes, those for whom affordable coverage is not available, those without coverage for fewer than 90 days, and those with incomes below 150% FPL.	• Require all individuals to have "acceptable health coverage". Those without coverage pay a penalty of 2.5% of modified adjusted gross income up to the cost of the average national premium for self-only or family coverage under a basic plan in the Health Insurance Exchange. Exceptions granted for dependents, religious objections, and financial hardship.	• The plan must put the country on a clear path to cover all Americans.
Employer requirements	• Assess employers with more than 50 employees that do not offer coverage a fee for each employee who receives a tax credit for health insurance through an exchange. The penalty is the lesser of a flat dollar amount equal to the average national tax credit for each full-time employee receiving a tax credit or $400 times the total number of full-time employees in the firm. • Exempt employers with 50 or fewer employees from the penalty. • Require employers with 200 or more employees to automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of coverage if they have coverage from another source.	• Require employers to offer health coverage to their employees and contribute at least 60% of the premium cost or pay $750 for each uninsured full-time employee and $375 for each uninsured part-time employee who is not offered coverage. For employers subject to the assessment, the first 25 workers are exempted. • Exempt employers with 25 or fewer employees from the requirement to provide coverage.	• Require employers to offer coverage to their employees and contribute at least 72.5% of the premium cost for single coverage and 65% of the premium cost for family coverage of the lowest cost plan that meets the essential benefits package requirements or pay 8% of payroll into the Health Insurance Exchange Trust Fund. [*E&L Committee amendment: Provide hardship exemptions for employers that would be negatively affected by job losses as a result of requirement.*] • Eliminate or reduce the pay or play assessment for small employers with annual payroll of less than $400,000: – Annual payroll less than $250,000: exempt – Annual payroll between $250,000 and $300,000: 2% of payroll; – Annual payroll between $300,000 and $350,000: 4% of payroll;	Not specified.

	Senate Finance Committee America's Healthy Future Act of 2009	Senate HELP Committee Affordable Health Choices Act (S. 1679)	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)	President Obama Principles for Health Reform
Employer requirements (continued)			– Annual payroll between $350,000 and $400,000: 6% of payroll. [*E&C Committee amendment: Extend the reduction in the pay or play assessment for small employers with annual payroll of less than $750,000 and replace the above schedule with the following:* – *Annual payroll less than $500,000: exempt* – *Annual payroll between $500,000 and $585,000: 2% of payroll;* – *Annual payroll between $585,000 and $670,000: 4% of payroll;* – *Annual payroll between $670,000 and $750,000: 6% of payroll.*] • Require employers that offer coverage to automatically enroll into the employer's lowest cost premium plan any individual who does not elect coverage under the employer plan or does not opt out of such coverage.	
Expansion of public programs	• Expand Medicaid to all individuals (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL (to be implemented in 2014). Adults with incomes between 100-133% FPL will have the option of obtaining coverage through Medicaid or with federal subsidies through the exchange. All newly eligible adults will be guaranteed a benchmark benefit package that at least meets the minimum creditable coverage standards.	• Expand Medicaid to all individuals (children, pregnant women, parents, and adults without dependent children) with incomes up to 150% FPL. Individuals eligible for Medicaid will be covered through state Medicaid programs and will not be eligible for credits to purchase coverage through American Health Benefit Gateways.	• Expand Medicaid to all individuals (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL. Newly eligible, non-traditional (childless adults) Medicaid beneficiaries may enroll in coverage through the Exchange if they were enrolled in qualified health coverage during the six months before becoming Medicaid eligible. Provide Medicaid coverage for all newborns who lack acceptable coverage and provide optional Medicaid coverage to	• As a foundation for health reform, the President signed the Children's Health Insurance Program Reauthorization Act (CHIPRA), which provides coverage to 11 million children.

	Senate Finance Committee America's Healthy Future Act of 2009	Senate HELP Committee Affordable Health Choices Act (S. 1679)	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)	President Obama Principles for Health Reform
Expansion of public programs (continued)	Require states to provide premium assistance to any Medicaid beneficiary with access to employer-sponsored insurance if it is cost-effective for the state. To finance the coverage for the newly eligible (those who were not previously eligible for a full benchmark benefit package or who were eligible for a capped program but were not enrolled), states will receive an increase in the federal medical assistance percentage (FMAP). Initially, the percentage point increase in the FMAP will be 27.3 for states that already cover adults with incomes above 100% FPL and 37.3 for other states. These percentage point increases will be adjusted over time so that by 2019, all states will receive an FMAP increase of 32.3 percentage points for the newly eligible. High need states—those with total Medicaid enrollment that is below the national average for enrollment as a percentage of the state population and unemployment rates of 12% or higher for August 2009—will receive full federal funding for the newly eligible for five years. • Require states to maintain current income eligibility levels for children in Medicaid and the Children's Health Insurance Program (CHIP) until 2019. CHIP benefit package and cost-sharing rules will continue as under current law. Beginning in 2014, states will receive a 23 percentage point increase in the CHIP match rate up to a cap of 100% and a	• Grant individuals eligible for the Children's Health Insurance Program (CHIP) the option of enrolling in CHIP or enrolling in a qualified health plan through a Gateway.	low-income HIV-infected individuals and for family planning services to certain low-income women. In addition, increase Medicaid payment rates for primary care providers to 100% of Medicare rates. [*E&C Committee amendment: Require states to submit a state plan amendment specifying the payment rates to be paid under the state's Medicaid program.*] The coverage expansions (except the optional expansions) and the enhanced provider payments will be fully financed with federal funds. [*E&C Committee amendment: Replace full federal financing for Medicaid coverage expansions with 100% federal financing through 2014 and 90% federal financing beginning in year 2015.*] • Require Children's Health Insurance Program (CHIP) enrollees to obtain coverage through the Health Insurance Exchange (in the first year the Exchange is available) provided the Health Choices Commissioner determines that the Exchange has the capacity to cover these children and that procedures are in place to ensure the timely transition of CHIP enrollees into the Exchange without an interruption of coverage. [*E&C Committee amendment: Require that CHIP enrollees not be enrolled in an Exchange plan until the Secretary certifies that coverage is at least comparable to coverage under an average CHIP plan in effect in 2011. The Secretary must also determine*	

	Senate Finance Committee America's Healthy Future Act of 2009	Senate HELP Committee Affordable Health Choices Act (S. 1679)	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)	President Obama Principles for Health Reform
Expansion of public programs (continued)	.15 percentage point increase in the Medicaid match rate. CHIP-eligible children who are unable to enroll in the program due to enrollment caps will be eligible for tax credits in the state exchanges.		*that there are procedures to transfer CHIP enrollees into the exchange without interrupting coverage or with a written plan of treatment.*]	
Premium subsidies to individuals	• Provide refundable and advanceable premium credits to individuals and families with incomes between 133-400% FPL in 2013, and including individuals and families with incomes between 100-133% FPL in 2014, to purchase insurance through the health insurance exchanges. The premium credits will be tied to the second lowest-cost silver plan in the area and will be provided on a sliding scale basis from 2% of income for those at 100% FPL to 12% of income for those between 300-400% FPL. • Exclude individuals with incomes below 100% FPL from eligibility for the premium credits. These individuals will be eligible for coverage through the Medicaid program. • Provide cost-sharing subsidies to eligible individuals and families with incomes between 100-200% FPL. For those with incomes between 100-150% FPL, the cost-sharing subsidies will result in coverage for 90% of the benefit costs of the plan. For those with incomes between 150-200%, the cost-sharing subsidies will result in coverage for 80% of the benefit costs of the plan. • Limit availability of premium credits and cost-sharing subsidies through the exchanges to U.S.	• Provide premium credits on a sliding scale basis to individuals and families with incomes up to 400% FPL to purchase coverage through the Gateway. The premium credits will be based on the average cost of the three lowest cost qualified health plans in the area, but will be such that individuals with incomes less than 400% FPL pay no more than 12.5% of income and individuals with incomes less than 150% FPL pay 1% of income, with additional limits on cost sharing. • Limit availability of premium credits through the Gateway to U.S. citizens and lawfully residing immigrants who meet income limits and are not eligible for employer-based coverage that meets minimum qualifying criteria and affordability standards, Medicare, Medicaid, TRICARE, or the Federal Employee Health Benefits Program. Individuals with access to employer-based coverage are eligible for the premium credits if the cost of the employee premium exceeds 12.5% of the individuals' income.	• Provide affordability premium credits to eligible individuals and families with incomes up to 400% FPL to purchase insurance through the Health Insurance Exchange. The premium credits will be based on the average cost of the three lowest cost basic health plans in the area and will be set on a sliding scale such that the premium contributions are limited to the following percentages of income for specified income tiers: 133-150% FPL: 1.5 - 3% of income 150-200% FPL: 3 - 5% of income 200-250% FPL: 5 - 7% of income 250-300% FPL: 7 - 9% of income 300-350% FPL: 9 - 10% of income 350-400% FPL: 10 - 11% of income [*E&C Committee amendment: Replaces the above subsidy schedule with the following:* *133-150% FPL: 1.5 - 3% of income* *150-200% FPL: 3 – 5.5% of income* *200-250% FPL: 5.5 - 8% of income* *250-300% FPL: 8 - 10% of income* *300-350% FPL: 10 - 11% of income* *350-400% FPL: 11 - 12% of income*] [*E&C Committee amendment: Increase the affordability credits annually by the estimated savings achieved through adopting a formulary in the public health insurance option, pharmacy benefit manager transparency*	• The plan must protect families' from bankruptcy or debt because of health care costs. • The American Recovery and Reinvestment Act makes coverage more affordable for Americans who lose their jobs and their access to employer-based health coverage by offering a subsidy of 65 percent of the premium costs for COBRA coverage.

	Senate Finance Committee America's Healthy Future Act of 2009	Senate HELP Committee Affordable Health Choices Act (S. 1679)	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)	President Obama Principles for Health Reform
Premium subsidies to individuals (continued)	citizens and legal immigrants who meet income limits. Employees who are offered coverage by an employer are not eligible for premium credits unless the employer plan does not have an actuarial value of at least 65% or if the employee share of the premium exceeds 10% of income. • Require verification of both income and citizenship status in determining eligibility for the federal premium credits.		*requirements, developing accountable care organization pilot programs in Medicaid, and administrative simplification.*] [*E&C Committee amendment: Increase the affordability credits annually by the estimated savings achieved through limiting increases in premiums for plans in the Exchange to no more than 150% of the annual increase in medical inflation and by requiring the Secretary to negotiate directly with prescription drug manufacturers to lower the prices for Medicare Part D plans.*] • Provide affordability cost-sharing credits to eligible individuals and families with incomes up to 400% FPL. The cost-sharing credits reduce the cost-sharing amounts and annual cost-sharing limits and have the effect of increasing the actuarial value of the basic benefit plan to the following percentages of the full value of the plan for the specified income tier: 133-150% FPL: 97% 150-200% FPL: 93% 200-250% FPL: 85% 250-300% FPL: 78% 300-350% FPL: 72% 350-400% FPL: 70% • Limit availability of premium and cost-sharing credits to US citizens and lawfully residing immigrants who meet the income limits and are not enrolled in qualified or grandfathered employer or individual coverage, Medicare, Medicaid (except those eligible to enroll in the Exchange), TRICARE, or VA coverage (with some	

	Senate Finance Committee America's Healthy Future Act of 2009	Senate HELP Committee Affordable Health Choices Act (S. 1679)	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)	President Obama Principles for Health Reform
Premium subsidies to individuals (continued)			exceptions). Individuals with access to employer-based coverage are eligible for the premium and cost-sharing credits if the cost of the employee premium exceeds 11% of the individuals' income [*E&C Committee amendment: To be eligible for the premium and cost-sharing credits, the cost of the employee premium must exceed 12% of individuals' income.*].	
Premium subsidies to employers	• Provide small employers with fewer than 25 employees and average annual wages of less than $40,000 that purchase health insurance for employees with a tax credit. *Phase I:* For tax years 2011 and 2012, provide a tax credit of up to 35% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost or 50% of a benchmark premium. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than $20,000. Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 25% of the employer's contribution toward the employee's health insurance premium. *Phase II:* For tax years 2013 and later, for eligible small businesses that purchase coverage through the state exchange, provide a tax credit	• Provide qualifying small employers with a health options program credit. To qualify for the credit, employers must have fewer than 50 full-time employees, pay an average wage of less than $50,000, and must pay at least 60% of employee health expenses. The credit is equal to $1,000 for each employee with single coverage and $2,000 for each employee with family coverage, adjusted for firm size (phasing out as firm size increases) and number of months of coverage provided. Bonus payments are given for each additional 10% of employee health expenses above 60% paid by the employer. Employers may not receive the credit for more than three consecutive years. Self-employed individuals who do not receive premium credits for purchasing coverage through the Gateway are eligible for the credit. • Create a temporary reinsurance program for employers providing health insurance coverage to retirees ages 55 to 64. Program will reimburse employers for	• Provide small employers with fewer than 25 employees and average wages of less than $40,000 with a health coverage tax credit. The full credit of 50% of premium costs paid by employers is available to employers with 10 or fewer employees and average annual wages of $20,000 or less. The credit phases-out as firm size and average wage increases and is not permitted for employees earning more than $80,000 per year. • Create a temporary reinsurance program for employers providing health insurance coverage to retirees ages 55 to 64. Program will reimburse employers for 80% of retiree claims between $15,000 and $90,000. Payments from the reinsurance program will be used to lower the costs for enrollees in the employer plan. Appropriate $10 billion over ten years for the reinsurance program.	Not specified.

