



FOCUS *on* Health Reform

Agenda Item 4.1
8/13/09 Meeting



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 Policy Options	Senate HELP Committee Affordable Health Choices Act	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)	President Obama Principles for Health Reform
Date plan announced	April – May 2009	June 9, 2009	June 19, 2009	February 26, 2009
Overall approach to expanding access to coverage	<p>The Senate Finance Committee released a series of papers laying out options for health reform. While not a formal proposal, these papers offer a framework for achieving health reform goals and present the range of options the Committee will consider as it works to draft health reform legislation.</p> <p>Require all individuals to have health insurance. Create a Health Insurance Exchange through which individuals and small businesses can purchase health coverage, with subsidies available to individuals/families with incomes between 100 and 400% of the federal poverty level. Impose new regulations on the non-group and small group insurance markets. Expand Medicaid and CHIP and offer a temporary Medicare buy-in for the pre-Medicare population.</p>	<p>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.</p>	<p>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.</p>	<p>President Obama outlined eight principles for health care reform in his FY 2010 Budget overview. The President has indicated that comprehensive health reform should:</p> <ul style="list-style-type: none"> • 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.

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Individual mandate	<ul style="list-style-type: none"> Require all individuals to have insurance that meets minimum coverage standards. Enforced through an excise tax equal to a percentage of the premium for the lowest cost option available through the Health Insurance Exchange in the area where the individual resides. Exemptions will be granted for financial hardship; if the lowest cost plan option exceeds 10% of an individual's income; and if the individual has income below 100% of the poverty level. 	<ul style="list-style-type: none"> Require individuals to have qualifying health coverage. Enforced through a minimum tax penalty of no more than \$750 per year. 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, and those without coverage for fewer than 90 days. 	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> The plan must put the country on a clear path to cover all Americans.
Employer requirements	<ul style="list-style-type: none"> Proposed Option A: Require employers with more than \$500,000 in total payroll per year to offer coverage to their employees and contribute at least 50% of the premium or pay an assessment. The employer assessment could be structured in several ways: 1) a set fee per enrollee per month based on total annual payroll; 2) a tiered penalty calculated as a percentage of payroll; or 3) a larger penalty only on firms with annual payroll of more than \$1,500,000. Proposed Option B: No employer "pay or play" requirement. 	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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.] 	Not specified.

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Employer requirements (continued)			<ul style="list-style-type: none"> • Eliminate or reduce the pay or play assessment for small employers with annual payroll of less than \$400,000: <ul style="list-style-type: none"> - 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; - 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: <ul style="list-style-type: none"> - 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. 	

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Expansion of public programs	<p>Medicaid</p> <ul style="list-style-type: none"> Expand Medicaid to all individuals with incomes up to 115% FPL, with a possible increase in eligibility for parents, pregnant women, and children to a higher level. Coverage could be provided through the current program structure or by enrolling children, pregnant women, parents, and childless adults in the Health Insurance Exchange. Another alternative is to enroll all populations except childless adults in Medicaid. Under this approach, childless adults would not be eligible for Medicaid but would be given tax credits to purchase coverage through the Exchange or to buy-in to Medicaid. <p>Children's Health Insurance Program</p> <ul style="list-style-type: none"> After September 30, 2013, expand CHIP eligibility to 275% FPL. Once the Health Insurance Exchange is fully operational, CHIP enrollees would obtain coverage through the Exchange and states would be required to continue to provide services not covered by plans in the Exchange, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. <p>Medicare</p> <ul style="list-style-type: none"> Until the Health Insurance Exchange is underway, allow individuals aged 55-64 without coverage to buy-in to Medicare at full-cost. Phase-out or reduce the two-year waiting period for Medicare eligibility for people with disabilities. 	<ul style="list-style-type: none"> 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. 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. 	<ul style="list-style-type: none"> 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 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.] 	<ul style="list-style-type: none"> 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.

