

To: Interested Parties
From: The Glover Park Group
Re: October 7, 2009

Report to the California HealthCare Foundation and California Policy Staff

UPDATE ON HEALTH REFORM PROCESS

The House and Senate continue to make progress toward passing national health care reform legislation. In order to formally pass its bill out of committee, the Senate Finance Committee must wait for the Congressional Budget Office (CBO) to release cost estimates, which is now expected to occur late this week or early the week of October 12th. Meanwhile, work is underway behind the scenes in both House and Senate chambers to produce bills that can pass. The goal for each chamber is to move the process along in order for the President to sign a bill before the end of the year.

SENATE

Last week, the Senate Finance Committee completed debate on amendments to Chairman Baucus' bill, America's Healthy Future Act of 2009. In all, over 110 amendments were added to the bill with many others debated and either defeated or withdrawn.

Notable amendments addressed during the final days of the markup include:

- Rockefeller amendment on CHIP -- The underlying mark would have moved the CHIP program into the exchange and required states to provide wrap around

benefits. The Rockefeller amendment, which passed 13-9, would keep current CHIP enrollees in the program instead of moving them to the exchange.

- Public Option Amendments -- The underlying mark includes a nonprofit coop provision that would compete with insurers. Two amendments were offered during the committee markup to strip the coop proposal and replace it with a public option. The first amendment, offered by Senator Rockefeller, would have replaced the coop with a public option with rates tied to Medicare. The amendment failed 8-15. Senator Schumer also offered an amendment to strip the coop provision and replace it with a public option with negotiated rates instead of Medicare rates. This amendment also failed 10-13, with Chairman Baucus, and Sens. Conrad and Lincoln voting against it.
- Schumer-Snowe amendment on affordability -- The committee voted 22-1 to adopt the Schumer amendment which would reduce the penalty excise tax on individuals who do not purchase insurance and delay its implementation date until 2014. The amendment would phase in the excise taxes over several years and drop the penalty to a maximum of \$750 per adult in 2017, down from \$950 in the chairman's mark. The maximum penalty for individuals would be \$200 in 2014, \$400 in 2015, \$600 in 2016, and \$750 in 2017. For families, the maximum penalties would double in each year. In addition, the amendment would waive the individual mandate for individuals who are unable to find insurance that costs less than 8 percent of their adjusted gross income. Under the chairman's mark, the threshold for qualifying for the hardship waiver was set at 10 percent. CBO estimates that this provision would leave 2 million additional people without insurance in 2019 than without the amendment.
- Rockefeller amendment on Medicare Commission -- The Committee adopted amendments by Sen. Rockefeller to create a MedPAC-type entity that would have the power to set Medicare reimbursement rates. The original amendment

carved out hospital payment from the purview of the new Medicare Commission. A later amendment adopted by the committee would allow the new commission to make "supplemental, nonbinding recommendations" regarding Medicare payment updates for hospitals for the first 10 years of its operation. The new language stipulates that the supplemental recommendations would not be included in commission proposals to reduce excess cost growth in a given year. The new language also stipulates that the commission can make recommendations to reduce spending for Medicare Part C and Part D, such as through reductions in federal premium subsidies to Medicare Advantage prescription drug plans as well as other prescription drug plans and could reduce performance bonuses to MA plans.

- Cantwell amendment -- The amendment creates a federally funded, non-Medicaid, state plan that is designed to combine private sector competition with the purchasing power of the states. It would be available to people with incomes between 133 and 200 percent of the federal poverty level, who are under the age of 65 and do not have access to affordable employer sponsored coverage. Funding would come from individual tax credit subsidies for individuals from 133 to 200 percent of poverty. States would use their share of federal dollars to negotiate with private insurers. Negotiated health packages would have to meet minimum benefit package and premium cost sharing levels that are contained in the Chairman's Mark. The program would begin July 1, 2013.

A final vote on the bill to report out of committee will occur as soon as scores from the CBO are available, which could be as early as Thursday of this week. Once that is complete, a merged HELP/Finance bill could be brought to the floor as early as the week of October 12th. The process of merging the Finance Committee bill with the Senate HELP is already underway as key staff from those committees as well as Leadership have been working to produce one bill that can get 60 votes on the floor.

Moving forward, the floor debate on this bill will likely address many of the same issues that were raised during the committee markup in both committees and could include:

- **Employer mandate:** The underlying mark includes a free rider provision that would require employers who do not offer health coverage to pay substantial amounts for low- and moderate-income employees receiving subsidies to purchase coverage in a health insurance exchange. During the Finance Committee markup, Senator Kerry offered and withdrew an amendment that would replace the free rider proposal with an employer mandate similar to what is in the Senate HELP and House Tri-Committee bill.
- **Affordability --** Even though the Finance bill includes changes to the underlying mandate provision through the Schumer-Snowe amendment, there will likely be amendments during floor debate to further address this issue.
- **Public option --** The Senate HELP bill includes a public option whereas the Finance Committee bill has a nonprofit coop provision. Liberal Democrats have indicated that one or more public option amendments will be offered during floor debate.
- **Payfors (offsets) --** The Finance Committee bill includes a number of excise taxes to offset financing provisions in the bill. Among the offsets are taxes on device manufacturers, insurance companies that offer high cost insurance plans, and a broad based tax on all insurance companies. It is likely that amendments to remove the excise tax on device manufacturers as well as to increase the threshold on high cost health plans will be offered during floor debate. Additional revenues or cuts would have to be found in order for these amendments to be budget-neutral.