	Senate Finance Committee America's Healthy Future Act of 2009	Senate HELP Committee Affordable Health Choices Act (S. 1679)	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)	President Obama Principles for Health Reform
Premium subsidies to employers (continued)	of up to 50% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost or 50% of a benchmark premium. The credit will be available for two years. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than $20,000. Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 35% of the employer's contribution toward the employee's health insurance premium. • Create a temporary reinsurance program for employers providing health insurance coverage to retirees ages 55 to 64. Program will reimburse employers or insurers for 80% of retiree claims between $15,000 and $90,000. Appropriate $5 billion to finance the program.	80% of retiree claims between $15,000 and $90,000. Program will end when the state Gateway is established. Payments from the reinsurance program will be used to lower the costs for enrollees in the employer plan.		
Tax changes related to health insurance	• Impose a tax on individuals without qualifying coverage of $750 per adult per year to be phased-in beginning in 2014. • Impose an excise tax in 2013 on insurers of employer-sponsored health plans with aggregate values that exceed $8,000 for individual coverage and $21,000 for family coverage (these threshold values will be indexed to the consumer price index for urban consumers (CPI-U) plus 1%). The threshold amounts will be increased for retired individuals	• Impose a minimum tax on individuals without qualifying health care coverage of $750 per individual per year (maximum family penalty of 4 times the individual penalty).	• Impose a tax on individuals without acceptable health care coverage of 2.5% of modified adjusted gross income.	Not specified.

	Senate Finance Committee America's Healthy Future Act of 2009	Senate HELP Committee Affordable Health Choices Act (S. 1679)	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)	President Obama Principles for Health Reform
Tax changes related to health insurance (continued)	age 55 and up and for employees engaged in high-risk professions by $1,850 for individual coverage and $5,000 for family coverage. In the 17 states with the highest health care costs, the threshold amount is increased by 20% initially; this premium increase is subsequently reduced by half each year until it is phased out in 2015. The tax is equal to 40% of the value of the plan that exceeds the threshold amounts and is imposed on the issuer of the health insurance policy, which in the case of a self-insured plan is the plan administrator or, in some cases, the employer. The aggregate value of the health insurance plan includes reimbursements under a flexible spending account for medical expenses (health FSA) or health reimbursement arrangement (HRA), employer contributions to a health savings account (HSA), and coverage for dental, vision, and other supplementary health insurance coverage. • Conform the definition of medical expenses for purposes of employer provided health coverage (including HRAs and health FSAs), HSAs, and Archer medical savings accounts to the definition for purposes of the itemized deduction for medical expenses. This change will exclude the costs for over-the-counter drugs not prescribed by a doctor from being reimbursed through an HRA or health FSA and from being reimbursed on a tax-free basis through an HSA or Archer MSA.			

	Senate Finance Committee America's Healthy Future Act of 2009	Senate HELP Committee Affordable Health Choices Act (S. 1679)	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)	President Obama Principles for Health Reform
Tax changes related to health insurance (continued)	• Increase the tax on distributions from a health savings account that are not used for qualified medical expenses to 20% (from 10%) of the disbursed amount. • Limit the amount of contributions to a flexible spending account for medical expenses to $2,500 per year. • Increase the threshold for the itemized deduction for unreimbursed medical expenses from 7.5% of adjusted gross income to 10% of adjusted gross income for regular tax purposes. Individuals age 65 and older are exempt from the increased threshold. • Impose new fees on segments of the health care sector: – $2.3 billion annual fee on the pharmaceutical manufacturing sector; – $4 billion annual fee on the medical device manufacturing sector; and – $6.7 billion annual fee on the health insurance sector.			

	Senate Finance Committee America's Healthy Future Act of 2009	Senate HELP Committee Affordable Health Choices Act (S. 1679)	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)	President Obama Principles for Health Reform
Creation of insurance pooling mechanisms	• Provide immediate assistance until the new insurance market rules go into effect for those with pre-existing conditions by creating a temporary high-risk pool. Individuals who have been denied health coverage due to a pre-existing medical condition and who have been uninsured for at least six months will be eligible to enroll in the high-risk pool and receive subsidized premiums. The high-risk pool will exist until 2013. • Create state-based exchanges for the individual market and small business health options program (SHOP) exchanges for the small group market. Allow small businesses with up to 100 employees to purchase coverage through the SHOP exchanges beginning in 2015 and permit states to allow businesses with more than 100 employees to purchase coverage in the SHOP exchange beginning in 2017. • Restrict access to coverage through the exchanges to U.S. citizens and legal immigrants. • Create the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of non-profit, member-run health insurance companies in all 50 states and District of Columbia. To be eligible to receive funds, organizations must not be an existing organization, substantially all of its activities must consist of the issuance of qualified health benefit plans in each state in which it is licensed, governance of the organization must be subject to a majority vote of its members,	• Create state-based American Health Benefit Gateways, administered by a governmental agency or non-profit organization, through which individuals and small employers can purchase qualified coverage. States may form regional Gateways or allow more than one Gateway to operate in a state as long as each Gateway serves a distinct geographic area. • Restrict access to coverage through the Gateways to individuals who are not incarcerated and who are not eligible for employer-sponsored coverage that meets minimum qualifying criteria and affordability standards, Medicare, Medicaid, TRICARE, or the Federal Employee Health Benefits Program. • Create a community health insurance option to be offered through state Gateways that complies with the requirements of being a qualified health plan and meets the same requirements as other plans relating to guarantee issue and renewability, insurance rating rules, quality improvement and reporting, solvency standards, licensure, and benefit plan information. Require the community health insurance plan to provide the essential benefits package and offer coverage at all cost-sharing tiers. Require that the costs of the community health insurance plan be financed through revenues from premiums, require the plan to negotiate payment rates with providers, and contract with qualified nonprofit entities to administer the plan.	• Create a National Health Insurance Exchange, through which individuals and employers (phasing-in eligibility for employers starting with smallest employers) can purchase qualified insurance, including from private health plans and the public health insurance option. • Restrict access to coverage through the Exchange to individuals who are not enrolled in qualified or grandfathered employer or individual coverage, Medicare, Medicaid (with some exceptions), TRICARE, or VA coverage (with some exceptions).	• The plan should provide portability of coverage and should offer Americans a choice of health plans.

	Senate Finance Committee America's Healthy Future Act of 2009	Senate HELP Committee Affordable Health Choices Act (S. 1679)	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)	President Obama Principles for Health Reform
Creation of insurance pooling mechanisms (continued)	must operate with a strong consumer focus, and any profits must be used to lower premiums, improve benefits, or improve the quality of health care delivered to its members. Require CO-OPs to meet the same requirements as private insurance plans in the exchanges related to solvency, licensure, provider payments, network adequacy, and any applicable state premium assessments. • Require all state-licensed insurers in the individual and small group markets to participate in the exchanges. • Require guarantee issue and renewability and allow rating variation based only on age (limited to 4 to 1 ratio), tobacco use (limited to 1.5. to 1 ratio), family composition, and geography in the non-group and the small group market (new rules for small group market will be phased-in over five years). Require risk adjustment in the individual and small group markets and prohibit insurers from rescinding coverage. • Require the exchanges to develop a standardized format for presenting insurance options, create a web portal to help consumers find insurance, maintain a call center for customer service, and establish procedures for enrolling individuals and businesses and for determining eligibility for tax credits. Permit exchanges to contract with state Medicaid agencies to determine eligibility for tax credits in the exchanges.	Permit the plan to develop innovative payment policies to promote quality, efficiency, and savings to consumers. Require each State to establish a State Advisory Council to provide recommendations on policies and procedures for the community health insurance option. • Require guarantee issue and renewability of health insurance policies in the individual and small group markets; prohibit pre-existing condition exclusions; prohibit insurers from rescinding coverage except in cases of fraud; and allow rating variation based only on family structure, geography, the actuarial value of the health plan benefit, tobacco use (limited to 1.5 to 1 ratio), and age (limited to 2 to 1 ratio). • Require plans participating in the Gateway to provide coverage for at least the essential health care benefits, meet network adequacy requirements, and make information regarding plan benefits service area, premium and cost sharing, and grievance and appeal procedures available to consumers. • Create three benefit tiers of plans to be offered through the Gateways based on the percentage of allowed benefit costs covered by the plan: – Tier 1: includes the essential health benefits, covers 76% of the benefit costs of the plan, and limits out-of-pocket costs to the Health Savings Account (HSA) current law limit ($5,950 for individuals and $11,900 for families in 2010);	[*E&C Committee amendment: Permit members of the armed forces and those with coverage through TRICARE or the VA to enroll in a health benefits plan offered through the Exchange.*] • Create a new public health insurance option to be offered through the Health Insurance Exchange that must meet the same requirements as private plans regarding benefit levels, provider networks, consumer protections, and cost-sharing. Require the public plan to offer basic, enhanced, and premium plans, and permit it to offer premium plus plans. Finance the costs of the public plan through revenues from premiums. For the first three years, set provider payment rates in the public plan at Medicare rates and allow bonus payments of 5% for providers that participate in both Medicare and the public plan and for pediatricians and other providers that don't typically participate in Medicare. In subsequent years, permit the Secretary to establish a process for setting rates. [*E&C Committee amendment: Require the public health insurance option to negotiate rates with providers so that the rates are not lower than Medicare rates and not higher than the average rates paid by other qualified health benefit plan offering entities.*] Health care providers participating in Medicare are considered participating providers in the public plan unless they opt out.	

	Senate Finance Committee America's Healthy Future Act of 2009	Senate HELP Committee Affordable Health Choices Act (S. 1679)	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)	President Obama Principles for Health Reform
Creation of insurance pooling mechanisms (continued)	• Create four benefit categories of plans plus a separate "young invincible plan" to be offered through the exchange, and in the individual and small group markets: – *Bronze plan* represents minimum creditable coverage and would cover 65% of the benefit costs of the plan, with an out-of-pocket limit equal to the Health Savings Account (HSA) current law limit ($5,950 for individuals and $11,900 for families in 2010); – *Silver plan* includes minimum benefits, covers 70% of the benefit costs of the plan, with the HSA out-of-pocket limits; – *Gold plan* includes the minimum benefits, covers 80% of the benefit costs of the plan, with the HSA out-of-pocket limits; – *Platinum plan* includes the minimum benefits, covers 90% of the benefit costs of the plan, with the HSA out-of-pocket limits; – *Young Invincible plan* available to those 25 years old and younger and provides catastrophic coverage only with the coverage level set at the HSA current law levels except that prevention benefits would be exempt from the deductible. • Reduce the out-of-pocket limits for those with incomes up to 400% FPL to the following levels: – 100-200% FPL: one-third of the HSA limits ($1,983/individual and $3,967/family);	– Tier 2: includes the essential health benefits, covers 84% of the benefit costs of the plan, and limits out-of-pocket costs to 50% of the HSA limit ($2,975 for individuals and $5,950 for families); and – Tier 3: includes the essential health benefits, covers 93% of the benefit costs of the plan, and limits out-of pocket costs to 20% of the HSA limit ($1,190 for individuals and $2,380 for families). • Require states to adjust payments to health plans based on the actuarial risk of plan enrollees using methods established by the Secretary. • Require the Gateway to certify participating health plans, provide consumers with information allowing them to choose among plans (including through a centralized website), contract with navigators to conduct outreach and enrollment assistance, create a single point of entry for enrolling in coverage through the Gateway or through Medicaid, CHIP or other federal programs, and assist consumers with the purchase of long-term care services and supports. • Prohibit plans participating in the Gateways from discriminating against any provider because of a willingness or unwillingness to provide abortions.	Permit the public plan to develop innovative payment mechanisms, including medical home and other care management payments, value-based purchasing, bundling of services, differential payment rates, performance based payments, or partial capitation and modify cost sharing and payment rates to encourage use of high-value services. [*E&C Committee amendment: Clarify that the public health insurance option must meet the same requirements as other plans relating to guarantee issue and renewability, insurance rating rules, network adequacy, and transparency of information.*] [*E&C Committee amendment: Require the public health insurance option to adopt a prescription drug formulary.*] • Create four benefit categories of plans to be offered through the Exchange: – *Basic plan* includes essential benefits package and covers 70% of the benefit costs of the plan; – *Enhanced plan* includes essential benefits package, reduced cost sharing compared to the basic plan, and covers 85% of benefit costs of the plan; – *Premium plan* includes essential benefits package with reduced cost sharing compared to the enhanced plan and covers 95% of the benefit costs of the plan;	

	Senate Finance Committee America's Healthy Future Act of 2009	Senate HELP Committee Affordable Health Choices Act (S. 1679)	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)	President Obama Principles for Health Reform
Creation of insurance pooling mechanisms (continued)	– 200-300% FPL: one-half of the HSA limits ($2,975/individual and $5,950/family); – 300-400% FPL: two-thirds of the HSA limits ($3,987/individual and $7,973/family). • Permit states the option of creating a Basic Health Plan for uninsured individuals with incomes between 133-200% FPL. States opting to provide this coverage will contract with multiple private plans to provide coverage at the level of plans in the exchanges. They are encouraged to include innovative features in the contracts, such as care coordination and incentives for using preventive services and should seek to contract with managed care plans that meet specific performance measures. States will receive 85% of the funds that would have been paid as federal premium and cost-sharing subsidies for eligible individuals in the state with incomes between 133-200% FPL to establish the Basic Health Plan. Individuals with incomes between 133-200% FPL in states creating Basic Health Plans will not be eligible for subsidies in the exchanges. • Require that at least one plan in the exchanges provide coverage for abortions beyond those for which federal funds are permitted and require that at least one plan in the exchange does not provide coverage for abortions beyond those for which federal funds are permitted (in cases of rape or incest or to save the life of the	• Following initial federal support, the Gateway will be funded by a surcharge of no more than 4% of premiums collected by participating health plans.	– *Premium plus plan* is a premium plan that provides additional benefits, such as oral health and vision care. • Require guarantee issue and renewability; allow rating variation based only on age (limited to 2 to 1 ratio), premium rating area, and family enrollment; and limit the medical loss ratio to a specified percentage. • Require plans participating in the Exchange to be state licensed, report data as required, implement affordability credits, meet network adequacy standards, provide culturally and linguistically appropriate services, contract with essential community providers, and participate in risk pooling. Require participating plans to offer one basic plan for each service area and permit them to offer additional plans. [*E&C Committee amendment: Require plans to provide information related to end-of-life planning to individuals and provide the option to establish advance directives and physician's order for life sustaining treatment.*] • Require risk adjustment of participating Exchange plans. • Provide information to consumers to enable them to choose among plans in the Exchange, including establishing a telephone hotline and maintaining a website and provide information on open enrollment periods and how to enroll.	