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Expansion of public programs (continued)	<p>Public Health Insurance Option</p> <ul style="list-style-type: none"> • Proposed Option A: Create a new public plan to be offered through the Exchange that will be subject to the same rating and risk adjustment rules as the private plans. The public plan could be administered by the federal government, by multiple third-party administrators, or by the states. • Proposed Option B: Do not create a public plan option. 		<ul style="list-style-type: none"> • 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 that there are procedures to transfer CHIP enrollees into the exchange without interrupting coverage or with a written plan of treatment.] 	

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Premium subsidies to individuals	<ul style="list-style-type: none"> • Provide refundable tax credits to individuals and families with incomes between 100 and 400% FPL to purchase insurance through the Health Insurance Exchange. The level of the premium tax credit could be set as a percentage of income or as a percentage of the premium, with additional limits on cost-sharing. 	<ul style="list-style-type: none"> • 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 individuals who 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. 	<ul style="list-style-type: none"> • 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 requirements, developing accountable care organization pilot programs in Medicaid, and administrative simplification.] 	<ul style="list-style-type: none"> • 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.

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Premium subsidies to individuals (continued)			<p>[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.]</p> <p>* 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:</p> <p>133-150% FPL: 97% 150-200% FPL: 93% 200-250% FPL: 85% 250-300% FPL: 78% 300-350% FPL: 72% 350-400% FPL: 70%</p>	

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Premium subsidies to individuals (continued)			<ul style="list-style-type: none"> 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 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	<ul style="list-style-type: none"> Provide certain small employers that purchase insurance for their employees with a tax credit. The full credit of 50% of the average total premium cost paid by the employer would be available to employers with 10 or fewer employees and whose employees have average annual wages of less than \$20,000. The tax credit would be phased out as firm size and earnings increase. The tax credit would not be payable in advance or refundable. 	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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. 	Not specified.

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Premium subsidies to employers (continued)		<p>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.</p> <ul style="list-style-type: none"> • 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. 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. 	<ul style="list-style-type: none"> • 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. 	
Tax changes related to health insurance	<ul style="list-style-type: none"> • Considers several health insurance-related tax changes affecting the tax preference for employer-sponsored insurance, health savings accounts, flexible spending accounts, and deductions for medical expenses. 	<ul style="list-style-type: none"> • Impose a minimum tax on individuals without qualifying health care coverage of no more than \$750 per year. 	<ul style="list-style-type: none"> • Impose a tax on individuals without acceptable health care coverage of 2.5% of modified adjusted gross income. 	Not specified.

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Creation of insurance pooling mechanisms	<ul style="list-style-type: none"> • Create one national or multiple regional Health Insurance Exchanges through which individuals and small employers can purchase qualified insurance. • Require all state-licensed insurers in the non-group and small group markets to participate in the Health Insurance Exchange(s). • Require guarantee issue and renewability and allow rating variation based only on age, tobacco use, family composition, and geography (not health status) in the Exchange(s). • Require the Exchange(s) 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. 	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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). [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. 	<ul style="list-style-type: none"> • The plan should provide portability of coverage and should offer Americans a choice of health plans.

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Creation of insurance pooling mechanisms (continued)		<ul style="list-style-type: none"> • Create a community health insurance option to be offered through state Gateways that complies with the requirements of being a qualified health plan. 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. 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. • Create three benefit tiers of plans to be offered through the Gateways based on the percentage of allowed benefit costs covered by the plan: <ul style="list-style-type: none"> – Tier 1: includes the essential health benefits and covers 76% of the benefit costs of the plan; – Tier 2: includes the essential health benefits and covers 84% of the benefit costs of the plan; – Tier 3: includes the essential health benefits and covers 93% of the benefit costs of the plan. 	<p>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. 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.]</p>	