HOUSE

Negotiations on a final House bill continue behind the scenes as Speaker Nancy Pelosi and Majority Leader Steny Hoyer work with the diverse members of the Democratic caucus to write a bill that can muster 218 votes. Their ability to succeed will depend heavily on the policy-based substance of the bill as well as payfors.

The inclusion of a public option remains a sticking point, but the focus is on the issue of whether payment rates are tied to Medicare or based on negotiation. The original House bill required the public plan to pay providers 5 percent more than Medicare reimbursement rates. But as part of a package of concessions to Blue Dogs, the House Energy and Commerce Committee accepted an amendment that requires the HHS Secretary to negotiate rates with providers. That version of the plan will save only \$25 billion. However, a public plan tied to Medicare rates would save \$110 billion over 10 years. At this time it does not appear that the votes are available for a public option tied to Medicare rates.

Offsets continue to be a sticking point among House Democrats. This week, over 100 House Democrats joined in a letter to the Speaker in opposition to a tax on high cost (or "Cadillac") health plans. This offset is included in the Senate Finance Committee package as a means to slow the growth of health care costs as well as provide offsets of \$200 billion. This letter signals the difficulty a House-Senate conference will have in resolving differences in the legislation between the two bills.

The timing of a floor vote is still unsettled and depends in large part on scores from the CBO as well as whether the package has 218 votes to pass. While Speaker Pelosi has stated that her goal is to have a bill on the House floor by the week of October 19, that date could easily slip until early November.

Health Care Reform – California Considerations and Concerns

- A comprehensive overhaul of our nation's health care delivery and insurance systems is essential and Governor Schwarzenegger fully endorses that premise.
- The framework for national reform emerging in the House and Senate closely resembles the Governor's 2007 plan for reforming California's health care system. Successful reform of the health system will depend on a strong commitment to these core principles:
 - Cost containment and affordability;
 - Prevention, wellness and health quality; and
 - Coverage for all.
- Federal health reform proposals that impose billions of dollars in new costs on California each year are not supportable.

Cost Containment and Affordability

- California cannot afford, and the Governor will not support, unfunded federal mandates or restrictive maintenance of effort requirements. Ultimately the cost of these mandates will be borne by state taxpayers through higher taxes and/or cuts to priority state programs. The federal government must fully fund any mandated Medicaid expansions.

House proposals to reform the nation's health system have tried to recognize the affordability issue for state government, but that commitment has wavered. The Energy and Commerce passed bill requires states to pick up 10 percent of any Medicaid eligibility expansion, including related provider rate increases. The *Senate* proposal would selectively pass on about 15 percent of new costs to California related to a Medicaid eligibility expansion, and provides no enhanced matching rate for any Medicaid reimbursement rate increases necessary to ensure appropriate and timely access for the existing and newly expanded Medicaid population. The State is still refining the estimated net fiscal impact of these proposals.

House proposals include maintenance of effort provisions that would lock in place existing Medicaid eligibility standards and procedures forever – forcing state legislatures into autopilot spending that will lead to chronic budget shortfalls. The Senate Finance Committee proposal includes maintenance of effort provisions through 2014, when the expansions are due to begin.

- The House mandates higher rates for primary care services and proposes to cover 90 percent of that increased cost. The Senate does not mandate such rate increases, implies that such rate increases are unnecessary and does not provide any enhanced match if Medicaid rate increases turn out to be necessary to keep pace in the new market place. California believes that the basic economics of supply and demand will require significant Medicaid rate increases in order to expand health care provider networks sufficiently to ensure the expanded Medicaid population has timely and appropriate access to health services. Therefore we think the proposal currently being debated in the Senate Finance Committee significantly understates the financial impact to states and will lock in and expand chronic state budget shortfalls.

The State believes strongly that health care providers will only participate in sufficient numbers in an expanded Medi-Cal program if rates are raised significantly from where they are today. The projections below provide a starting point for estimating the fiscal impact on California resulting from the mandated eligibility expansion of Medicaid to 133 percent of FPL in both the House and Senate versions. We start by assuming rates in Medicaid are increased to 100 percent of Medicare – this would cost \$16 billion annually in California. We believe about \$4 billion of this cost is associated with the eligibility expansion (adding 1.6 million Californians to Medi-Cal) and about \$12 billion is due to rate increases as described. This

translates to \$8 billion *annually* in General Fund costs under California's regular 50 percent match rate. As described above, the House covers 90 percent of the eligibility expansions costs and 90 percent of rate costs for primary care – reducing the \$8 billion number. The Senate would cover about 85 percent of the eligibility expansion costs and provide no enhanced match on the rate side of the equation. Because of the many different Medicaid health care provider reimbursement rates we are still analyzing the fiscal impacts to the state from both bills including any potential savings related to provisions under the bills.

While \$6 billion to \$8 billion annually in new state costs looks like an outside range based on existing details in the Senate bill, the data below puts this into the perspective of the current state budget.