	Senate Finance Committee America's Healthy Future Act of 2009	Senate HELP Committee Affordable Health Choices Act (S. 1679)	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)	President Obama Principles for Health Reform
Creation of insurance pooling mechanisms (continued)	woman). Prohibit plans participating in the exchanges from discriminating against any provider because of a willingness or unwillingness to provide, pay for, provide coverage of, or refer for abortions.		• [*E&C Committee amendment: Prohibit plans participating in the Exchange from discriminating against any provider because of a willingness or unwillingness to provide abortions.*] . • [*E&C Committee amendment: Facilitate the establishment of non-for-profit, member-run health insurance cooperatives to provide insurance through the Exchange.*] • Allow states to operate state-based exchanges if they demonstrate the capacity to meet the requirements for administering the Exchange.	
Benefit design	• Create minimum creditable coverage that provides a comprehensive set of services, covers 65% of the actuarial value of the covered benefits, limits annual cost-sharing to $5,950/individual and $11,900/family, does not impose annual or lifetime limits on coverage, and is not more extensive than the typical employer plan. Require the Secretary to define and annually update the benefit package through a transparent and public process. (See description of benefit categories in Creation of insurance pooling mechanism.)	• Create the essential health care benefits package that provides a comprehensive array of services and prohibits inclusion of lifetime or annual limits on the dollar value of the benefits. The essential health benefits must be included in all qualified health plans and must be equal to the scope of benefits provided by a typical employer plan. Create a temporary, independent commission to advise the Secretary in the development of the essential health benefit package.	• Create an essential benefits package that provides a comprehensive set of services, covers 70% of the actuarial value of the covered benefits, limits annual cost-sharing to $5,000/individual and $10,000/family, and does not impose annual or lifetime limits on coverage. The Health Benefits Advisory Council, chaired by the Surgeon General, will make recommendations on specific services to be covered by the essential benefits package as well as cost-sharing levels. [*E&L Committee amendment: Require early and periodic screening, diagnostic, and treatment (EPSDT) services for children under age 21 be included in the essential benefits package.*]	Not specified.

	Senate Finance Committee America's Healthy Future Act of 2009	Senate HELP Committee Affordable Health Choices Act (S. 1679)	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)	President Obama Principles for Health Reform
Benefit design (continued)	• Prohibit abortion coverage from being required as part of the minimum benefits package; require segregation of public subsidy funds from private premium payments for plans that choose to cover abortion services beyond Hyde—which allows coverage for abortion services to save the life of the woman and in cases of rape or incest; and require there be no effect on state or federal laws on abortions.	• Specify the criteria for minimum qualifying coverage for purposes of meeting the individual mandate for coverage, and an affordability standard such that coverage is deemed unaffordable if the premium exceeds 12.5% of an individual's adjusted gross income.	[*E&C Committee amendment: Prohibit abortion coverage from being required as part of the essential benefits package; require segregation of public subsidy funds from private premiums payments for plans that choose to cover abortion services beyond Hyde—which allows coverage for abortion services to save the life of the woman and in cases of rape or incest; and require there be no effect on state or federal laws on abortions.*] • All qualified health benefits plans, including those offered through the Exchange and those offered outside of the Exchange (except certain grandfathered individual and employer-sponsored plans) must provide at least the essential benefits package.	
Changes to private insurance	• Impose the same insurance market regulations relating to guarantee issue, premium rating, prohibitions on pre-existing condition exclusions, risk adjustment, and rescissions in the individual market, in the exchange, and in the small group market, phasing in the new rules for small group market over five years. (See new rating and market rules in Creation of insurance pooling mechanism.) • Require health plans to report the proportion of premium dollars spent on items other than medical care and require plans to compile information on coverage in a standard format.	• Impose the same insurance market regulations relating to guarantee issue, premium rating, prohibitions on pre-existing condition exclusions, and prohibitions on insurance plan rescissions in the individual and group markets and in the American Health Benefit Gateways. (See new rating and market rules in Creation of insurance pooling mechanism). • Require health insurers to report their medical loss ratio. • Require health insurers to provide financial incentives to providers to better coordinate care through case management and chronic disease management, promote wellness and health improvement activities, improve patient safety,	• Prohibit coverage purchased through the individual market from qualifying as acceptable coverage for purposes of the individual mandate unless it is grandfathered coverage. Individuals can purchase a qualifying health benefit plan through the Health Insurance Exchange. • Impose the same insurance market regulations relating to guarantee issue, premium rating, and prohibitions on pre-existing condition exclusions in the insured group market and in the Exchange (see creation of insurance pooling mechanism).	• The plan must end barriers to coverage for people with pre-existing medical conditions.

	Senate Finance Committee America's Healthy Future Act of 2009	Senate HELP Committee Affordable Health Choices Act (S. 1679)	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)	President Obama Principles for Health Reform
Changes to private insurance (continued)	• Require all new policies (except stand-alone dental, vision, and long-term care insurance plans) to comply with one of the four benefit categories, including those offered through the exchanges and those offered outside of the exchanges. Require health plans in the individual and small group markets to at least offer coverage in the silver and gold categories. Existing individual and employer-sponsored plans do not have to meet the new benefit standards. (See description of benefit categories in Creation of insurance pooling mechanism.) • Require small employers to provide a plan with a deductible that does not exceed $2,000 for individuals and $4,000 for families unless contributions are offered that offset deductible amounts above these limits. This deductible limit will not affect the actuarial value of bronze plans and does not apply to "young invincible" plans. (See description of benefit categories in Creation of insurance pooling mechanism.) • Allow states the option of merging the individual and small group markets. • Create a temporary reinsurance program to help stabilize premiums during the first three years of operation of the exchanges when the risk of adverse selection due to enforcement of the new rating rules and market changes is greatest. Finance the reinsurance program through mandatory contributions by health insurers.	reduce medical errors, and provide culturally and linguistically appropriate care. • Provide dependent coverage for children up to age 26 for all individual and group policies. • Require insurers and group plans to notify enrollees if coverage does not meet minimum qualifying coverage standards for purposes of satisfying the individual mandate for coverage. • Permit licensed health insurers to sell health insurance policies outside of the Gateway. States will regulate these outside-the-Gateway plans.	• Limit health plans' medical loss ratio to a percentage specified by the Secretary to be enforced through a rebate back to consumers. [*E&L Committee amendment: Limit health plans' medical loss ratio to at least 85%.*] • Improve consumer protections by establishing uniform marketing standards, requiring fair grievance and appeals mechanisms, and prohibiting insurers from rescinding health insurance coverage except in cases of fraud. • Adopt standards for financial and administrative transactions to promote administrative simplification. • Create the Health Choices Administration to establish the qualifying health benefits standards, establish the Exchange, administer the affordability credits, and enforce the requirements for qualified health benefit plan offering entities, including those participating in the Exchange or outside the Exchange.	

	Senate Finance Committee America's Healthy Future Act of 2009	Senate HELP Committee Affordable Health Choices Act (S. 1679)	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)	President Obama Principles for Health Reform
Changes to private insurance (continued)	• Allow insurers to offer a national health plan with a uniform benefits package in the states in which they are licensed. National plans would be required to offer plans with silver and gold benefit packages and would be exempt from state benefit requirements. Allow states to opt out of the national plan. • Permit states to form health care choice compacts and allow insurers to sell policies in any state participating in the compact. Insurers selling policies through a compact would only be subject to the laws and regulations of the state where the policy is written or issued.			
State role	• Require states to create health insurance exchanges for individuals and small businesses and require state insurance commissioners to provide oversight of health plans with regard to the new insurance market regulations, consumer protections, rate reviews, solvency, reserve fund requirements, and premium taxes, and to define rating areas. • Require states to enroll newly eligible Medicaid beneficiaries into state Medicaid programs, coordinate enrollment with the new exchanges, and implement other specified changes to the Medicaid program. Require states to maintain current Medicaid and CHIP eligibility levels for children until 2019. States must also maintain current Medicaid eligibility levels for adults above 133% FPL until 2013 and until	• Establish American Health Benefit Gateways meeting federal standards and adopt individual and small group market regulation changes. • Implement Medicaid eligibility expansions and adopt federal standards and protocols for facilitating enrollment of individuals in federal and state health and human services programs. • Create temporary "RightChoices" programs to provide uninsured individuals with immediate access to preventive care and treatment for identified chronic conditions. States will receive federal grants to finance these programs.	• Require states to enroll newly eligible Medicaid beneficiaries into the state Medicaid programs and to implement the specified changes with respect to provider payment rates, benefit enhancements, quality improvement, and program integrity. • Require states to maintain Medicaid and CHIP eligibility standards, methodologies, or procedures that were in place as of June 16, 2009 as a condition of receiving federal Medicaid or CHIP matching payments. • Require states to enter into a Memorandum of Understanding with the Health Insurance Exchange to coordinate enrollment of individuals in Exchange-participating health plans and under the state's Medicaid program.	Not specified.

	Senate Finance Committee America's Healthy Future Act of 2009	Senate HELP Committee Affordable Health Choices Act (S. 1679)	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)	President Obama Principles for Health Reform
State role (continued)	2014 for those with incomes at or below 133% FPL. A state is exempt from the maintenance of effort requirement for non-disabled adults with incomes above 133% FPL from January 2011 if the state certifies that it is experiencing a budget deficit or will experience a deficit in the following year. • Require states to establish an ombudsman office to serve as an advocate for people with private coverage in the individual and small group markets. • Permit states to obtain a waiver of certain new health insurance requirements if the state can demonstrate that it provides health coverage to all residents that is at least as comprehensive as the coverage required under an exchange plan and that the state plan is budget-neutral to the federal government over 10 years.		• May require states to determine eligibility for affordability credits through the Health Insurance Exchange.	
Cost containment	• Restructure payments to Medicare Advantage plans to base payments on plan bids with bonus payments for quality, performance improvement, and care coordination. Grandfather the extra benefits in MA plans in areas where plan bids are at or below 75% of traditional fee-for-service Medicare (these plans are required to participate in the new competitive bidding process). Provide transitional extra benefits for MA beneficiaries in certain areas if they experience a significant reduction in extra benefits under competitive bidding.	• Establish a Health Care Program Integrity Coordinating Council, a Fraud, Waste, and Abuse Commission, and two new federal department positions to oversee and coordinate policy, program development, and oversight of health care fraud, waste, and abuse in public and private coverage. • Simplify health insurance administration by adopting standards for financial and administrative transactions, including timely and transparent claims and denial management processes and use of standard electronic transactions.	• Simplify health insurance administration by adopting standards for financial and administrative transactions, including timely and transparent claims and denial management processes and use of standard electronic transactions. • [*E&C Committee amendment: Limit annual increases in the premiums charged under any health plans participating in the Exchange to no more than 150% of the annual percentage increase in medical inflation. Provide exceptions if this limit would threaten a health plan's financial viability.*]	• The plan should reduce high administrative costs, unnecessary tests and services, waste, and other inefficiencies that consume money with no added benefit.

	Senate Finance Committee America's Healthy Future Act of 2009	Senate HELP Committee Affordable Health Choices Act (S. 1679)	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)	President Obama Principles for Health Reform
Cost containment (continued)	• Reduce annual market basket updates for inpatient hospital, home health, skilled nursing facility, hospice and other Medicare providers, and adjust for productivity. • Freeze the threshold for income-related Medicare Part B premiums through 2019, and reduce the Medicare Part D premium subsidy for those with incomes above $85,000/individual and $170,000/couples. • Establish an independent Medicare Commission to submit proposals for reducing excess Medicare cost growth by targeted amounts. Proposals submitted by the Commission must be acted on by Congress and if a legislative package with the targeted level of Medicare savings is not enacted, the Commission's proposal will go into effect automatically. The Commission would be prohibited from submitting proposals that would ration care, increase revenues or change benefits, eligibility or Medicare beneficiary cost sharing (including Parts A and B premiums), but would not be prohibited from making recommendations to reduce premium subsidies for Medicare Advantage or stand-alone Part D prescription drug plans. Hospitals and hospices would not be subject to cost reductions proposed by the Commission. Beginning January 1, 2019, the growth target for Medicare spending would be set at GDP per capita plus one percent.		• Modify provider payments under Medicare including: – Modify market basket updates to account for productivity improvements for inpatient hospital, home health, skilled nursing facility, and other Medicare providers; and – Reduce payments for potentially preventable hospital readmissions. • Restructure payments to Medicare Advantage plans, phasing to 100% of fee-for-services payments, with bonus payments for quality. • Increase the Medicaid drug rebate percentage and extend the prescription drug rebate to Medicaid managed care plans. Require drug manufacturers to provide drug rebates for dual eligibles enrolled in Part D plans. • [*E&C Committee amendment: Require the Secretary to negotiate directly with pharmaceutical manufacturers to lower drug prices for Medicare Part D plans and Medicare Advantage Part D plans.*] • [*E&C Committee amendment: Authorize the Food and Drug Administration to approve generic versions of biologic drugs and grant biologics manufacturers 12 years of exclusive use before generics can be developed.*] • Reduce Medicaid DSH payments by $6 billion in 2019, imposing the largest percentage reductions in state DSH allotments in states with the lowest uninsured rates and those that do not target DSH payments.	