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Creation of insurance pooling mechanisms (continued)		<ul style="list-style-type: none"> • Require guarantee issue and renewability of health insurance policies in the individual and small group markets; prohibit pre-existing condition exclusions; and allow rating variation based only on family structure, geography, the actuarial value of the health plan benefit, tobacco use, and age (with only 2 to 1 variation). • 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. • 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. 	<p>[E&C Committee amendment: Require the public health insurance option to adopt a prescription drug formulary.]</p> <ul style="list-style-type: none"> • Create four benefit categories of plans to be offered through the Exchange: <ul style="list-style-type: none"> – <i>Basic plan</i> includes essential benefits package and covers 70% of the benefit costs of the plan; – <i>Enhanced plan</i> includes essential benefits package, reduced cost sharing compared to the basic plan, and covers 85% of benefit costs of the plan; – <i>Premium plan</i> includes essential benefits package with reduced cost sharing compared to the enhanced plan and covers 95% of the benefit costs of the plan; – <i>Premium plus plan</i> 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. 	

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Creation of insurance pooling mechanisms (continued)		<ul style="list-style-type: none"> • Following initial federal support, the Gateway will be funded by a surcharge of no more than 4% of premiums collected by participating health plans. 	<ul style="list-style-type: none"> • 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. • [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.] 	

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Creation of insurance pooling mechanisms (continued)			<ul style="list-style-type: none"> • Allow states to operate state-based exchanges if they demonstrate the capacity to meet the requirements for administering the Exchange. 	
Benefit design	<ul style="list-style-type: none"> • Create four benefit categories (lowest, low, medium, and high). Require all plans to provide a comprehensive set of services and prohibit inclusion of lifetime limits on coverage or annual limits on benefits. • All policies (except certain grandfathered employer-sponsored plans) must comply with one of the four benefit categories, including those offered through the Exchange and those offered outside of the Exchange. 	<ul style="list-style-type: none"> • 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. • 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. 	<ul style="list-style-type: none"> • 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.] [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.] 	Not specified.

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Benefit design (continued)			<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Require guarantee issue and renewability and allow rating variation based only on age, tobacco use, family composition, and geography (not health status) in the non-group, micro-group (2-10 employees), and small group markets. Require risk adjustment in all markets. Require all state-licensed insurers in the non-group and small group markets to participate in the Health Insurance Exchange. Require all insurers to issue policies in each of the four new benefit categories. Allow states the option of merging the non-group and small group markets. 	<ul style="list-style-type: none"> Impose the same insurance market regulations relating to guarantee issue, premium rating, and prohibitions on pre-existing condition exclusions in the individual and small group markets and in the American Health Benefit Gateways (see 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, and reduce medical errors. 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. 	<ul style="list-style-type: none"> 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). 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. 	<ul style="list-style-type: none"> The plan must end barriers to coverage for people with pre-existing medical conditions.

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Changes to private insurance (continued)			<ul style="list-style-type: none"> • 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. 	
State role	<ul style="list-style-type: none"> • Allow states the option of merging the non-group and small group insurance markets. • Require state insurance commissioners to provide oversight of health plans with regard to consumer protections, rate reviews, solvency, reserve fund requirements, and premium taxes and to define rating areas. 	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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. • May require states to determine eligibility for affordability credits through the Health Insurance Exchange. 	Not specified.