- \$8 billion is nearly 10 percent of the entire 2010 state general fund budget of \$85 billion.
 - \$8 billion is more than 50 percent of the current Medi-Cal program, including American Recovery and Reinvestment Act (ARRA) funds, which temporarily reduce general fund support for Medi-Cal.
 - For the foreseeable future any revenue increases associated with a normal growth economy (which is likely years away) are already committed for the 51 percent of the state budget that is constitutionally required or is obligated to repay over \$10 billion in K-14 education funding cuts, \$5 billion to replace expiring ARRA funds, and \$8 billion to replace one-time budget actions in the 2010 budget.
- California's current Medicaid program, even though it is one of the most efficient in the country, is fiscally unsustainable. As a result, the Governor cannot support adding new costs to a base program that is already fiscally unsustainable. As part of health care reform, Congress should be working to improve the long term fiscal stability of state Medicaid programs. Specific examples include:
 - **Dual eligibles.** The federal government should take full responsibility for financing and coordinating the care of those dually eligible for Medicare and Medicaid in order to make an appreciable reduction in the cost trend for this group. At a minimum, states should be allowed to coordinate the care for this population in order to improve health outcomes and be allowed to keep a share of federal savings across programs (Medicare, Medicaid, etc.).
 - **Long-term care services.** Medicaid can no longer be expected to be the primary provider of long term care services nationwide. Alternative financing mechanisms for long term care and increasing the affordability and availability of long term care insurance are essential.
 - **FMAP methodology.** The regular federal medical assistance percentage (FMAP) should be modified to more accurately reflect need by including the rate of poverty and the cost of providing health care services in a state, in addition to the current methodology which looks solely at per capita income.
 - **Rx rebates.** States must be allowed to collect Medicaid pharmaceutical rebates under managed care programs, as well as extending these rebates to the dually eligible under Medicare Part D (as they were prior to the enactment of Part D).
 - **Family planning state plan.** The state plan option should be available for family planning services to the extent that states are given the authority to implement such an option consistent with the administration of their existing waivers.
 - **Part D Clawback.** Congress should drop the state requirement to fund the Part D clawback entirely. At a minimum, Congress should correct the calculation of the Medicare Part D clawback so that state-by-state payments fully account for the value of rebates on an accrual basis (vs. a cash basis), include the full impact of pharmacy cost savings measures that were implemented in the Part D transition years that are not adequately captured in the current calculation, and allow the use of state specific growth factors rather than national growth factors.
 - **Disproportionate Share Hospitals.** Medicaid and Medicare disproportionate share hospital (DSH) payments must remain largely intact. Today, DSH payments cover only a portion of bad debt and charity care costs. Even with an individual mandate, states will fall short of 100% percent coverage due to hardship exemptions and undocumented immigrants. If DSH is cut considerably, it should be redistributed to states in a way that recognizes the number of

undocumented immigrants and hardship exemptions; and states should maintain control of Medicaid DSH distributions.

- **Payment reforms.** Payment reforms must be implemented under both Medicare and Medicaid to ensure the best and most appropriate care is provided to individuals, rather than the current system that rewards the quantity of care. States should be allowed to implement their own payments reforms under Medicaid that mirror those proposed in Medicare or to demonstrate the value of alternative reimbursement methodologies.
- **Medicaid program administration.** Medicaid administration needs to be streamlined. States need significantly more flexibility in the future to improve health outcomes within their states, including the authority to structure programs that are fiscally sustainable for beneficiaries and taxpayers. States should be given broad authority to realign benefits, within reasonable parameters set by the federal government, and be allowed to test new administrative structures that could include more centralization to leverage the full benefits of information technology and web-based applications. Any eligibility expansions should be done in a way that reduces administrative complexity rather than increasing it.
- **Wrap-around benefits and premium assistance.** Because of the complexity of administering a “benefit wrap around” or premium assistance program in large markets, states should not be mandated to provide these programs when integrating Medicaid and CHIP programs, with the new insurance exchanges. States should have the option to construct alternative ways of ensuring federal benefit and coverage standards are satisfied.

Coverage of Low-Income Children in an Exchange in Place of CHIP

- There is considerable value in ensuring that families are able to get their coverage through the same insurance plan. Thus transitioning coverage for children currently enrolled in CHIP into an Exchange where they would have coverage with their parents in a family plan is a positive step.
- Requiring an EPSDT wrap however, is problematic. EPSDT is supplemental coverage that requires an administrator to compare coverage under each product with the EPSDT “ideal” and have arrangements in place to provide additional coverage. It is highly complex to administer, costly to provide and exposes the administrator to considerable litigation risk. Rather than requiring an undefined supplemental benefit, the basic benefit package provided to a family should be a comprehensive one. This is the approach used in employer sponsored coverage to great success. At a minimum, the entity responsible for operating the Exchange should also be responsible for managing any wrap.

Prevention, Wellness and Health Quality

- Prevention and wellness - for individuals and in our communities – is the cornerstone of long-term success in addressing rising health care costs and improving the health of the U.S. population. The Governor encourages Congress to enact aggressive incentives in this area to maximize the long term fiscal and health benefits that prevention, wellness and healthy lifestyles in general can bring.
- The Governor stressed the importance of prevention in his own health care reform proposal, which recognized that prevention and wellness are shared responsibilities between individuals and the broader community.
- **Healthy benefit design.** Individuals must take responsibility for their own behaviors, but government can and must assist with appropriate incentives and benefit design:
 - Encourage utilization of proven clinical preventive services by eliminating beneficiary cost sharing for such services.
 - Provide refunds or other incentives to Medicare and Medicaid beneficiaries who successfully complete behavior modification programs, such as smoking cessation or weight loss.