	Senate Finance Committee America's Healthy Future Act of 2009	Senate HELP Committee Affordable Health Choices Act (S. 1679)	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)	President Obama Principles for Health Reform
Cost containment (continued)	• Reduce Medicare DSH payments by an amount proportional to the percentage point decrease in the uninsured for the period evaluated. • Eliminate the Medicare Improvement Fund. • Allow providers organized as accountable care organizations (ACOs) that voluntarily meet quality thresholds to share in the cost-savings they achieve for the Medicare program. To qualify as an ACO, organizations must agree to be accountable for the overall care of their Medicare beneficiaries, have adequate participation of primary care physicians and specialists, define processes to promote evidence-based medicine, report on quality and costs measure, and coordinate care. Create a chronic care coordination pilot program to provide the highest cost Medicare beneficiaries with primary care services in their home and allow participating teams of health professionals to share in any savings if they achieve quality outcomes, patient satisfaction, and cost savings. • Create an Innovation Center within the Centers for Medicare and Medicaid Services to test, evaluate, and expand in Medicare, Medicaid, and CHIP different payment structures and methodologies to foster patient-centered care, improve quality, and slow Medicare costs growth. Payment reform models that improve quality and reduce the rate of costs could be expanded throughout the Medicare, Medicaid, and CHIP programs.		• Require hospitals and ambulatory surgical centers to report on health care-associated infections to the Centers for Disease Control and Prevention and refuse Medicaid payments for certain health care-associated conditions. • Reduce waste, fraud, and abuse in public programs by allowing provider screening, enhanced oversight periods, and enrollment moratoria in areas identified as being at elevated risk of fraud in all public programs, and by requiring Medicare and Medicaid program providers and suppliers to establish compliance programs.	

	Senate Finance Committee America's Healthy Future Act of 2009	Senate HELP Committee Affordable Health Choices Act (S. 1679)	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)	President Obama Principles for Health Reform
Cost containment (continued)	• Reduce payments for preventable hospital readmissions in Medicare: for hospitals with readmission rates above a certain threshold reduce payments by 20% if a patient is re-hospitalized with a preventable readmission within seven days and by 10% if a patient is re-hospitalized with a preventable readmission within 15 days, and reduce payments by 1% to hospitals with the highest rates of hospital acquired conditions. • Increase the Medicaid drug rebate percentage for brand name drugs to 23.1, increase the Medicaid rebate for non-innovator, multiple source drugs to 13% of average manufacturer price, and extend the drug rebate to Medicaid managed care plans. • Reduce a state's Medicaid DSH allotment by 50% (25% for low DSH states) once the uninsured rate decreases by at least 50%. DSH allotments will be further reduced, not to fall below 35% of the total allotment in 2012 if states' uninsured rates continue to decrease. Exempt any portion of the DSH allotment used to expand Medicaid eligibility through a section 1115 waiver. • Establish demonstration projects in Medicaid and CHIP to allow pediatric medical providers organized as accountable care organizations to share in cost-savings. • Prohibit federal payments to states for Medicaid services related to health care acquired conditions.			

	Senate Finance Committee America's Healthy Future Act of 2009	Senate HELP Committee Affordable Health Choices Act (S. 1679)	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)	President Obama Principles for Health Reform
Cost containment (continued)	• Eliminate fraud, waste, and abuse in public programs through more intensive screening of providers, the development of the "One PI database" to capture and share data across federal and state programs, increased penalties for submitting false claims, and increase funding for anti-fraud activities.			
Improving quality/health system performance	• Simplify health insurance administration by adopting a single set of operating rules for eligibility verification, claims status, claims payment, and the electronic transfer of funds. • Establish a non-profit Patient-Centered Outcomes Research Institute to identify research priorities and conduct research that compares the clinical effectiveness of medical treatments. The Institute will be overseen by an appointed multi-stakeholder Board of Governors and will be assisted by expert advisory panels. • Encourage states to develop and test alternatives to the current civil litigation system as a way to improve patient safety, reduce medical errors, increase the availability of a prompt and fair resolution of disputes, and improve access to liability insurance, while preserving an individual's right to seek redress in court. Recommend that Congress consider establishing a state demonstration project to evaluate alternatives to the current litigation system.	• Develop a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health. Publish an annual national health care quality report card. Create an inter-agency Working Group on Health Care Quality to coordinate and streamline federal quality activities related to the national quality strategy. • Develop, through a multi-stakeholder process, quality measures that allow assessments of health outcomes; continuity and coordination of care; safety, effectiveness and timeliness of care; health disparities; and appropriate use of health care resources. Require public reporting on quality measures through a user-friendly website.	• Support comparative effectiveness research by establishing a Center for Comparative Effectiveness Research within the Agency for Healthcare Research and Quality to conduct, support, and synthesize research on outcomes, effectiveness, and appropriateness of health care services and procedures. An independent CER Commission will oversee the activities of the Center. [*E&C Committee amendment: Prohibit use of comparative effectiveness research findings to deny or ration care or to make coverage decisions in Medicare.*] • Strengthen primary care and care coordination by increasing Medicaid payments for primary care providers, providing Medicare bonus payments to primary care practitioners (with larger bonuses paid to primary care practitioners serving in health professional shortage areas).	• The plan must ensure the implementation of patient safety measures and provide incentives for changes in the delivery system to reduce unnecessary variability in patient care. It must support the widespread use of health information technology and the development of data on the effectiveness of medical interventions to improve the quality of care delivered. • To lay the foundation for improving the health care delivery system and quality of care, the American Recovery and Reinvestment Act invests $19 billion in health information technology, including $17 billion in incentives to providers to encourage their use of electronic medical records, and provides $1.1 billion for comparative effectiveness research.

	Senate Finance Committee America's Healthy Future Act of 2009	Senate HELP Committee Affordable Health Choices Act (S. 1679)	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)	President Obama Principles for Health Reform
Improving quality/health system performance (continued)	• Establish a national Medicare pilot program to develop and evaluate paying a bundled payment for acute, inpatient hospital services and post-acute care services for an episode of care that begins three days prior to a hospitalization and spans 30 days following discharge. If the pilot program achieves stated goals, develop a plan for making the pilot a permanent part of the Medicare program. • Establish a hospital value-based purchasing program in Medicare to pay hospitals based on performance on quality measures and extend the Medicare physician quality reporting initiative beyond 2010. • Improve care coordination for dual eligibles by creating a new office within the Centers for Medicare and Medicaid services, the Federal Coordinated Health Care Office, to align Medicare and Medicaid benefits, administration, oversight rules, and policies for dual eligibles. • Develop a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health. Create processes for the development of quality measures involving input from multiple stakeholders and for selecting quality measures to be used in reporting to and payment under federal health programs. Establish the Medicaid Quality Measurement Program to establish priorities for the development and advancement of quality measures for adults in Medicaid.	• Create a Center for Health Outcomes Research and Evaluation within the Agency for Healthcare Research and Quality to conduct and support research on the effectiveness of health care services and procedures to provide providers and patients with information on the most effective therapies for preventing and treating health conditions. The Center will be overseen by an appointed multi-stakeholder advisory council. • Provide grants for improving health system efficiency, including grants to establish community health teams to support a medical home model; to implement medication management services for treatment of chronic conditions; to design and implement regional emergency care and trauma systems. • Require hospitals to report preventable readmission rates; hospitals with high re-admission rates will be required to work with local patient safety organizations to improve their rates. • Create a Patient Safety Research Center charged with identifying, evaluating, and disseminating information on best practices for improving health care quality. • Develop interoperable standards for using HIT to enroll individuals in public programs and provide grants to states and other governmental entities to adopt and implement enrollment technology.	• Conduct Medicare pilot programs to test payment incentive models for accountable care organizations and bundling of post-acute care payments, and conduct pilot programs in Medicare and Medicaid to assess the feasibility of reimbursing qualified patient-centered medical homes. [*E&C Committee amendment: Adopt accountable care organization, bundled payment, and medical home models on a large scale if pilot programs prove successful at reducing costs.*] [*E&C Committee amendment: Conduct accountable care organization pilot programs in Medicaid.*] • [*E&C Committee amendment: Establish the Center for Medicare and Medicaid Payment Innovation Center to test payment models that address populations experiencing poor clinical outcomes or avoidable expenditures. Evaluate all models and expand those models that improve quality without increasing spending or reduce spending without reducing quality, or both.*] • [*W&M Committee amendment: Require the Institute of Medicine to conduct a study on geographic variation in health care spending and recommend strategies for addressing this variation by promoting high-value care.*] • Improve coordination of care for dual eligibles by creating a new office or program within the Centers for Medicare and Medicaid Services.	

	Senate Finance Committee America's Healthy Future Act of 2009	Senate HELP Committee Affordable Health Choices Act (S. 1679)	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)	President Obama Principles for Health Reform
Improving quality/health system performance (continued)	• Require enhanced collection and reporting of data on race, ethnicity, and primary language. Also require collection of access and treatment data for people with disabilities.	• Require enhanced collection and reporting of data on race, ethnicity, gender, geographic location, primary language, and underserved rural and frontier populations.	• Establish the Center for Quality Improvement to identify, develop, evaluate, disseminate, and implement best practices in the delivery of health care services. Develop national priorities for performance improvement and quality measures for the delivery of health care services. • Require disclosure of financial relationships between health entities, including physicians, hospitals, pharmacists, and other providers, and manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies. • Reduce racial and ethnic disparities by conducting a study on the feasibility of developing Medicare payment systems for language services, providing Medicare demonstration grants to reimburse culturally and linguistically appropriate services and developing standards for the collection of data on race, ethnicity, and primary language. • [*E&C Committee amendment: Conduct a national public education campaign to raise awareness about the importance of planning for care near the end of life.*]	
Prevention/wellness	• Provide Medicare beneficiaries access to a comprehensive health risk assessment and creation of a personalized prevention plan, eliminate cost-sharing for certain preventive services in Medicare. Cover only proven preventive services in Medicare and Medicaid and provide incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs.	• Develop a national prevention and health promotion strategy that sets specific goals for improving health. Create a prevention and public health investment fund to expand and sustain funding for prevention and public health programs.	• Develop a national strategy to improve the nation's health through evidenced-based clinical and community-based prevention and wellness activities. Create task forces on Clinical Preventive Services and Community Preventive Services to develop, update, and disseminate evidenced-based recommendations on the use of clinical and community prevention services.	• The plan must invest in public health measures proven to reduce cost drivers in our system, such as obesity, sedentary lifestyles, and smoking, as well as guarantee access to proven preventive treatments. The American Recovery and Reinvestment Act provides $1 billion for prevention and wellness.

	Senate Finance Committee America's Healthy Future Act of 2009	Senate HELP Committee Affordable Health Choices Act (S. 1679)	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)	President Obama Principles for Health Reform
Prevention/wellness (continued)	• Require Medicaid coverage for tobacco cessation services for pregnant women, and for states that provide coverage for and remove cost-sharing for preventive services recommended by the US Preventive Services Task Force and recommended immunizations, provide a one percentage point increase in the FMAP for these services and for the tobacco cessation services. • Create a new Medicaid state plan option to permit Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a health home. Provide states taking up the option with 90% FMAP for two years. • Prohibit insurance plans (except existing grandfathered plans and those that use a value-based insurance design) from charging cost-sharing for preventive services. • Allow insurers to vary premium rates based on tobacco use. Any insurer that rates based on tobacco use must provide coverage for comprehensive tobacco cessation programs, including counseling and pharmacotherapy. • Provide grants to small businesses to establish comprehensive, evidence-based workplace wellness programs. • Permit employers to offer employees rewards of up to 30% of the cost of coverage for participating in a wellness program. Rewards may be in the	• Award competitive grants to state and local governments and community-based organizations to implement and evaluate proven community preventive health activities to reduce chronic disease rates and address health disparities. • Prohibit insurance plans from charging cost-sharing (except minimal cost-sharing) for preventive services. Permit insurers to create incentives for health promotion and disease prevention practices. • Permit employers to offer employees rewards—in the form of premium discounts, waivers of cost-sharing requirements, or benefits that would otherwise not be provided—of up to 30% of the cost of coverage for participating in a wellness program and meeting certain health-related standards. Employers must offer an alternative standard for individuals for whom it is unreasonably difficult or inadvisable to meet the standard. The limit may be increased to 50% of the cost of coverage if deemed appropriate. Encourage employers to provide wellness programs by conducting targeted educational campaigns to raise awareness of the value of these programs. • Provide grants to states to create temporary Right Choices Programs to provide uninsured adults with incomes below 350% FPL access to a one-time health risk appraisal, referrals for preventive services, and referrals to safety net providers for treatment of diagnosed illnesses.	• Improve prevention by covering only proven preventive services in Medicare and Medicaid. Eliminate any cost-sharing for preventive services in Medicare and increase Medicare payments for certain preventive services to 100% of actual charges or fee schedule rates.	

	Senate Finance Committee America's Healthy Future Act of 2009	Senate HELP Committee Affordable Health Choices Act (S. 1679)	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)	President Obama Principles for Health Reform
Prevention/wellness (continued)	form of premium discounts, waivers of cost-sharing requirements, or benefits that would otherwise not be provided. Rewards may be increased to 50% of the cost of coverage if a report finds the increase appropriate. Establish 10-state pilot programs in 2014 to permit participating states to apply similar rewards for participating in wellness programs in the individual market.	• Establish a 5-year national public education campaign focused on preventing oral disease and award grants to demonstrate the effectiveness of research-based dental caries disease management activities.		
Long-term care	• Extend the Medicaid Money Follows the Person Rebalancing Demonstration program through September 2016 and allocate $10 million per year for five years to continue the Aging and Disability Resource Center initiatives. • Provide states that undertake reforms to increase nursing home diversions and access to home and community-based services in their Medicaid programs with a targeted increase in the federal matching rate for five years. • Establish the Community First Choice Option in Medicaid to provide community-based attendant supports and services to individuals with disabilities who require an institutional level of care. Provide states with an enhanced federal matching rate of an additional six percentage points for reimbursable expenses in the program. Sunset the option after five years. • Improve transparency of information about skilled nursing facilities (SNF) and nursing homes, enforcement of SNF and nursing home standards and rules, and training of SNF and nursing home staff.	• Establish a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program). The program will provide individuals with functional limitations a cash benefit to purchase non-medical services and supports necessary to maintain community residence. The program is financed through voluntary payroll deductions: all working adults will be automatically enrolled in the program, unless they choose to opt-out.	• [*E&C Committee amendment: Establish a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program). The program will provide individuals with functional limitations a cash benefit to purchase non-medical services and supports necessary to maintain community residence. The program is financed through voluntary payroll deductions: all working adults will be automatically enrolled in the program, unless they choose to opt-out.*] • Improve transparency of information about skilled nursing facilities and nursing facilities.	Not specified.