	Senate Finance Committee Policy Options	Senate HELP Committee Affordable Health Choices Act	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)	President Obama Principles for Health Reform
Cost containment	<ul style="list-style-type: none"> • Encourage adoption and use of health information technology by expanding eligibility for the Medicare HIT incentives in the American Recovery and Reinvestment Act to include additional providers. • 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 violating EMTALA, and increase funding for anti-fraud activities. • Restructure payments to Medicare Advantage plans to promote efficiency and quality. • Require drug or device manufacturers to disclose payments and incentives given to providers and any investment interest held by a physician. • Improve transparency of information about skilled nursing facilities. • Allow providers organized as accountable care organizations that voluntarily meet quality thresholds to share in the cost-savings they achieve for the Medicare program. 	<ul style="list-style-type: none"> • Establish a Health Care Program Integrity Coordinating Council and two new federal department positions to oversee 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. 	<ul style="list-style-type: none"> • 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.] • Modify provider payments under Medicare including: <ul style="list-style-type: none"> – 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. 	<ul style="list-style-type: none"> • 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 Policy Options	Senate HELP Committee Affordable Health Choices Act	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)	President Obama Principles for Health Reform
Cost containment (continued)			<ul style="list-style-type: none"> • [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. • 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 Policy Options	Senate HELP Committee Affordable Health Choices Act	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	<ul style="list-style-type: none"> • Strengthen primary care and chronic care management by providing bonus payments to certain primary care providers and providing reimbursement for certain care management activities for patients with hospital stays related to a major chronic condition. • Establish a framework to set national priorities for comparative clinical effectiveness research. • Create a Chronic Care Management Innovation Center within CMS to disseminate innovations that foster patient-centered care coordination innovations for high-cost, chronically ill Medicare beneficiaries. • Bundle payments for acute, inpatient hospital services and post-acute care services occurring within 30 days of discharge from a hospital. • Establish a hospital value-based purchasing program to pay hospitals based on performance on quality measures. • Develop a strategy for the development, selection, and implementation of quality measures that involves input from multiple stakeholders. Improve public reporting of quality and performance information that includes making information available on the web. • 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. 	<ul style="list-style-type: none"> • Develop a national strategy to improve the delivery of health care services, patient health outcomes, and population health that includes publishing 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. • Create a Center for Health Outcomes Research and Evaluation within the Agency for Healthcare Research and Quality to conduct and synthesize 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. • 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; to design and implement regional emergency care and trauma systems. 	<ul style="list-style-type: none"> • 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). • 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.] 	<ul style="list-style-type: none"> • 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.

Improving quality/health system performance (continued)	Senate Finance Committee Policy Options	Senate HELP Committee Affordable Health Choices Act	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)	President Obama Principles for Health Reform
		<ul style="list-style-type: none"> • 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. • Create an inter-agency Working Group to coordinate and streamline federal quality activities. • 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. 	<p>[E&C Committee amendment: Conduct accountable care organization pilot programs in Medicaid.]</p> <ul style="list-style-type: none"> • [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. • 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. 	

	Senate Finance Committee Policy Options	Senate HELP Committee Affordable Health Choices Act	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)			<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Improve prevention by covering only proven preventive services in Medicare and Medicaid and providing incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs. • Promote prevention and wellness by providing grants to states to implement innovative approaches to promoting integration of health care services to improve health and wellness outcomes and providing tax credits to small businesses that implement proven wellness programs. 	<ul style="list-style-type: none"> • 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. • 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. 	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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 Policy Options	Senate HELP Committee Affordable Health Choices Act	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)	President Obama Principles for Health Reform
Prevention/wellness (continued)		<ul style="list-style-type: none"> • Permit insurers to create incentives for health promotion and disease prevention practices. • Encourage employers to provide wellness programs by conducting targeted educational campaigns to raise awareness of the value of these programs and by increasing the allowable premium discount for employees who participate in these programs from 20 percent to 30 percent. • Create a temporary Right Choices Program to provide uninsured adults with access to preventive services. 	<ul style="list-style-type: none"> • 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. 	
Long-term care	<ul style="list-style-type: none"> • Improve the availability of long-term care services by increasing access to home and community based services through changes in Medicaid program requirements and through grants to states. 	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • [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 Policy Options	Senate HELP Committee Affordable Health Choices Act	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)	President Obama Principles for Health Reform
Other investments	<ul style="list-style-type: none"> • Change the Medicaid FMAP formula to include data on a state's poverty level and increase Medicaid FMAP rates during economic downturns to assist states in financing increased Medicaid enrollment. • Reform Graduate Medical Education to increase training of primary care providers and promote training in outpatient settings, and ensure the availability of residency programs in rural and underserved areas. 	<ul style="list-style-type: none"> • 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. • Reform Graduate Medical Education to increase the supply, education, and training of doctors, nurses, and other health care workers, especially in pediatric, geriatric, and primary care. • Improve access to care by providing additional funding to increase the number of community health centers and school-based health centers. 	<ul style="list-style-type: none"> • Make improvements to the Medicare program: <ul style="list-style-type: none"> – 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. 	<ul style="list-style-type: none"> • 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 Policy Options	Senate HELP Committee Affordable Health Choices Act	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)	President Obama Principles for Health Reform
Other investments (continued)			<p>[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.]</p> <ul style="list-style-type: none"> • 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.] 	
Financing	Not specified. Considering a range of options for achieving savings and for generating new revenues.	The Congressional Budget Office estimates this proposal will cost \$615 billion over 10 years. Because the Senate HELP Committee does not have jurisdiction over the Medicare and Medicaid programs nor 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.	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.