- Facilitate individual and health care provider efforts to manage chronic diseases (such as diabetes and hypertension) by providing access to community-based chronic disease self-management support, including the use of community health workers, and by incorporating prevention and self-management into electronic health records.
- Provide incentives for proven clinical interventions to reduce deaths from chronic disease by ensuring no cost-share for the ABCS: aspirin, blood pressure control, cholesterol control, and tobacco cessation counseling and therapy.
- **Healthy communities.** Population-based strategies are an essential component of the overall effort to promote prevention and improve health outcomes.
 - Promoting healthy communities will require thinking smarter about transportation, housing, agriculture, education, and economic policies that affect health and healthy behaviors. Consideration of health in a broad array of policies, for example through the use of health impact assessments, is essential for healthy communities. Proposals to develop evidenced-based nurse home visitation programs for first-time pregnant women is an example of a prevention and wellness/healthy communities initiative that can provide enhanced health outcomes for mother and child, reduce long run health care costs, and reduce potential social service intervention costs.
 - Community transformation grants should support policy, environmental, programmatic and infrastructure changes that address chronic disease risk factors and inequities and promote healthy living.
 - Investments in core public health infrastructure can be strengthened through a Prevention and Wellness Trust Fund.
- **Quality infrastructure.** The Governor supports the development of a transparent, strong and maneuverable health quality information infrastructure that provides consumers (and payers) with the necessary information to evaluate the cost and effectiveness of the care they are receiving. Reforms should include:
 - **Center for Quality Improvement.** Center for Quality Improvement to improve patient safety, reduce medical errors and health-care associated infections, and improve outcomes and satisfaction.
 - **Health information technology.** Systematic use of health information technology and health information exchange to measure and improve health outcomes. This information should be available, consistent with HIPAA, to public health agencies.

Coverage for All

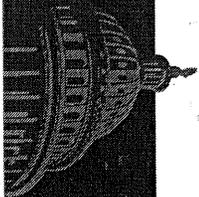
- The Governor believes the most effective path to coverage for all is an enforceable and effective individual mandate, combined with insurance reform that guarantees issuance of coverage, and subsidies for lower income individuals.
- The individual mandate must provide effective incentives to help prevent adverse selection that could occur if the mandate is too weak.
- Individual participation can be facilitated if health insurance exchanges are transparent and user friendly to help consumers compare insurance options.
- States should maintain a strong role in regulating the insurance market and have the ability to maintain and operate their own exchanges, with the understanding that some national standards will need to be established.
- States have a long record of protecting consumers in health insurance markets and will be able to act more nimbly, while recognizing state or regional nuances in the health care market, much more so than a one-

size-fits-all national exchange. Congress should work to maintain the states' central role in regulating insurance markets.

- California has had experience in providing coverage through an exchange. It opened in 1993 and had to close in December 2006. For an exchange to be successful, there must be insurance rules in place that preclude insurers from cherry picking healthy lives as well as making the exchange the sole locus of subsidies for subsidized populations.

Transition to the new system. To help promote a responsible and effective transition to the new health care model envisioned by pending proposals, Congress should work with states to develop reasonable timeframes for mandated program changes and provide short term financial assistance to states, including:

- Maintaining the enhanced FMAP rates under ARRA until the proposed reforms are in place;
- Developing alternatives to maintenance of effort (MOE) provisions until Medicaid coverage expansions are in place;
- Eliminating the five year federal ban on Medicaid matching support for legal immigrants health care costs;
- Delaying the phase-out of Medicaid managed care provider taxes pending the enactment of new rates;
- Reimbursing states for Medicaid costs owed associated with the federal government's improper classification of certain permanent disability cases.
- Provide funding so that California's high risk pool could become qualified as a risk pool under federal law. This would require funding to help California eliminate the lower cap on benefits it has (\$75,000 benefit maximum) and funding to eliminate its waiting list.



FOCUS on Health Reform



HEALTH CARE REFORM PROPOSALS

Achieving comprehensive health reform has emerged as a leading priority of the President and Congress. This summary of the Senate Finance Committee America's Healthy Future Act of 2009, the Senate HELP Committee Affordable Health Choices Act and the House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200) describes the key components of these leading health reform proposals. The House Tri-Committee summary incorporates the major amendments to the legislation adopted by the three committees of jurisdiction during their mark-ups of the bill. These amendments are identified using an abbreviation for the House panel that approved it — "E&C" for the Committee on Energy and Commerce; "E&L" for the Committee on Education and Labor; and "W&M" for the Committee on Ways and Means.