	Senate Finance Committee America's Healthy Future Act of 2009	Senate HELP Committee Affordable Health Choices Act (S. 1679)	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)	President Obama Principles for Health Reform
Other investments	• Make improvements to the Medicare program: – Provide a 50% discount on brand-name prescriptions filled in the Medicare Part D coverage gap for enrollees, other than those who receive low-income subsidies and those with incomes above $85,000/individual and $170,000/couples; – Make Part D cost-sharing for full-benefit dual eligible beneficiaries receiving home and community-based care services equal to the cost-sharing for those who receive institutional care; and – Provide a one-year increase in physician payments under Medicare to prevent a reduction in fees that would otherwise take effect, with 10% bonus payments for primary care. Provide general surgeons and primary care physicians practicing in health professional shortage areas with a 10% Medicare bonus. • Establish a multi-stakeholder Workforce Advisory Committee to develop a national workforce strategy for recruiting, training, and retaining a health care workforce that meets current and projected health care needs. • Increase the number of Graduate Medical Education (GME) training positions by redistributing currently unused slots, with priorities given to primary care and general surgery and to states with the lowest resident physician-to-population ratios, and increase flexibility in laws and	• Establish a National Health Care Workforce Commission to make recommendations and disseminate information on health workforce priorities, goals, and policies including education and training, workforce supply and demand, and retention practices. • Increase the supply of health care professionals by increasing loans for nursing students and establishing loan repayment programs for public health workers and pediatric specialists. Expand funding for the National Health Service Corps. • Support training of health professionals in direct care, primary care, and dentistry; provide health education and training grants for professionals in geriatric care and mental and behavioral health; and provide prevention, public health, and cultural competence training for health care professionals. • Improve access to care by providing additional funding to increase the number of community health centers and school-based health centers and nurse-managed health clinics.	• Make improvements to the Medicare program: – Reform the sustainable growth rate for physicians, with incentive payments for primary care services, and for services in efficient areas; – Eliminate the Medicare Part D coverage gap (phased in over 15 years) and require drug manufacturers to provide a 50% discount on brand-name prescriptions filled in the coverage gap; – Increase the asset test for Medicare Savings Program and Part D Low-Income Subsidies to $17,000/$34,000; and – Eliminate any cost-sharing for preventive services in Medicare and increase Medicare payments for certain preventive services to 100% of actual charges or fee schedule rates. • Reform Graduate Medical Education to increase training of primary care providers by redistributing residency positions and promote training in outpatient settings and support the development of primary care training programs. • Support training of health professionals, including advanced education nurses, who will practice in underserved areas; establish a public health workforce corps; and promote training of a diverse workforce and provide cultural competence training for health care professionals.	• As an initial investment in strengthening the health care workforce, the American Recovery and Reinvestment Act provides $500 million to train the next generation of doctors and nurses.

	Senate Finance Committee America's Healthy Future Act of 2009	Senate HELP Committee Affordable Health Choices Act (S. 1679)	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)	President Obama Principles for Health Reform
Other investments (continued)	regulations that govern GME funding to promote training in outpatient settings, and ensure the availability of residency programs in rural and underserved areas. Establish Teaching Health Centers, defined as community-based, ambulatory patient care centers, including federally qualified health centers and other federally-funded health centers, that are eligible for Medicare payments for the expenses associated with operating primary care residency programs. • Establish a graduate nurse education demonstration program to provide Medicare reimbursement to hospitals for costs associated with training advance practice nurses. • Impose additional requirements on non-profit hospitals to conduct a community needs assessment every three years and adopt an implementation strategy to meet the identified needs, adopt and widely publicize a financial assistance policy that indicates whether free or discounted care is available and how to apply for the assistance, limit charges to patients who qualify for financial assistance to the amount generally billed to insured patients, and make reasonable attempts to inform patients about the financial assistance policy before undertaking extraordinary collection actions.		[*E&C Committee amendment: Support the development of interdisciplinary mental and behavioral health training programs.] [E&C Committee amendment: Establish a training program for oral health professionals.*] • Provide grants to each state health department to address core public health infrastructure needs. • Conduct a study of the feasibility of adjusting the federal poverty level to reflect variations in the cost of living across different areas. • [*E&L Committee amendment: Grant waivers to requirements related to the Employee Retirement Income Security Act of 1974 (ERISA) to states seeking to establish a state single payer system.*]	

	Senate Finance Committee America's Healthy Future Act of 2009	Senate HELP Committee Affordable Health Choices Act (S. 1679)	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)	President Obama Principles for Health Reform
Financing	CBO estimates the cost of the coverage components of the Chairman's Mark, as amended during mark-up, to be $829 billion over ten years. These costs are financed through a combination of savings from Medicare and Medicaid and new taxes and fees. The net savings from Medicare and Medicaid are estimated to be $404 billion over ten years and the primary sources of these savings include incorporating productivity improvements into Medicare market basket updates, reducing payments to Medicare Advantage plans, creating the Medicare Commission charged with finding savings in the program, changing the Medicaid drug rebate provisions, and cutting Medicaid and Medicare DSH payments. (See descriptions of cost savings provisions in Cost containment.) The largest source of new revenue will come from an excise tax on high cost insurance, which CBO estimates will raise $201 billion over ten years. Additional revenue provisions will generate $196 billion over the same time period. (See Tax changes related to health insurance.) CBO estimates the proposal will reduce the deficit by $81 billion over ten years.	The Congressional Budget Office estimates this proposal will cost $645 billion over 10 years. Because the Senate HELP Committee does not have jurisdiction over the Medicare and Medicaid programs or revenue raising authority, mechanisms for financing the proposal will be developed in conjunction with the Senate Finance Committee.	The Congressional Budget Office estimates the net cost of the proposal (less payments from employers and uninsured individuals) to be $1.042 trillion over ten years. Approximately half of the cost of the plan is financed through savings from Medicare and Medicaid, including incorporating productivity improvements into Medicare market basket updates, reducing payments to Medicare Advantage plans, changing drug rebate provisions, reducing potentially preventable hospital readmissions, and cutting Medicaid DSH payments. The remaining costs are financed through a surcharge imposed on families with incomes above $350,000 and individuals with incomes above $280,000. The surcharge is equal to 1% for families with modified adjusted gross income between $350,000 and $500,000; 1.5% for families with modified adjusted gross income between $500,000 and $1,000,000; and 5.4% for families with modified adjusted gross income greater than $1,000,000. These surcharge percentages may be adjusted if federal health reform achieves greater than expected savings.	President Obama dedicated $630 billion over ten years toward a Health Reform Reserve Fund in his budget outline released in February 2009 to partially offset the cost of health reform.
Sources of information	http://www.finance.senate.gov/sitepages/baucus.htm	http://help.senate.gov/	Ways and Means Committee: http://waysandmeans.house.gov/MoreInfo.asp?section=52 Energy and Commerce Committee: http://energycommerce.house.gov/index.php?option=com_content&view=article&id=1687&catid=156&Itemid=55 Education and Labor Committee: http://edlabor.house.gov/newsroom/2009/07/ed-labor-approves-historic-hea.shtml	http://www.whitehouse.gov/omb/budget/ http://www.HealthReform.gov

	Sens. Tom Coburn and Richard Burr Reps. Paul Ryan and Devin Nunes Patients' Choice Act of 2009 (S. 1099 and H.R. 2520)	Rep. John Conyers U.S. National Health Care Act (H.R. 676)	Rep. John Dingell National Health Insurance Act (H.R. 15)
Date plan announced	May 20, 2009	January 26, 2009	January 6, 2009 (Has introduced similar legislation in each Congressional session since 1957)
Overall approach to expanding access to coverage	Create state-based health insurance exchanges through which private plans offer coverage meeting certain benefit and other standards. Employers can continue to provide coverage to their employees, but the current tax preference for employer-sponsored insurance will be replaced with a tax credit of $2,290 for individuals and $5,710 for families to provide incentives for insurance coverage. Maintain Medicaid coverage for low-income people with disabilities, but integrate low-income families currently eligible for Medicaid into private insurance.	Create a public health insurance program for all U.S. residents. Replace employer coverage and eliminate the Medicare, Medicaid and CHIP programs. Individuals are not required to pay premiums or cost-sharing. Require conversion to a non-profit health care system. Provide for global budgets for hospitals and negotiate annual reimbursement rates with physicians and other non-institutional providers. Finance program by redirecting current federal and state health care spending, impose an employer/employee payroll tax, and leverage additional taxes.	Create a national health insurance program for individuals meeting eligibility requirements. Require states to administer the program and provide for equivalent care for "needy" individuals who do not meet eligibility requirements. A National Health Insurance Board determines allotments for the classes of covered services. Financed by a value-added tax imposed on certain transactions.
Individual mandate	• No requirement for individuals to have coverage. Permit states to establish procedures to automatically enroll individuals into low-cost, high-deductible coverage through the exchange and to provide incentives to individuals to maintain coverage from year to year.	• All individuals residing in the US are covered under the United States National Health Care Act (USNHC).	• Individuals meeting certain requirements are entitled to benefits under the National Health Insurance Program.
Employer requirements	No provision.	No provision.	No provision.
Expansion of public programs	• Restructure the Medicaid program to provide acute care only to low-income people with disabilities, children in foster care, low-income women with breast or cervical cancer, and certain TB-infected individuals. Integrate low-income families into private insurance by providing them with a tax credit plus other financial support. Eliminate the entitlement for long-term care services under Medicaid and replace it with a block grant to states for long-term care services for eligible elderly and disabled individuals. • Allow private facilities to compete with Veteran's Administration facilities to provide care to veterans. • Allow eligible American Indians to access medical care outside of Indian Health Service facilities.	• Create a new public plan, the USNHC program, that provides coverage for a comprehensive set of benefits, including long-term care services, to all US residents. • Eliminate the Medicare, Medicaid, and CHIP programs as beneficiaries of these programs are eligible for the USNHC program. • VA health programs will remain independent for 10 years after which they will either remain independent or be integrated into the USNHC program. The Indian Health Service will remain independent for 5 years after which it will be integrated into the USNHC program.	• Create a new public plan, covering medical, dental, podiatric, home-nursing, hospital, and auxiliary services. A National Health Insurance Board, in consultation with a National Advisory Medical Council determines the scope of benefits consistent with the statute. • Continue Medicare, but enrollees may be transferred into the new program in the future. Medicare beneficiaries are covered under the new program for services that are not covered by Medicare. • Require states to provide equivalent services to those not eligible under the new plan. Current federal Medicaid funds and other federal funds provided to states under the Social Security Act are available for this purpose.

	Sens. Tom Coburn and Richard Burr Reps. Paul Ryan and Devin Nunes Patients' Choice Act of 2009 (S. 1099 and H.R. 2520)	Rep. John Conyers U.S. National Health Care Act (H.R. 676)	Rep. John Dingell National Health Insurance Act (H.R. 15)
Premium subsidies to individuals	• Provide a qualified health insurance credit of $2,290 for individuals and $5,710 for families to be used to purchase health insurance. Individuals enrolled in Medicare or military coverage and people with disabilities enrolled in Medicaid are not eligible for the tax credit. Any tax credit amount exceeding the cost of a health insurance plan purchased by an individual or family will be deposited into a medical savings account. • Provide a supplemental debit card to families with incomes below 200% FPL to be used to pay for private health insurance costs. The amounts available on the debit cards range from $5,000 for families with incomes below 100% FPL to $2,000 for families with incomes between 180 and 200% FPL. Additional amounts provided for pregnancy ($1,000) and infants under age 1 ($500).	• Individuals are not required to pay premiums to obtain coverage nor are they charged copayments or coinsurance for covered benefits.	• Individuals are not required to pay premiums to obtain coverage.
Premium subsidies to employers	No provision.	No provision.	No provision.
Tax changes related to health insurance	• Reform the tax code to eliminate the exclusion of the value of health insurance plans offered by employers from workers' taxable income. • Allow individuals and families purchasing high-deductible health plans that are less than the value of the tax credit to deposit the excess amount into a medical savings account. • Change health savings account (HSA) requirements by allowing health insurance premiums for high-deductible health plans to be paid tax-free from an HSA, increasing the allowable contribution amounts for people with chronic conditions, and permitting high-deductible health plans to cover preventive services, maintenance costs of chronic diseases, and concierge-style primary care services.	No provision.	No provision.