	Senate Finance Committee Policy Options	Senate HELP Committee Affordable Health Choices Act	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)	President Obama Principles for Health Reform
Financing (continued)			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.	
Sources of information	Go to following link: http://finance.senate.gov/sitepages/baucus.htm then select these items 5-11-09 Baucus, Grassley Policy Options for Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans 4-28-09 Baucus, Grassley Policy Options for Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs	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	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> All individuals residing in the US are covered under the United States National Health Care Act (USNHC). 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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)**

	<p>Sens. Tom Coburn and Richard Burr Reps. Paul Ryan and Devin Nunes Patients' Choice Act of 2009 (S. 1099 and H.R. 2520)</p>	<p>Rep. John Conyers U.S. National Health Care Act (H.R. 676)</p>	<p>Rep. John Dingell National Health Insurance Act (H.R. 15)</p>
<p>Premium subsidies to individuals</p>	<ul style="list-style-type: none"> • 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). 	<ul style="list-style-type: none"> • Individuals are not required to pay premiums to obtain coverage nor are they charged copayments or coinsurance for covered benefits. 	<ul style="list-style-type: none"> • Individuals are not required to pay premiums to obtain coverage.
<p>Premium subsidies to employers</p>	<p>No provision.</p>	<p>No provision.</p>	<p>No provision.</p>
<p>Tax changes related to health insurance</p>	<ul style="list-style-type: none"> • 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. 	<p>No provision.</p>	<p>No provision.</p>

**Sens. Tom Coburn and Richard Burr
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Creation of insurance pooling mechanisms	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • Provide the following classes of personal health services: <ul style="list-style-type: none"> – 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.	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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. 	<p>No provision.</p>	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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)

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(H.R. 676)

Rep. John Dingell
National Health Insurance Act
(H.R. 15)

<p>Cost containment (continued)</p>	<ul style="list-style-type: none"> • 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. 		
<p>Improving quality/health system performance</p>	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • Require state and local administration to: <ul style="list-style-type: none"> – 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.
<p>Prevention/wellness</p>	<ul style="list-style-type: none"> • 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. 	<p>No provision.</p>	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Make changes to Medicaid long-term care services to provide states 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. 	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> All individuals residing in the US are entitled to coverage under the American Health Security Act. 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> Prohibit employers from offering health benefits that duplicate those provided by State health security programs. 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> Individuals are not required to pay premiums to obtain coverage nor are they charged copayments or coinsurance for covered benefits. 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • Impose a new health care income tax on individuals of 2.2% of taxable income. 	<ul style="list-style-type: none"> • Individual premium payments for AmeriCare coverage are considered a tax and subject to withholding.
Creation of insurance pooling mechanisms	<ul style="list-style-type: none"> • 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. 	<p>No provision other than pooling achieved through state health security programs.</p>	<p>No provision other than pooling achieved through AmeriCare.</p>

	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	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • Prohibit insurers from duplicating State health security program but they may offer coverage for benefits not covered by the health security program. 	<ul style="list-style-type: none"> • Allow AmeriCare supplemental policies to be offered that meet minimum federal standards, including standardized benefits, limitations on sales commissions, and the following: <ul style="list-style-type: none"> – 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	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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)	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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.