	Senate Finance Committee America's Healthy Future Act of 2009	Senate HELP Committee Affordable Health Choices Act	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)
Date plan announced	September 16, 2009 (as amended by Committee during mark-up)	June 9, 2009 (passed by Committee July, 15, 2009)	June 19, 2009
Overall approach to expanding access to coverage	Require most U.S. citizens and legal residents to have health insurance. Create state-based health insurance exchanges through which individuals can purchase coverage, with premium and cost-sharing credits available to individuals/families with income between 100-400% of the federal poverty level (the poverty level is \$18,310 for a family of three in 2009) and create separate exchanges through which small businesses can purchase coverage. Assess a fee on certain employers that do not offer coverage for each employee who receives a tax credit for health insurance through an exchange, with exceptions for small employers. Impose new regulations on health plans in the exchange and in the individual and small group markets. Expand Medicaid to all individuals with incomes up to 133% of the federal poverty level.	Require individuals to have health insurance. Create state-based American Health Benefit Gateways through which individuals and small businesses can purchase health coverage, with subsidies available to individuals/families with incomes up to 400% of the federal poverty level (or \$73,240 for a family of three in 2009). Require employers to provide coverage to their employees or pay an annual fee, with exceptions for small employers, and provide certain small employers a credit to offset the costs of providing coverage. Impose new regulations on the individual and small group insurance markets. Expand Medicaid to all individuals with incomes up to 150% of the federal poverty level.	Require all individuals to have health insurance. Create a Health Insurance Exchange through which individuals and smaller employers can purchase health coverage, with premium and cost-sharing credits available to individuals/families with incomes up to 400% of the federal poverty level (or \$73,240 for a family of three in 2009). Require employers to provide coverage to employees or pay into a Health Insurance Exchange Trust Fund, with exceptions for certain small employers, and provide certain small employers a credit to offset the costs of providing coverage. Impose new regulations on plans participating in the Exchange and in the small group insurance market. Expand Medicaid to 133% of the poverty level.

	Senate Finance Committee America's Healthy Future Act of 2009	Senate HELP Committee Affordable Health Choices Act	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)
Individual mandate	<ul style="list-style-type: none"> Require U.S. citizens and legal residents to have qualifying health coverage. Enforced through a tax penalty of \$750 per adult per year. The penalty will be phased-in according to the following schedule: \$0 in 2013; \$200 in 2014; \$400 in 2015; \$600 in 2016; and \$750 in 2017. Exemptions will be granted for financial hardship, religious objections, American Indians, and if the lowest cost plan option exceeds 8% of an individual's income or if the individual has income below 133% of the poverty level. 	<ul style="list-style-type: none"> Require individuals to have qualifying health coverage. Enforced through a minimum tax penalty of \$750 per individual per year (maximum penalty per family of 4 times the individual penalty). Exemptions to the individual mandate will be granted to residents of states that do not establish an American Health Benefit Gateway, members of Indian tribes, those for whom affordable coverage is not available, those without coverage for fewer than 90 days, and those with incomes below 150% FPL. 	<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.
Employer requirements	<ul style="list-style-type: none"> Assess employers with more than 50 employees that do not offer coverage a fee for each employee who receives a tax credit for health insurance through an exchange. The penalty is the lesser of a flat dollar amount equal to the average national tax credit for each full-time employee receiving a tax credit or \$4,000 times the total number of full-time employees in the firm. Exempt employers with 50 or fewer employees from the penalty. Require employers with 200 or more employees to automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of coverage if they have coverage from another source. 	<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: <i>Provide hardship exemptions for employers that would be negatively affected by job losses as a result of requirement.</i>] 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.

Employer requirements (continued)			[E&C Committee amendment: Extend the reduction in the pay or play assessment for small employers with annual payroll of less than \$750,000 and replace the above schedule with the following: - Annual payroll less than \$500,000: exempt - Annual payroll between \$500,000 and \$585,000: 2% of payroll; - Annual payroll between \$585,000 and \$670,000: 4% of payroll; - Annual payroll between \$670,000 and \$750,000: 6% of payroll.] * Require employers that offer coverage to automatically enroll into the employer's lowest cost premium plan any individual who does not elect coverage under the employer plan or does not opt out of such coverage.
Expansion of public programs	<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 (to be implemented in 2014). Adults with incomes between 100-133% FPL will have the option of obtaining coverage through Medicaid or with federal subsidies through the Exchange. All newly eligible adults will be guaranteed a benchmark benefit package that at least meets the minimum creditable coverage standards. Require states to provide premium assistance to any Medicaid beneficiary with access to employer-sponsored insurance if it is cost-effective for the state. To finance the coverage for the newly eligible (those who were not previously eligible for a full benchmark benefit package or who were eligible for a capped program but were not enrolled), states will receive an increase in the federal medical assistance percentage (FMAP). Initially, the percentage point increase in the FMAP will be 27.3 for states that already cover adults with incomes above 100% FPL and 37.3 for other states. These percentage point increases will be adjusted over time so that by 2019, all states will receive an FMAP increase of 32.3 percentage points for the newly eligible. 	<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.]