	Sens. Tom Coburn and Richard Burr Reps. Paul Ryan and Devin Nunes Patients' Choice Act of 2009 (S. 1099 and H.R. 2520)	Rep. John Conyers U.S. National Health Care Act (H.R. 676)	Rep. John Dingell National Health Insurance Act (H.R. 15)
Creation of insurance pooling mechanisms	• Provide states with the option of creating State Health Insurance Exchanges through which individuals can purchase qualified private insurance. To encourage the establishment of exchanges, states may be eligible for grants to develop and implement exchanges and may also receive a 1% increase in federal Medicaid payments. States may form regional exchanges. • Require plans participating in the Exchanges to provide coverage on a guarantee issue basis and prohibit discrimination based on pre-existing conditions. • Require plans to provide coverage similar to that provided to Members of Congress. • Require establishment of a mechanism to prevent insurers from charging excessive premiums. Such mechanism may include risk-adjustment among insurance plans participating in the Exchange, health security pools for high-risk individuals, or reinsurance for high-risk individuals.	No provision other than pooling achieved through USNHC.	No provision other than pooling achieved through new public program.
Benefit design	• Provide coverage that meets the same statutory requirements used for the health benefits for Members of Congress. Qualifying health insurance for purposes of obtaining premium credits includes coverage for inpatient and outpatient care, emergency benefits, and physician care and has responsible annual and lifetime benefit maximums.	• Provide coverage for all medically necessary services, including primary care and prevention; inpatient care; outpatient care; emergency care; prescription drugs; durable medical equipment; long-term care; palliative care; mental health services; dental services; chiropractic services; basic vision correction; hearing services; and podiatric care.	• Provide the following classes of personal health services: – Medical services including primary and specialty care; – Dental services; – Podiatric services; – Home-nursing services; – Hospital services, for a maximum of 60 days in a benefit year; – Auxiliary services including diagnostic laboratory services, X-ray and related therapy, physiotherapy, optometry services, prescription drugs, and eyeglasses.
Changes to private insurance	No provision.	• Prohibit insurers from duplicating USNHC benefits but they may offer coverage for benefits not covered by the USNHC program.	No provision.

	Sens. Tom Coburn and Richard Burr Reps. Paul Ryan and Devin Nunes Patients' Choice Act of 2009 (S. 1099 and H.R. 2520)	Rep. John Conyers U.S. National Health Care Act (H.R. 676)	Rep. John Dingell National Health Insurance Act (H.R. 15)
State role	• Create, at state option, state health insurance exchanges that meet federal standards. • Form voluntary compacts (at state option) with other state exchanges to diversify pooling, ease administrative burdens, and increase the availability of innovative insurance products.	No provision.	• Assume responsibility for administration of the program. States must submit a state plan of operations that designates a state agency for administering the program benefits; creates, among other things, an advisory committee; establishes local health service areas to further decentralize program administration; and provides a plan for ensuring that benefits will be provided efficiently and to all areas of the state.
Cost containment	• Encourage adoption and use of health information technology by providing incentives to hospitals and individual providers. Create personal health records maintained by an independent health record bank and available to the individual through a card, much like an ATM card. • Allow providers to form accountable care organizations and receive bonuses in Medicare if they improve quality and satisfaction while also lowering costs. • Adopt competitive bidding for Medicare Advantage plans and set the benchmark bid to 106% of Medicare fee-for-service payments. • Require Medicare beneficiaries making more than $170,000 per year (for couples) to pay more for Medicare Part B and Part D premiums.	• Establish annual budgets for health care professional staffing, capital expenditures, reimbursement for providers, and health professional education. • Pay institutional providers, including hospitals, nursing homes, community or migrant health centers, home care agencies, and other institutional and prepaid group practices, a monthly lump sum to cover operating expenses. • Pay physicians and other non-institutional providers based on a simplified fee scheduled or as a salaried employee in an institution receiving a global budget or in a group practice or HMO receiving capitation payments. • Establish a uniform electronic billing system and create an electronic patient record system. • Allow only public or not-for-profit institutions to participate in USNHC. Private physicians, clinics, and other participating providers may not be investor owned. • Require USNHC program to negotiate annually prices for drugs, medical supplies, and assistive equipment. • Establish a prescription drug formulary that encourages best practices in prescribing and promotes use of generics and other lower cost alternatives.	• Require the National Health Insurance Board to establish allotments for each of five classes of services to be provided under the program (medical services, dental services, home-nursing services, hospital services, and auxiliary services). Allotments are made to the states based on population, medical professionals and facilities, and cost of services. • Require a study of cost control mechanisms, including an analysis of the impact on medical malpractice claims and liability insurance on health care costs.

	Sens. Tom Coburn and Richard Burr Reps. Paul Ryan and Devin Nunes Patients' Choice Act of 2009 (S. 1099 and H.R. 2520)	Rep. John Conyers U.S. National Health Care Act (H.R. 676)	Rep. John Dingell National Health Insurance Act (H.R. 15)
Cost containment (continued)	• Enhance efforts to detect and eliminate fraud and abuse in the Medicare program by establishing procedures to identify and investigate unusual billing, investigating providers and suppliers using identification of ineligible beneficiaries, and imposing penalties on facilities employing physicians or other employees convicted of Medicare or Medicaid fraud. • Adopt medical malpractice reforms that create independent expert panels or state "health courts" or both to review cases and render decisions. Parties will still have access to state courts if not satisfied with decisions.		
Improving quality/health system performance	• Create a new Health Care Services Commission to establish uniform measures for reporting price and quality information. The HSC, managed by five commissioners from the private sector appointed by the President, will issue a report containing guidelines regulating the publication and dissemination of health care information and will be authorized to enforce these standards.	• Require participating providers to meet state quality and licensing guidelines. • Create a National Board of Universal Quality and Access to address issues, such as access to care, quality improvement, administrative efficiency, budget adequacy, reimbursement levels, capital needs, long term care, and staffing levels. • Establish a universal standard of care relating to appropriate staffing levels; appropriate medical technology; scope of work in the workplace; best practices; salary levels for medical professional and support staff.	• Require state and local administration to: – Promote coordination among providers, between providers and public health centers and educational and research institutions. – Emphasize prevention of disease, disability, and premature death. – Insure the provision of efficient, high quality services.
Prevention/wellness	• Emphasize prevention by developing a national strategic prevention plan, creating a web-based prevention tool capable of producing personalized prevention plans, and implementing national science-based media campaigns on health promotion and disease prevention. • Reward seniors who adopt healthier behaviors with lower Medicare premiums.	No provision.	• Emphasize prevention of disease, disability, and premature death.

	Sens. Tom Coburn and Richard Burr Reps. Paul Ryan and Devin Nunes Patients' Choice Act of 2009 (S. 1099 and H.R. 2520)	Rep. John Conyers U.S. National Health Care Act (H.R. 676)	Rep. John Dingell National Health Insurance Act (H.R. 15)
Long-term care	• Make changes to Medicaid long-term care services to provide sates with a defined allotment for Medicaid long-term care services in exchange for having the Medicare program assume responsibility for the premiums, cost-sharing, and deductibles for low-income Medicare beneficiaries and ensure choice between institutionalized and home-based long-term care services.	• Provide coverage for long-term care services through the USNHC program and establish regional budgets to cover these long-term care services. • Encourage long-term care to be provided in home and community-based settings, as opposed to in institutions.	No provision.
Other investments	No provision.	• Establish a USNHC Employment Transition Fund to assist people who lose their jobs as a result of the transition to the new national system. • Create a mechanism to facilitate the conversion of for-profit providers of care to not-for-profit status and provide compensation for the financial losses associated with the conversion.	• Provide grants for training and education of professional and technical personnel needed to provide or administer benefits. Makes available $5 million in 2010 and 2011; and up to one half of one percent of benefit payments annually thereafter.
Financing	Financing will come from the specified cost-containment provisions, converting Medicaid acute care services from defined benefits to defined contributions, block granting Medicaid long-term care services, and eliminating the tax exclusion for employer-sponsored insurance. To ensure revenue-neutrality of the reform proposal, the qualified health insurance credits in any year are limited to savings generated through entitlement reform and repeal of the tax exclusion for employer-sponsored insurance.	The USNHC program will be funded through the USNHC Trust Fund. Funding for the Trust Fund will come from redirecting existing federal payments for health care; increasing the income tax for the top 5% of earners, instituting a modest and progressive payroll tax, and imposing a tax on stock and bond transactions.	Program will be financed through a National Health Care Trust Fund. The trust fund will be funded with a value-added tax of 5 percent imposed on certain transactions.
Sources of information	http://coburn.senate.gov/public/index.cfm?FuseAction=HealthCareReform.Home&ContentRecord_id=5e3b30a4-802a-23ad-4b44-14f0219114c6	http://conyers.house.gov/index.cfm?FuseAction=Issues.Home&Issue_id=063b74a4-19b9-b4b1-126b-f67f60e05f8c	http://www.house.gov/dingell/issue_healthcare.shtml

	Rep. Tom Price (Republican Study Committee) Empowering Patients First Act (H.R. 3400)	Sen. Bernie Sanders American Health Security Act of 2009 (S. 703)	Rep. Pete Stark AmeriCare Health Care Act of 2009 (H.R. 193)
Date plan announced	July 30, 2009	March 25, 2009	January 6, 2009
Overall approach to expanding access to coverage	Allow people who purchase coverage in the individual market to deduct the cost of premiums from their income taxes. Provide refundable tax credits to individuals and families with incomes below 300% FPL to purchase insurance in the individual market. Establish Association Health Plans and Individual Membership Associations through which employers and individuals can purchase coverage. Implement state high-risk pools or reinsurance programs to provide coverage for people with pre-existing health conditions. Require states to provide coverage to 90% of children with family incomes below 200% FPL as a condition for expanding child eligibility to 300% FPL, and require states to provide vouchers to children eligible for Medicaid and CHIP, to be used to purchase private insurance.	Create a state-based public health insurance program for all U.S. residents. Replace employer coverage and eliminate the Medicare, Medicaid and CHIP programs. Individuals are not required to pay premiums or cost-sharing. Provide for global budgets for hospitals and negotiate annual reimbursement rates with physicians and other non-institutional providers. Finance program by redirecting current federal and state health care spending, impose an employer/employee payroll tax, and leverage a new health care income tax.	Create a new public plan, modeled on Medicare, as default coverage for all Americans. Individuals in a qualified group plan or Medicare may opt out of AmeriCare. Require employers and individuals to contribute toward the cost of the plan, with federal premium subsidies available for individuals below 300% FPL. Use Medicare's administrative structure to govern the plan. Financed by premium contributions from employers and individuals, state maintenance of effort payments, and from general revenue.
Individual mandate	• No requirement for individuals to have coverage. Permit employers to automatically enroll individuals in the lowest cost group health plan as long as they can opt out of coverage.	• All individuals residing in the US are entitled to coverage under the American Health Security Act.	• All U.S. residents are entitled to coverage under AmeriCare. Individuals may choose not to enroll in the AmeriCare plan if they have coverage under a group health plan.
Employer requirements	• Permit employers to offer employees a defined contribution for the purchase of health insurance in the individual market. • Require employers to disclose to employees the total amount the employer spends on the employee's health insurance premium.	• Prohibit employers from offering health benefits that duplicate those provided by State health security programs.	• Require employers to contribute at least 80% of the AmeriCare premiums for employees or at least 80% of the cost of the group plan if the employer provides qualifying employee coverage. Employers with fewer than 100 employees will be given an additional three years to come into compliance with this provision. A surcharge may be imposed on employers to prevent adverse selection.

	Rep. Tom Price (Republican Study Committee) Empowering Patients First Act (H.R. 3400)	Sen. Bernie Sanders American Health Security Act of 2009 (S. 703)	Rep. Pete Stark AmeriCare Health Care Act of 2009 (H.R. 193)
Expansion of public programs	• Require states to achieve coverage for 90% of children with family incomes below 200% FPL who are eligible for public coverage before they can expand CHIP for children with family incomes between 200% FPL and 300% FPL. Require states to provide premium assistance for Medicaid and CHIP enrollees with access to employer-sponsored insurance. Require states to offer vouchers to individuals who would otherwise be eligible for Medicaid and CHIP for the purchase of alternative private health insurance.	• Create a new state-based American Health Security Program that provides coverage for a comprehensive set of benefits to all U.S. residents. • Eliminate the Medicare, Medicaid, and CHIP programs as beneficiaries of these programs are eligible for State Health Security Programs. • Veteran's Affairs and Indian Health Service programs remain independent.	• Create a new public plan, modeled on Medicare, as default coverage for all Americans. • AmeriCare plan enrollees are subject to deductibles ($350 individual/$500 family) and coinsurance of 20% until limits on out-of-pocket (OOP) expenses are met. The OOP limits are $2,500 per individual and $4,000 per family. Deductibles and limits are indexed to inflation. • Prohibit coverage under state Medicaid and CHIP programs for benefits covered by AmeriCare plans.
Subsidies to individuals	• Provide a refundable tax credit of $2,000 for individuals and $5,000 for a family of four with incomes up to 200% FPL for the purchase of health insurance in the individual market. Phase down the credit for individuals and families with incomes between 200% FPL and 300% FPL. Citizens and legal permanent residents of the United States are eligible for the tax credit. • Permit individuals eligible for other health benefit programs, including Medicare, Medicaid, CHIP, TRICARE, Veterans' Affairs, the Federal Employee Health Benefits Program, and subsidized group coverage to receive a tax credit instead of coverage through the program.	• Individuals are not required to pay premiums to obtain coverage nor are they charged copayments or coinsurance for covered benefits.	• Low-income individuals (family income <200% FPL) are not required to pay premiums and are not subject to deductibles and co-insurance. • Provide premium subsidies and reduced deductibles for individuals with family incomes between 200% and 300% FPL. • Limit OOP costs for deductibles and coinsurance to 5% of income for those between 200 and 300% FPL, and 7.5% of income for those between 300 and 500% FPL. • No deductibles and coinsurance for pregnancy-related services and covered benefits provided to children (up to age 24).
Subsidies to employers	• Provide small employers (50 and fewer employees) with a temporary tax credit to adopt auto-enrollment procedures and to contribute toward coverage for employees who choose to purchase private coverage in the individual market.	No provision.	No provision.