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Healthy Americans Act
(S. 391)**

**Former Majority Leaders:
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Crossing Our Lines: Working Together to Reform the U.S. Health System**

<p>Creation of insurance pooling mechanisms</p>	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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.
<p>Benefit design</p>	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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.
<p>Changes to private insurance</p>	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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.

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<p>State role</p>	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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.
<p>Cost containment</p>	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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. <ul style="list-style-type: none"> – 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.

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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 quality 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.

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Long-term care	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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	<p>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.</p> <p>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.</p>	<p>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.</p>
Sources of information	<p>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</p>	<p>http://www.bpcleadersproject.org/</p>

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The Kaiser Family Foundation is a non-profit private operating foundation, based in Menlo Park, California, dedicated to producing and communicating the best possible analysis and information on health issues.

HOW HEALTH INSURANCE REFORM WILL BENEFIT CALIFORNIA

Released by Kathleen Sebelius on www.healthreform.gov

8/10/09

Stable and Secure Health Care for California How Health Insurance Reform will Benefit California

LOWER COSTS FOR RESIDENTS OF CALIFORNIA

- **Ending the Hidden Tax – Saving You Money:** Right now, providers in California lose over \$5.1 billion in bad debt which often gets passed along to families in the form of a hidden premium “tax”.¹ Health insurance reform will tackle this financial burden by improving our health care system and covering the uninsured, allowing the 355 hospitals² and the 115,740 physicians³ in California to better care for their patients.
- **Health Insurance Premium Relief:** Premiums for residents of California have risen 114% since 2000.⁴ Through health insurance reform, 5,104,400 to 5,859,500 middle class California residents will be eligible for premium credits to ease this burden.⁵
- **Strengthening Small Businesses:** 516,362 employers in California are small businesses.⁶ With tax credits and a health insurance exchange where they can shop for health plans, insurance coverage will become more affordable for them.
- **Reforms that Reduce Your Costs:** Under health insurance reform, insurance companies will be prevented from placing annual or lifetime caps on the coverage you receive. Insurance companies will also have to abide by yearly limits on how much they can charge for out-of-pocket expenses, helping 155,200 households in California struggling under the burden of high health care expenses.⁷

INCREASE YOUR CHOICES: PROTECTING WHAT WORKS AND FIXING WHAT'S BROKEN

- **Insurance Stability and Security:** Health insurance reform will strengthen our system of employer-based health insurance, with an additional 332,600 people in California potentially getting insurance through their work.⁸ Health insurance reform will also ensure that you will always have guaranteed choices of quality, affordable health insurance if you lose your job, switch jobs, move or get sick.
- **Eliminating Discrimination for Pre-Existing Conditions, Health Status or Gender:** 9% of people in California have diabetes⁹, and 25% have high blood pressure¹⁰ – two conditions that insurance companies

could use as a reason to deny you health insurance. Health insurance reform will prevent insurance companies from denying coverage based on your health, and it will end discrimination that charges you more if you're sick or a woman.

- **One-Stop Shopping – Putting Families in Charge:** With the new health insurance exchange, you can easily and simply compare insurance prices and health plans and decide which quality affordable option is right for you and your family. These proposals will help the 6,701,900 residents of California who currently do not have health insurance to obtain needed coverage, and it will also help the 2,420,600 California residents who currently purchase insurance in the individual insurance market.¹¹
- **Guaranteeing Choices:** The largest health insurer in California holds 30% of the market, which limits the choices that you have for finding coverage.¹² With a competitive public insurance option, you will have more choices and increased competition that holds insurance companies accountable.