	Senate Finance Committee America's Healthy Future Act of 2009	Senate HELP Committee Affordable Health Choices Act	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)
Expansion of public programs (continued)	<p>High need states—those with total Medicaid enrollment that is below the national average for enrollment as a percentage of the state population and unemployment rates of 12% or higher for August 2009—will receive full federal funding for the newly eligible for five years.</p> <ul style="list-style-type: none"> Require states to maintain current income eligibility levels for children in Medicaid and the Children's Health Insurance Program (CHIP) until 2019. CHIP benefit package and cost-sharing rules will continue as under current law. Beginning in 2014, states will receive a 23 percentage point increase in the CHIP match rate up to a cap of 100% and a .15 percentage point increase in the Medicaid match rate. CHIP-eligible children who are unable to enroll in the program due to enrollment caps will be eligible for tax credits in the state exchanges. 		<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. <i>LE&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.</i>
Premium subsidies to individuals	<ul style="list-style-type: none"> Provide refundable and advanceable premium credits to individuals and families with incomes between 133-400% FPL in 2013, and including individuals and families with incomes between 100-133% FPL in 2014, to purchase insurance through the health insurance exchanges. The premium credits will be tied to the second lowest-cost silver plan in the area and will be provided on a sliding scale basis from 2% of income for those at 100% FPL to 12% of income for those between 300-400% FPL. Exclude individuals with incomes below 100% FPL from eligibility for the premium credits. These individuals will be eligible for coverage through the Medicaid program. Provide cost-sharing subsidies to eligible individuals and families with incomes between 100-200% FPL. For those with incomes between 100-150% FPL, the cost-sharing subsidies will result in coverage for 90% of the benefit costs of the plan. For those with incomes between 150-200%, the cost-sharing subsidies will result in coverage for 80% of the benefit costs of the plan. 	<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 U.S. citizens and lawfully residing immigrants who meet income limits and are not eligible for employer-based coverage that meets minimum qualifying criteria and affordability standards, Medicare, Medicaid, TRICARE, or the Federal Employee Health Benefits Program. Individuals with access to employer-based coverage are eligible for the premium credits if the cost of the employee premium exceeds 12.5% of the individuals' income. 	<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

Senate Finance Committee America's Healthy Future Act of 2009	Senate HELP Committee Affordable Health Choices Act	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)
<p>Premium subsidies (continued)</p>	<ul style="list-style-type: none"> Limit availability of premium credits and cost-sharing subsidies through the exchanges to U.S. citizens and legal immigrants who meet income limits. Employees who are offered coverage by an employer are not eligible for premium credits unless the employer plan does not have an actuarial value of at least 65% or if the employee share of the premium exceeds 10% of income. Require verification of both income and citizenship status in determining eligibility for the federal premium credits. 	<p>[E&C Committee amendment: Replaces the above subsidy schedule with the following:</p> <p>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]</p> <p>[E&C Committee amendment: Increase the affordability credits annually by the estimated savings achieved through adopting a formula in the public health insurance option, pharmacy benefit manager transparency requirements, developing accountable care organization pilot programs in Medicaid, and administrative simplification.] [E&C Committee amendment: Increase the affordability credits annually by the estimated savings achieved through limiting increases in premiums for plans in the Exchange to no more than 150% of the annual increase in medical inflation and by requiring the Secretary to negotiate directly with prescription drug manufacturers to lower the prices for Medicare Part D plans.]</p> <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 133-150% FPL: 97% 150-200% FPL: 93% 200-250% FPL: 85% 250-300% FPL: 78% 300-350% FPL: 72% 350-400% FPL: 70%

Senate Finance Committee
America's Healthy Future Act of 2009

Senate HELP Committee
Affordable Health Choices Act

House Tri-Committee
America's Affordable Health Choices Act of 2009
(H.R. 3200)

<p>Premium subsidies to individuals (continued)</p>			<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].
<p>Premium subsidies to employers</p>	<ul style="list-style-type: none"> • Provide small employers with fewer than 25 employees and average annual wages of less than \$40,000 that purchase health insurance for employees with a tax credit. <i>Phase I:</i> For tax years 2011 and 2012, provide a tax credit of up to 35% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost or 50% of a benchmark premium. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than \$20,000. Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 25% of the employer's contribution toward the employee's health insurance premium. <i>Phase II:</i> For tax years 2013 and later, for eligible small businesses that purchase coverage through the state exchange, provide a tax credit of up to 50% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost or 50% of a benchmark premium. The credit will be available for two years. The full credit will be available to employers with 	<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. 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. 	<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. • 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 \$70,000. 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.

	Senate Finance Committee America's Healthy Future Act of 2009	Senate HELP Committee Affordable Health Choices Act	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)
<p>Premium subsidies to employers (continued)</p>	<p>10 or fewer employees and average annual wages of less than \$20,000. Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 35% of the employer's contribution toward the employee's health insurance premium.</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 or insurers for 80% of retiree claims between \$15,000 and \$90,000. Appropriate \$5 billion to finance the program. 	<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. 	
<p>Tax changes related to health insurance</p>	<ul style="list-style-type: none"> • Impose a tax on individuals without qualifying coverage of \$750 per adult per year to be phased-in beginning in 2014. • Impose an excise tax in 2013 on insurers of employer-sponsored health plans with aggregate values that exceed \$8,000 for individual coverage and \$21,000 for family coverage (these threshold values will be indexed to the consumer price index for urban consumers [CPI-U] plus 1%). The threshold amounts will be increased for retired individuals age 55 and up and for employees engaged in high-risk professions by \$1,850 for individual coverage and \$5,000 for family coverage. In the 17 states with the highest health care costs, the threshold amount is increased by 20% initially; this premium increase is subsequently reduced by half each year until it is phased out in 2015. The tax is equal to 40% of the value of the plan that exceeds the threshold amounts and is imposed on the issuer of the health insurance policy, which in the case of a self-insured plan is the plan administrator or, in some cases, the employer. The aggregate value of the health insurance plan includes reimbursements under a flexible spending account for medical expenses (health FSA) or health reimbursement arrangement (HRA), employer contributions to a health savings account (HSA), and coverage for dental, vision, and other supplementary health insurance coverage. 	<ul style="list-style-type: none"> • Impose a minimum tax on individuals without qualifying health care coverage of \$750 per individual per year (maximum family penalty of 4 times the individual penalty). 	<ul style="list-style-type: none"> • Impose a tax on individuals without acceptable health care coverage of 2.5% of modified adjusted gross income.