	Rep. Tom Price (Republican Study Committee) Empowering Patients First Act (H.R. 3400)	Sen. Bernie Sanders American Health Security Act of 2009 (S. 703)	Rep. Pete Stark AmeriCare Health Care Act of 2009 (H.R. 193)
Tax changes related to health insurance	• Reform the tax code to permit individuals and families to deduct the amount paid for premiums purchased in the individual market from taxable income. Cap the deduction at the value of the national exclusion for employer-sponsored insurance. • Provide tax credits to individuals and families with incomes below 300% FPL to purchase health insurance in the individual market. • Allow physicians to deduct costs related to providing uncompensated care required under Emergency Medical Treatment and Active Labor Act (EMTALA). Limit the deduction amount to the Medicare payment amount for the services provided.	• Impose a new health care income tax on individuals of 2.2% of taxable income.	• Individual premium payments for AmeriCare coverage are considered a tax and subject to withholding.
Creation of insurance pooling mechanisms	• Encourage states to implement a high-risk pool, a reinsurance pool, or other risk adjustment mechanism to subsidize the purchase of private health insurance for a high-risk population. Current high-risk pools may qualify if they only cover high-risk populations. New high-risk pools are required to offer at least one high-deductible plan option with a health savings account, multiple competing plan options, and may only cover high-risk populations. Provide a Federal block grant to states to operate qualified high-risk pools and reinsurance pools. • Establish certified Association Health Plans through which member employers can purchase health coverage for their employees. Permit association health plans to determine what benefits will be covered under the plans they offer and allow the same variations in premiums as is permitted in the small group market. • Permit individuals to purchase health coverage through Individual Membership Associations (IMAs) that operate under the direction of an association. Require IMAs to provide coverage through contracts with licensed health insurers that meet state standards relating to consumer protections. Exempt IMAs from state laws relating to benefit mandates. Permit more than one IMA to operate in a geographic area.	No provision other than pooling achieved through state health security programs.	No provision other than pooling achieved through AmeriCare.

	Rep. Tom Price (Republican Study Committee) Empowering Patients First Act (H.R. 3400)	Sen. Bernie Sanders American Health Security Act of 2009 (S. 703)	Rep. Pete Stark AmeriCare Health Care Act of 2009 (H.R. 193)
Benefit design	• Allow tax credit and employer defined contribution to be used for all HIPAA eligible coverage, except certain limited or disease-specific plans. • Prohibit use of federal funds to be used to provide coverage for abortions, except to save the life of the woman or in cases of rape or incest.	• Provide coverage for services including hospital and professional services; community-based primary health care; preventive care; long-term acute and chronic care services, including home and community-based services; prescription drugs; dental services; mental health and substance abuse; diagnostics tests; outpatient therapy; durable medical equipment; and other services as specified by the American Health Security Standards Board.	• Provide the same benefits available through Medicare, with the addition of benefits, such as well-child visits, early and periodic screening, diagnostic, and treatment (EPSDT) services for children, prenatal and obstetric care, and family planning services to reflect the needs of a younger population.
Changes to private insurance	• Permit insurers to sell insurance policies across state lines. Insurers must designate one state as its primary state and the laws and regulations in the primary state apply to coverage offered in that state and in other states. Allow individuals whose premiums for individual health insurance exceed the national average premium by 10 percent or more to purchase coverage in another state. • Require insurance companies to disclose the true health insurance plan costs to employers.	• Prohibit insurers from duplicating State health security program but they may offer coverage for benefits not covered by the health security program.	• Allow AmeriCare supplemental policies to be offered that meet minimum federal standards, including standardized benefits, limitations on sales commissions, and the following: – Require insurers that offer AmeriCare supplemental policies to do so on a guarantee issue and renewability basis and prohibit them from charging higher premiums based on health status. – Require insurers offering AmeriCare supplemental policies to meet minimum medical loss ratios (85% for group policies; 75% for individual policies).
State role	• Encourage states to implement a high-risk pool, reinsurance pool, or other risk adjusted mechanism. States must have a high-risk pool, reinsurance pool, or other risk adjusted mechanism in place in order for state residents to be eligible to receive tax credits to purchase insurance. • Allow states to establish a Health Plan and Provider Portal website to provide information on all health plans and health care providers in the state.	• Create a state health security program to provide health care services to state residents. May join with one or more neighboring states to form a regional health security program. State programs must designate a single state agency to administer the program; establish state health security budgets; establish provider payment methodologies; license and regulate health providers and facilities; establish a quality review system; create an independent ombudsman program to resolve consumer complaints and disputes; publish an annual report on the operation of the state program; and create a fraud and abuse prevention and control unit.	• Require states to make maintenance of effort payments in the amount of the state share of Medicaid and CHIP spending for benefits replaced by the AmeriCare plan. • Allow states to impose more stringent requirements on entities offering AmeriCare supplemental policies than specified by the Secretary.

	Rep. Tom Price (Republican Study Committee) Empowering Patients First Act (H.R. 3400)	Sen. Bernie Sanders American Health Security Act of 2009 (S. 703)	Rep. Pete Stark AmeriCare Health Care Act of 2009 (H.R. 193)
Cost containment	• Adopt medical malpractice reforms that limit lawsuit rewards and create state health care tribunals to review cases and render decisions. Parties will still have access to state courts if not satisfied with decisions. • Reduce Medicaid and Medicare Disproportionate Hospital Share (DSH) funds if there is a decrease in the national uninsurance rate of 8% or more. • Enhance efforts to detect and eliminate fraud and abuse in Medicare and Medicaid by providing funding for the Office of the Inspector General of the Department of Health and Human Services. Identify instances where Medicare should be, but is not, acting as a secondary payer to an individual's private coverage. • Reinstate the Medicare Trigger, which requires the President to submit a plan to contain Medicare costs if 45% or more of the program's funding comes from general tax revenues for two consecutive years.	• Establish annual budgets for operating expenditures, administrative costs, health professional education, and quality assessment activities. • Require states to pay institutional providers, including hospitals and nursing facilities, through an annual prospective global budget and develop payment methodologies for independent health practitioners that include incentives to encourage practitioners to choose primary care medicine. • Limit national health security spending growth to the average annual percentage increase in the gross domestic product. • Establish individual and state capitation amounts and risk adjustment methodologies to be used for developing state and national global budgets. • Limit state administrative costs to 3% of total expenditures. • Create state fraud and abuse prevention and control units to investigate and prosecute violations of state law. • Develop provider payment methodologies that include global fees for related services furnished to individuals over time. • Establish prices for approved prescription drugs, devices, and equipment.	• Generally apply Medicare payment mechanisms, adjusted to reflect the AmeriCare population. • Limit payments to private plans offered through AmeriCare (similar to Medicare Advantage) to average per capita costs under AmeriCare. • Require AmeriCare to develop a fee schedule for outpatient drugs and biologics, to negotiate directly with drug companies for the purchase price of those drugs and biologics, and to encourage greater use of generics and lower cost alternatives. • Require AmeriCare contractors to submit electronic claims. • Apply Medicare provisions relating to fraud and abuse and administrative simplification to AmeriCare plans.
Improving quality/health system performance	• Prohibit comparative effectiveness research from being used to deny coverage of a health care service under a Federal health care program and require the Federal Coordinating Council for Comparative Effectiveness Research to present research findings to relevant specialty organizations before publicly releasing them. • Create a process to develop performance-based quality measures that could be applied to physician services under Medicare.	• Create an American Health Security Quality Council to review and evaluate practice guidelines and performance measures; adopt methodologies for profiling practice patterns and identifying outliers; and develop guidelines for medical procedures to be performed at centers of excellence. • Improve access to care through grants to support the development of primary care centers to serve medically underserved populations in urban and rural areas and the expansion of school health service sites.	• Apply Medicare provisions relating to outcomes research and quality to AmeriCare.

	Rep. Tom Price (Republican Study Committee) Empowering Patients First Act (H.R. 3400)	Sen. Bernie Sanders American Health Security Act of 2009 (S. 703)	Rep. Pete Stark AmeriCare Health Care Act of 2009 (H.R. 193)
Improving quality/health system performance (continued)	• Create a health plan and provider portal website to provide standardized information on health insurance plans and provider price and quality data. Provide states with funding to implement the standardized health plan and provider portal website.		
Prevention/wellness	• Allow insurers that offer health coverage through Individual Membership Associations and the individual market to establish premium discounts/rebates for individuals for adherence to health promotion and disease prevention programs. • Allow employers to vary premiums and cost-sharing up to 50 percent of the value of benefits under the plan, based on participation in a wellness program.	• Create an Office of Primary Care and Prevention Research to identify research related to primary care and prevention for children and adults and to establish a system for collecting, storing, analyzing, and disseminating information related to primary care and prevention research.	No provision.
Long-term care	Not specified.	• Provide coverage for acute and chronic long-term care services through the State American Health Security Programs. • Limit spending on home and community-based care to no more than 65% (or an established alternative ratio) of the average amount that would have been spent if all of the home-based long-term care beneficiaries had been residents of nursing facilities in the same area.	No provision.
Other investments	• Establish a student loan fund with public or non-profit schools of medicine or osteopathic medicine to provide loans for medical students, including for those who enter training programs in fields other than primary care. • Provide up to $50,000 of loan forgiveness for primary care providers who serve for at least 5 years or 3 years in a medically underserved area. • Reform the sustainable growth rate for physicians in the Medicare program.	• Redesign health professional education programs to promote primary care so that within five years at least 50% of residents in medical resident education programs are primary care residents and the number of mid-level primary care practitioners and dentists meets certain targets. • Provide funding to the Public Health Service to support the National Health Service Corps, health professions education, and nursing education. • Provide grants to states to support core public health functions, including data collection and analysis, investigation and control of adverse health events, health promotion and disease prevention activities, research on cost-effective public health practices, and integration and coordination of prevention programs and services.	No provision.

	Rep. Tom Price (Republican Study Committee) Empowering Patients First Act (H.R. 3400)	Sen. Bernie Sanders American Health Security Act of 2009 (S. 703)	Rep. Pete Stark AmeriCare Health Care Act of 2009 (H.R. 193)
Financing	Financing for the proposal will come from limiting malpractice lawsuits, cutting government payments to hospitals that serve a disproportionate number of uninsured, capping non-defense discretionary spending, and increased detection and elimination of waste, fraud and abuse in government programs.	The American Health Security Act will be funded through the American Health Security Act Trust Fund. Funding for the Trust Fund will come from redirecting existing federal payments for health care; imposing a payroll tax of 8.7% on employers and employees; and imposing a health care income tax of 2.2%.	Plan will be financed through an AmeriCare Trust Fund. The trust fund will be financed with employer and individual premium payments, state maintenance of effort payments, and general revenue for premium subsidies.
Sources of information	http://rsc.tomprice.house.gov/Solutions/EmpoweringPatientsFirstAct.htm	http://www.sanders.senate.gov/news/record.cfm?id=313855	http://www.stark.house.gov/index.php?option=com_content&task=view&id=1081&Itemid=103 http://www.stark.house.gov/index.php?option=com_content&task=view&id=1238&Itemid=84

	Sens. Ron Wyden and Bob Bennett Healthy Americans Act (S. 391)	Former Majority Leaders: Sens. Howard Baker, Tom Daschle, and Bob Dole Crossing Our Lines: Working Together to Reform the U.S. Health System
Date plan announced	February 5, 2009	June 17, 2009
Overall approach to expanding access to coverage	Require most Americans to purchase private coverage (called Healthy Americans Private Insurance or HAPI) meeting certain standards, with federal subsidies available for individuals/families up to 400% of the federal poverty level. State-based Health Help Agencies administer the offering of HAPI plans, which have to meet federal benefit and other standards. Employers can continue to sponsor health plans but many are unlikely to do so because the favorable tax treatment for individuals of employer-paid and insurance is eliminated.	Require all Americans and legal residents to have health insurance. Create state-based health insurance exchanges through which individuals and employers can purchase health coverage, with premium credits available to individuals/families with incomes up to 400% of the federal poverty level. Require employers to provide coverage to employees or pay a fee based on annual payroll, with exceptions for certain small employers, and provide certain small employers a credit to offset the costs of providing coverage. Impose new regulations on plans participating in the exchanges and in the individual and small group insurance markets. Expand Medicaid to 100% of the poverty level.
Individual mandate	• Require all citizens over age 19 to have insurance along with dependent children. Those without coverage are subject to a financial penalty based on the number of uncovered months and the weighted average of HAPI premiums.	• Require all Americans and legal residents to have health insurance that meets minimum creditable coverage standards. Enforcement options include: default enrollment in basic coverage through an employer or the exchange when starting a job, tax penalties including loss of federal deductions or exemptions, and a "fair share" fee added to income tax liability to reflect the cost of uncompensated care. Exceptions granted for religious objections and financial hardship.
Employer requirements	• Require employers to contribute an amount equal to a percentage of the average premium of their workforce times the number of workers. Percentage of the average premium varies for large and small employers from 2% to 25%. • For the first two years, permit employers previously providing health insurance to increase their workers' wages by the amount of the health insurance premium in lieu of the employer shared responsibility payment described above. • Employers who continue to sponsor health plans must provide information on HAPI plans to employees. • Require employers to deduct individual and family premiums from workers' payroll.	• Require employers to offer coverage to their employees or pay a fee based on the percentage of payroll. The fees would range from 1% of payroll for firms with annual payrolls between $1 million and $2 million and 3% of payroll for firms with annual payrolls above $3 million. • Exempt small businesses with payrolls less than $1 million.