ASSURE QUALITY, AFFORDABLE HEALTH CARE FOR AMERICANS

- **Preventive Care for Better Health:** 40% of California residents have not had a colorectal cancer screening, and 17% of women have not had a mammogram in the past 2 years.¹³ By requiring health plans to cover preventive services for everyone, investing in prevention and wellness, and promoting primary care, health insurance reform will work to create a system that prevents illness and disease instead of just treating it when it's too late and costs more.
- **Improving Care for Children and Seniors:** 22% of children in California have not visited a dentist in the past year,¹⁴ and 31% of seniors did not receive a flu vaccine¹⁵. Health reform will ensure coverage for kids' dental, vision, and hearing needs, and will promote quality coverage for America's seniors, including recommended immunizations.

¹ Hospital uncompensated care cost is estimated using a GAO model and the Hospital Cost Reports. Total uncompensated care is computed as hospital uncompensated care divided by 63% (Hadley and Holahan's study on "The Cost of Care for the Uninsured" for Kaiser in 2004 found that hospitals account for 63% of total uncompensated care). Data expressed in 2009 dollars using Centers for Medicare and Medicaid Services, "National Health Expenditure Data."

² 2007 AHA Annual Survey Copyright 2009 by Health Forum LLC, an affiliate of the American Hospital Association, special data request, March 2009. Available at <http://www.ahaonlinestore.com>.

³ American Medical Association, Physicians Professional Data, year of data 2008, copyright 2008: Special Data Request.

⁴ Center for Financing, Access and Cost Trends, AHRQ, Medical Expenditure Panel Survey - Insurance Component, 2000, Table II.D.1.

Center for Financing, Access and Cost Trends, AHRQ, Medical Expenditure Panel Survey - Insurance Component, 2006, Table X.D. Projected 2009 premiums based on Centers for Medicare and Medicaid Services, "National Health Expenditure Data."

⁵ U.S. Census Bureau, Current Population Survey. Annual Social and Economic Supplements, March 2007 and 2008.

⁶ Center for Financing, Access and Cost Trends, AHRQ, Medical Expenditure Panel Survey - Insurance Component, 2006, Table II.A.1a.

⁷ Center for Financing, Access and Cost Trends, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2006.

⁸ U.S. Census Bureau, Current Population Survey. HIA-4 Health Insurance Coverage Status and Type of Coverage by State--All Persons: 1999 to 2007, 2007. Calculations based on Congressional Budget Office. Letter to the Hon Charles Rangel on America's Affordable Health Choices Act, July 14, 2009.

⁹ Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2008.

¹⁰ Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2007.

¹¹ U.S. Census Bureau, Current Population Survey. Annual Social and Economic Supplements, March 2007 and 2008.

¹² American Medical Association. (2008,2009). "Competition in health insurance: A comprehensive study of U.S. Markets: 2008 Update," American Medical Association.

¹³ Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2007.

¹⁴ Child and Adolescent Health Measurement Initiative. 2007 National Survey of Children's Health, Data Resource Center for Child and Adolescent Health.

¹⁵ Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2007.

The Health Care Status Quo: Why California Needs Health Reform

Congress and the President are working to enact health care reform legislation that protects what works about health care and fixes what is broken. Californians know that inaction is not an option. Sky-rocketing health care costs are hurting families, forcing businesses to cut or drop health benefits, and straining state budgets. Millions are paying more for less. Families and businesses in California deserve better.

CALIFORNIANS CAN'T AFFORD THE STATUS QUO

- Roughly 19.7 million people in California get health insurance on the job¹, where family premiums average \$13,297, about the annual earning of a full-time minimum wage job.²
- Since 2000 alone, average family premiums have increased by 114 percent in California.³
- Household budgets are strained by high costs: 19 percent of middle-income California families spend more than 10 percent of their income on health care.⁴
- High costs block access to care: 13 percent of people in California report not visiting a doctor due to high costs.⁵
- California businesses and families shoulder a hidden health tax of roughly \$1,400 per year on premiums as a direct result of subsidizing the costs of the uninsured.⁶