	Senate Finance Committee America's Healthy Future Act of 2009	Senate HELP Committee Affordable Health Choices Act	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)
<p>Tax changes related to health insurance (continued)</p>	<ul style="list-style-type: none"> • Conform the definition of medical expenses for purposes of employer provided health coverage (including HRAs and health FSAs), HSAs, and Archer medical savings accounts to the definition for purposes of the itemized deduction for medical expenses. This change will exclude the costs for over-the-counter drugs not prescribed by a doctor from being reimbursed through an HRA or health FSA and from being reimbursed on a tax-free basis through an HSA or Archer MSA. • Increase the tax on distributions from a health savings account that are not used for qualified medical expenses to 20% (from 10%) of the disbursed amount. • Limit the amount of contributions to a flexible spending account for medical expenses to \$2,500 per year. • Increase the threshold for the itemized deduction for unreimbursed medical expenses from 7.5% of adjusted gross income to 10% of adjusted gross income for regular tax purposes. Individuals age 65 and older are exempt from the increased threshold. • Impose new fees on segments of the health care sector: <ul style="list-style-type: none"> – \$2.3 billion annual fee on the pharmaceutical manufacturing sector; – \$4 billion annual fee on the medical device manufacturing sector; and – \$6.7 billion annual fee on the health insurance sector. 	<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. 	<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.
<p>Creation of insurance pooling mechanisms</p>	<ul style="list-style-type: none"> • Provide immediate assistance until the new insurance market rules go into effect for those with pre-existing conditions by creating a temporary high-risk pool. Individuals who have been denied health coverage due to a pre-existing medical condition and who have been uninsured for at least six months will be eligible to enroll in the high-risk pool and receive subsidized premiums. The high-risk pool will exist until 2013. 		

Senate Finance Committee
America's Healthy Future Act of 2009

Senate HELP Committee
Affordable Health Choices Act

House Tri-Committee
America's Affordable Health Choices Act of 2009
(H.R. 3201)

<p>Creation of insurance pooling mechanisms (continued)</p>	<ul style="list-style-type: none"> • Create state-based exchanges for the individual market and small business health options program (SHOP) exchanges for the small group market. Allow small businesses with up to 100 employees to purchase coverage through the SHOP exchanges beginning in 2015 and permit states to allow businesses with more than 100 employees to purchase coverage in the SHOP exchange beginning in 2017. • Restrict access to coverage through the exchanges to U.S. citizens and legal immigrants. • Create the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of non-profit, member-run health insurance companies in all 50 states and District of Columbia. To be eligible to receive funds, organizations must not be an existing organization, substantially all of its activities must consist of the issuance of qualified health benefit plans in each state in which it is licensed, governance of the organization must be subject to a majority vote of its members, must operate with a strong consumer focus, and any profits must be used to lower premiums, improve benefits, or improve the quality of health care delivered to its members. Require CO-OPs to meet the same requirements as private insurance plans in the exchanges related to solvency, licensure, provider payments, network adequacy, and any applicable state premium assessments. • Require all state-licensed insurers in the individual and small group markets to participate in the exchanges. • Require guarantee issue and renewability and allow rating variation based only on age (limited to 4 to 1 ratio), tobacco use (limited to 1.5 to 1 ratio), family composition, and geography in the non-group and the small group market (new rules for small group market will be phased-in over five years). Require risk adjustment in the individual and small group markets and prohibit insurers from rescinding coverage. 	<ul style="list-style-type: none"> • Restrict access to coverage through the Gateways to individuals who are not incarcerated and who are not eligible for employer-sponsored coverage that meets minimum qualifying criteria and affordability standards, Medicare, Medicaid, TRICARE, or the Federal Employee Health Benefits Program. • Create a community health insurance option to be offered through state Gateways that complies with the requirements of being a qualified health plan and meets the same requirements as other plans relating to guarantee issue and renewability, insurance rating rules, quality improvement and reporting, solvency standards, licensure, and benefit plan information. Require the community health insurance plan to provide the essential benefits package and offer coverage at all cost-sharing tiers. Require that the costs of the community health insurance plan be financed through revenues from premiums, require the plan to negotiate payment rates with providers, and contract with qualified nonprofit entities to administer the plan. Permit the plan to develop innovative payment policies to promote quality, efficiency, and savings to consumers. Require each State to establish a State Advisory Council to provide recommendations on policies and procedures for the community health insurance option. • Require guarantee issue and renewability of health insurance policies in the individual and small group markets; prohibit pre-existing condition exclusions; prohibit insurers from rescinding coverage except in cases of fraud; and allow rating variation based only on family structure, geography, the actuarial value of the health plan benefit, tobacco use (limited to 1.5 to 1 ratio), and age (limited to 2 to 1 ratio). 	<ul style="list-style-type: none"> • 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. 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
---	---	---	---

Senate Finance Committee
America's Healthy Future Act of 2009

Senate HELP Committee
Affordable Health Choices Act

House Tri-Committee
America's Affordable Health Choices Act of 2009
(H.R. 3200)

Creation of insurance pooling mechanisms (continued)