	Sens. Ron Wyden and Bob Bennett Healthy Americans Act (S. 391)	Former Majority Leaders: Sens. Howard Baker, Tom Daschle, and Bob Dole Crossing Our Lines: Working Together to Reform the U.S. Health System
Expansion of public programs	• Eliminate Medicaid and CHIP as comprehensive coverage programs and instead provide supplemental, wrap-around coverage for low-income beneficiaries. Provides for a modified Medicaid long-term care services program.	• Expand Medicaid to all individuals with incomes up to 100% FPL. Initially, all individuals eligible for Medicaid and CHIP will obtain or retain coverage through state Medicaid programs. After five years, the HHS Secretary will be authorized to permit Medicaid and CHIP eligible individuals to enroll in the exchange provided such coverage does not result in increased cost sharing or loss of benefits. • Allow states to create a state plan option to provide another choice of coverage in the exchange. The state plan may be modeled after state self-insured plan, co-op plans with consumer boards, or other designs. The state plan must be actuarially sound; cannot be managed by the same entity that regulates the state's insurance markets; cannot leverage participation in public programs as a means of developing provider networks; cannot be provided special advantages with respect to risk adjustment, premium rating, reserve rules, marketing, and automatic enrollment; and must be self-sustaining. If, after five years, HHS determines that affordability and coverage goals have not been met, a proposal for a federal or a state plan to be offered in the exchanges will be considered by Congress under an expedited procedure.
Subsidies to individuals	• Provide premium subsidies for individuals and families with incomes between 100 and 400% FPL; those with incomes below 100% FPL would not pay premiums. • Provide a health care standard tax deduction for individuals and families with incomes above 100% FPL; would phase-out at higher income levels.	• Provide tax credits on a sliding scale basis to individuals and families with incomes up to 400% FPL to purchase insurance through the Health Insurance Exchanges and families with incomes below 100% FPL will be enrolled in Medicaid and pay no premiums. Within the exchange, those with incomes between 100 and 150% FPL will pay 2% of income; those with incomes between 150 and 250% FPL will pay 5% of income; those with incomes between 250 and 350% FPL will pay 10% of income; those between 350 and 400% FPL will pay 12.5%. The tax credits will be refundable and advanceable. • Limit premiums for individuals and families with incomes above 400% FPL to no more than 15 percent of their income.
Subsidies to employers	No provision.	• Provide small employers with fewer than 25 employees who are mostly low-wage with tax credits to help offer coverage to their workers.
Tax changes related to health insurance	• Reform the tax code to eliminate the exclusion of the value of health insurance plans offered by employers from workers' taxable income (with exceptions, such as for employer-paid retiree health coverage and coverage through a collectively bargained plan). • Provide a new health care standard deduction that phases out for higher income taxpayers.	• Cap the income tax exclusion for employer-sponsored insurance at the value of the FEHBP standard option and index that amount by medical inflation over time. Exempt retirees and individuals covered by collectively bargained agreements until those agreements expire.

	Sens. Ron Wyden and Bob Bennett Healthy Americans Act (S. 391)	Former Majority Leaders: Sens. Howard Baker, Tom Daschle, and Bob Dole Crossing Our Lines: Working Together to Reform the U.S. Health System
Creation of insurance pooling mechanisms	• Create new state-based purchasing pools (Health Help Agencies) that would offer a choice of HAPI plans. • Everyone, except people enrolled in Medicare, retiree benefit plans, or military-related coverage, are required to enroll in plans through the Health Help Agencies. (Note: employers can still sponsor health insurance but would have to inform employees of HAPI plans available through Health Help Agency.) • Participating plans provide coverage similar to that available through FEHBP. • Require insurers to offer HAPI coverage on a guaranteed issue basis and use adjusted community rating principles in setting premiums.	• Create state or regional Health Insurance Exchanges through which all individuals and small employers with 50 or fewer employees can purchase qualified insurance. Implement a federal fallback if states or regions do not create exchanges in a timely manner. • Require plans to offer benefits that are at least actuarially equivalent to four established federal standards. The four standard plan levels are: high (similar to the FEHBP Blue Cross Blue Shield Standard Option), medium (similar to a typical small group market plan), standard (similar to a typical individual market plan), and basic (equivalent to the federal minimum creditable coverage standard). Plans have flexibility to vary cost sharing in each of the standard plan levels. • Require guarantee issue and renewability; allow rating variation based only on age (limited to 5 to 1 ratio), geographic region, and family enrollment. States can opt to impose tighter consumer protections. • Require risk adjustment of participating Exchange plans. • Require exchanges to make available educational resources and consumer support tools and to adopt strategies to improve plan choice.
Benefit design	• Provide benefits through HAPI plans that are actuarially equivalent or greater in value than the benefits offered under the Blue Cross/Blue Shield Standard Plan provided under the Federal Employees Health Benefit Program (FEHBP). • Additionally provide benefits for wellness programs and incentives to promote the use of these programs, coverage for catastrophic medical events for an individual or family if lifetime limits are exhausted, and full parity for mental health benefits. • Create the Healthy America Advisory Committee to issue annual reports recommending modifications to the benefits, items, and services covered by HAPI plans.	• Create minimum creditable coverage standards for insurance plans offered in all markets. Creditable coverage will include: catastrophic protections, coverage for a comprehensive ranges of health care services, and coverage of preventive care and prescription drugs before the deductible. Creditable coverage must be at least as generous as a federal high-deductible plan. Permit states to increase the minimum standards provided that it does not increase federal costs.
Changes to private insurance	• Require insurers to offer coverage on a guaranteed issue basis and use adjusted community rating principles in setting premiums; prohibit discrimination based on health status. • Require insurers to meet established medical loss ratios. • Require insurers to create an electronic medical record for each covered individual.	• Require guarantee issue and renewability and allow rating variation based only on age (limited to a 5 to 1 ratio with state option to reduce the ratio), geographic region, and family enrollment in the individual and small group markets and the Exchange. Prohibit imposition of any pre-existing condition exclusions. Allow existing plans in the individual and small group markets to be grandfathered for five years before coming into compliance with new insurance market reforms. • Standardize health care claims processing to promote administrative simplification of payment systems and collect and publish data on medical loss ratios of plans participating in the individual and small group markets.

	Sens. Ron Wyden and Bob Bennett Healthy Americans Act (S. 391)	Former Majority Leaders: Sens. Howard Baker, Tom Daschle, and Bob Dole Crossing Our Lines: Working Together to Reform the U.S. Health System
State role	• Create Health Help Agencies and ensure that participating insurers meet requirements related to solvency and financial standards, consumer protections, and establishment of wellness programs. • Implement mechanisms, such as automatic enrollment, to ensure maximum enrollment of individuals into private insurance.	• Require states to establish, operate, and regulate state or regional exchanges and to report annually on the number of plans offered through the exchange, the range of premiums, and the number of individuals covered through the exchange.
Cost containment	• Adopt payment policies that reward providers for achieving quality and cost efficiency in prevention, early detection of disease, and chronic care management. • Require insurers to create and implement electronic medical records for each covered individual. • Require insurers to adopt uniform billing and claims forms. • Encourage more rigorous study of new drugs and devices by granting additional exclusivity and patent protections to those subjected to comparative effectiveness reviews. Disallow tax deductions for pharmaceutical manufacturers for direct to consumer advertising for most new drugs. • Require insurers and providers to publicly report data on medical outcomes, health care quality and costs. • Provide bonuses to states that enact medical malpractice reforms.	• Invest in meaningful and effective use of HIT and ensure that HIT bonus payments to providers are coordinated with new payments to achieve better care. • Reform provider payments in federal health programs to pay for high-value care. – Move from pay-for-reporting to pay-for-performance based on measures reflecting overall quality and coordination of care; – Implement medical home payments that hold providers accountable for patient results over time; – Expand the use of bundled payments for episodes of care and link to an expanded "Centers of Excellence" program in Medicare; – Limit public program payments for unnecessary or inappropriate care, such as for hospital-acquired conditions or hospital readmissions; and – Establish accountable care organizations (ACOs) in Medicare and permit ACOs that meet quality care benchmarks and reduce overall costs to share in the savings achieved. • Adjust Medicare market basket updates to reflect savings from delivery system reforms, such as bundled payments, and reduce Medicare payments to home health and skilled nursing facilities. • Restructure payments to Medicare Advantage plans to align more closely with fee-for-services payments and adopt incentives for quality reporting and performance improvement. • Reform prescription drug payments in Medicaid by increasing the drug rebate rate while eliminating the "best price" provision. • Adjust Medicare and Medicaid Disproportionate Share Hospital funding to reflect reductions in uncompensated care. Payments should be reduced by one-third over 10 years. • Create a regulatory pathway for the approval of biosimilar and biogeneric products. • Restructure Medicare and Medigap cost sharing and reallocate Medicare and Medicaid improvement funds.

	Sens. Ron Wyden and Bob Bennett Healthy Americans Act (S. 391)	Former Majority Leaders: Sens. Howard Baker, Tom Daschle, and Bob Dole Crossing Our Lines: Working Together to Reform the U.S. Health System
Improving quality/health system performance	• Encourage chronic care programs • Require hospitals to demonstrate improvements in quality control, including rapid response teams, heart attack treatments, procedures that reduce medication errors, infection prevention, procedures that reduce the incidence of ventilator-related illnesses. • Provide enhanced Medicare payments to primary care providers and require Medicare to develop a chronic disease management program. • Establish a website for sharing evidence-based best practices and develop a program for incorporating these best practices into medical school curricula. • Provide for improvements in end-of-life care.	• Support comparative effectiveness research that compares the risks, benefits, and costs of different health care practices, evaluates and revises policies that influence provider practices, and identifies strategies for targeting practices to specific groups of patients. • Improve quality monitoring and improvement by expanding funding for the prioritization, development, endorsement and implementation of qualify measures, requiring electronic quality reporting, and improving the evaluation of new payment reform programs. • Improve care coordination for people with chronic conditions through the creation of community health teams composed of care coordinators, nurse practitioners, social workers, nutritionists, and others to provide patient-centered care that integrates existing prevention and care management resources. • Improve coordination of care for dual eligibles by creating a new program that includes a mechanism for states and the federal government to provide financial support to deliver integrated Medicare and Medicaid services to this population. • Address racial and cultural disparities by enhancing comparative effectiveness research, realigning reimbursement to promote improved patient outcomes, ensuring adequate provider capacity in underserved areas, increasing the number of minorities entering the medical and health professions, and developing and adopting standards for the collection of data on race and ethnicity. • Create an Independence Health Care Council (IHCC) to assess overall system performance. The IHCC will analyze and report on cost and quality data in federal programs and issue recommendations for improving quality, reducing cost growth, and better coordinating the delivery, reimbursement, and financing of federal health programs.
Prevention/wellness	• Promote prevention by providing premium discounts (including for Medicare Part B premiums) for participation in approved wellness and chronic disease management programs. • Require HAPI plans to ensure that primary care providers and individuals create a care plan focused on wellness and prevention as part of the initial primary care visit.	• Support a sustained, nationwide focus on public health wellness through creation of a Public Health and Wellness Fund to invest in evidenced-based prevention and wellness activities. These activities and provisions include: no or limited cost sharing for proven preventive services, a new wellness visit for Medicare beneficiaries to receive a personalized health risk assessment and prevention plan, a federal tax credit for certified employer-based wellness programs that meet accountability and reporting requirements, and a $3 billion annual investment in wellness and prevention programs.

	Sens. Ron Wyden and Bob Bennett Healthy Americans Act (S. 391)	Former Majority Leaders: Sens. Howard Baker, Tom Daschle, and Bob Dole Crossing Our Lines: Working Together to Reform the U.S. Health System
Long-term care	• Permit states to create State Choices for Long-term Care Programs through their Medicaid programs to provide institutional and home and community-based long-term care for eligible individuals. • Create new long-term care insurance plans that meet standards developed by NAIC or by federal regulations. Require additional consumer protections for long-term care policies regarding guarantee renewal, prohibitions on limitations and exclusions, pre-existing conditions, and other issues.	No provision.
Other investments	• Provide grants to school districts and communities to increase access to school-based clinics. • Permit states to create State Choices for Long-term Care Programs through their Medicaid programs to provide institutional and home and community-based long-term care for eligible individuals. • Create new long-term care insurance plans that meet standards developed by NAIC or by federal regulations.	• Reform Graduate Medical Education to increase training of primary care providers, promote training in settings and geographic areas where providers will practice, and encourage integrated systems of care to increase reliance on a qualified non-physician workforce. Provide funding for the training of more nurses and allied health professionals. Revise scope of practice laws to encourage use of advanced practice nurses, pharmacists, and other allied health professionals. • Consider additional financial incentives to ensure adequate provider capacity in medically underserved urban and rural areas. • Provide full federal funding for the Medicaid expansion so that states are not required to pay any of the costs for the newly eligible populations.
Financing	In 2008, CBO scored an amended version of the bill which is very similar to this year's version. In that CBO estimate, Federal costs would be offset by revenues and savings in first year of full implementation, Thereafter, the bill would be more than self-financing because of indexing growth in the value of the health insurance deduction and the subsidized benefits. Financing will come from combination of individual premiums, employer assessments, state and federal savings in Medicaid, elimination of most Medicare and Medicaid disproportionate share hospital (DSH) payments, and changes in tax treatment of insurance.	The anticipated cost of health reform is $1.2 trillion over 10 years. The delivery system, reimbursement, employer "pay" contribution, and tax exclusion reforms in the proposal (and related interactions) are expected to achieve over $1 trillion in savings and new revenues. To ensure budget neutrality, Congress could enact additional Medicare or Medicaid savings, create an enforceable budget "trigger" mechanism to slow spending growth above a target level, or empower the Independent Health Care Council to develop additional recommendations for achieving federal spending growth targets.
Sources of information	http://wyden.senate.gov/issues/Legislation/Healthy_Americans_Act.cfm http://wyden.senate.gov/issues/Health_Care.cfm http://www.cbo.gov/ftpdocs/91xx/doc9184/05-01-HealthCare-Letter.pdf	http://www.bpcleadersproject.org/

Headquarters: 2400 Sand Hill Road Menlo Park, CA 94025 650.854.9400 Fax: 650.854.4800
Washington Offices and Barbara Jordan Conference Center: 1330 G Street, NW Washington, DC 20005 202.347.5270 Fax: 202.347.5274