AFFORDABLE HEALTH COVERAGE IS INCREASINGLY OUT OF REACH IN CALIFORNIA

- 19 percent of people in California are uninsured, and 71 percent of them are in families with at least one full-time worker.⁷
- The percent of Californians with employer coverage is declining: from 58 to 54 percent between 2000 and 2007.⁸
- While small businesses make up 77 percent of California businesses,⁹ only 46 percent of them offered health coverage benefits in 2006.¹⁰
- Choice of health insurance is limited in California. Kaiser Permanente alone constitutes 24 percent of the health insurance market share in California, with the top two insurance providers accounting for 44 percent.¹¹
- Choice is even more limited for people with pre-existing conditions. In California, premiums can vary based on demographic factors and health status, and coverage can exclude pre-existing conditions or even be denied completely in some cases.

CALIFORNIANS NEED HIGHER QUALITY, GREATER VALUE, AND MORE PREVENTATIVE CARE

- The overall quality of care in California is rated as "Average."¹²
- Preventative measures that could keep Californians healthier and out of the hospital are deficient, leading to problems across the age spectrum:
 - 15 percent of children in California are obese.¹³
 - 17 percent of women over the age of 50 in California have not

received a mammogram in the past two years.

- 40 percent of men over the age of 50 in California have never had a colorectal cancer screening.
- 69 percent of adults over the age of 65 in California have received a flu vaccine in the past year.¹⁴

The need for reform in California and across the country is clear.

California families simply can't afford the status quo and deserve better. President Obama is committed to working with Congress to pass health reform this year that reduces costs for families, businesses and government; protects people's choice of doctors, hospitals and health plans; and assures affordable, quality health care for all Americans.

¹ U.S. Census Bureau, Current Population Survey. HIA-4 Health Insurance Coverage Status and Type of Coverage by State--All Persons: 1999 to 2007, 2007.

² Center for Financing, Access and Cost Trends, AHRQ, Medical Expenditure Panel Survey - Insurance Component, 2006, Table X.D.

Projected 2009 premiums based on Centers for Medicare and Medicaid Services, "National Health Expenditure Data," available at <http://www.cms.hhs.gov/nationalhealthexpenddata/>.

³ Center for Financing, Access and Cost Trends, AHRQ, Medical Expenditure Panel Survey - Insurance Component, 2000, Table II.D.1.

Center for Financing, Access and Cost Trends, AHRQ, Medical Expenditure Panel Survey - Insurance Component, 2006, Table X.D.

Projected 2009 premiums based on Centers for Medicare and Medicaid Services, "National Health Expenditure Data," available at <http://www.cms.hhs.gov/nationalhealthexpenddata/>.

⁴ Center for Financing, Access and Cost Trends, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2006.

⁵ Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2007.

⁶ Furnas, B., Harbage, P. (2009). "The Cost Shift from the Uninsured." Center for American Progress.

⁷ U.S. Census Bureau, Current Population Survey. Annual Social and Economic Supplements, March 2007 and 2008.

⁸ U.S. Census Bureau, Current Population Survey. HIA-4 Health Insurance Coverage Status and Type of Coverage by State--All Persons: 1999 to 2007, 2007.

⁹ Center for Financing, Access and Cost Trends, AHRQ, Medical Expenditure Panel Survey - Insurance Component, 2006, Table II.A.1a.

¹⁰ Center for Financing, Access and Cost Trends, AHRQ, Medical Expenditure Panel Survey - Insurance Component, 2001, 2006, Table II.A.2.

¹¹ Health Care for America Now. (2009). "Premiums Soaring in Consolidated Health Insurance Market." Health Care for America Now.

¹² Agency for Health Care Research and Quality. 2007 State Snapshots. Available <http://statesnapshots.ahrq.gov/snapso7/index.jsp>.

¹³ Child and Adolescent Health Measurement Initiative. 2007 National Survey of Children's Health, Data Resource Center for Child and Adolescent Health.

¹⁴ Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2007.