<ul style="list-style-type: none"> • Require the exchanges to develop a standardized format for presenting insurance options, create a web portal to help consumers find insurance, maintain a call center for customer service, and establish procedures for enrolling individuals and businesses and for determining eligibility for tax credits. Permit exchanges to contract with state Medicaid agencies to determine eligibility for tax credits in the exchanges. • Create four benefit categories of plans plus a separate "young invincible plan" to be offered through the exchange, and in the individual and small group markets: <ul style="list-style-type: none"> - <i>Bronze plan</i> represents minimum creditable coverage and would cover 65% of the benefit costs of the plan, with an out-of-pocket limit equal to the Health Savings Account (HSA) current law limit (\$5,950 for individuals and \$11,900 for families in 2010); - <i>Silver plan</i> includes minimum benefits, covers 70% of the benefit costs of the plan, with the HSA out-of-pocket limits; - <i>Gold plan</i> includes the minimum benefits, covers 80% of the benefit costs of the plan, with the HSA out-of-pocket limits; - <i>Platinum plan</i> includes the minimum benefits, covers 90% of the benefit costs of the plan, with the HSA out-of-pocket limits; - <i>Young Invincible plan</i> available to those 25 years old and younger and provides catastrophic coverage only with the coverage level set at the HSA current law levels except that prevention benefits would be exempt from the deductible. • Reduce the out-of-pocket limits for those with incomes up to 400% FPL to the following levels: <ul style="list-style-type: none"> - 100-200% FPL: one-third of the HSA limits (\$1,983/individual and \$3,967/family); - 200-300% FPL: one-half of the HSA limits (\$2,975/individual and \$5,950/family); - 300-400% FPL: two-thirds of the HSA limits (\$3,967/individual and \$7,973/family). 	<ul style="list-style-type: none"> • Require plans participating in the Gateway to provide coverage for at least the essential health care benefits, meet network adequacy requirements, and make information regarding plan benefits service area, premium and cost sharing, and grievance and appeal procedures available to consumers. • Create three benefit tiers of plans to be offered through the Gateways based on the percentage of allowed benefit costs covered by the plan: <ul style="list-style-type: none"> - Tier 1: includes the essential health benefits, covers 76% of the benefit costs of the plan, and limits out-of-pocket costs to the Health Savings Account (HSA) current law limit (\$5,950 for individuals and \$11,900 for families in 2010); - Tier 2: includes the essential health benefits, covers 84% of the benefit costs of the plan, and limits out-of-pocket costs to 50% of the HSA limit (\$2,975 for individuals and \$5,950 for families); and - Tier 3: includes the essential health benefits, covers 93% of the benefit costs of the plan, and limits out-of-pocket costs to 20% of the HSA limit (\$1,190 for individuals and \$2,380 for families). • Require states to adjust payments to health plans based on the actuarial risk of plan enrollees using methods established by the Secretary. • Require the Gateway to certify participating health plans, provide consumers with information allowing them to choose among plans (including through a centralized website), contract with navigators to conduct outreach and enrollment assistance, create a single point of entry for enrolling in coverage through the Gateway or through Medicaid, CHIP or other federal programs, and assist consumers with the purchase of long-term care services and supports. 	<p>payment rates to encourage use of high-value services. [E&C Committee amendment: Clarify that the public health insurance option must meet the same requirements as other plans relating to guarantee issue and renewability, insurance rating rules, network adequacy, and transparency of information.] [E&C Committee amendment: Require the public health insurance option to adopt a prescription drug formulary.]</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. • 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.
---	---	---

Senate Finance Committee
America's Healthy Future Act of 2009

Senate HELP Committee
Affordable Health Choices Act

House Tri-Committee
America's Affordable Health Choices Act of 2009
(H.R. 3200)

<p>Creation of insurance pooling mechanisms (continued)</p>	<ul style="list-style-type: none"> • Permit states the option of creating a Basic Health Plan for uninsured individuals with incomes between 133-200% FPL. States opting to provide this coverage will contract with multiple private plans to provide coverage at the level of plans in the exchanges. They are encouraged to include innovative features in the contracts, such as care coordination and incentives for using preventive services and should seek to contract with managed care plans that meet specific performance measures. States will receive 85% of the funds that would have been paid as federal premium and cost-sharing subsidies for eligible individuals in the state with incomes between 133-200% FPL to establish the Basic Health Plan. Individuals with incomes between 133-200% FPL in states creating Basic Health Plans will not be eligible for subsidies in the exchanges. • Require that at least one plan in the exchanges provide coverage for abortions beyond those for which federal funds are permitted and require that at least one plan in the exchange does not provide coverage for abortions beyond those for which federal funds are permitted (in cases of rape or incest or to save the life of the woman). Prohibit plans participating in the exchanges from discriminating against any provider because of a willingness or unwillingness to provide, pay for, provide coverage of, or refer for abortions. 	<ul style="list-style-type: none"> • Prohibit plans participating in the Gateways from discriminating against any provider because of a willingness or unwillingness to provide abortions. • Following initial federal support, the Gateway will be funded by a surcharge of no more than 4% of premiums collected by participating health plans. 	<p>[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.]</p> <ul style="list-style-type: none"> • 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. <p>[E&C Committee amendment: Prohibit plans participating in the Exchange from discriminating against any provider because of a willingness or unwillingness to provide abortions.]</p> <p>[E&C Committee amendment: Facilitate the establishment of non-for-profit, member-run health insurance cooperatives to provide insurance through the Exchange.]</p> <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.
<p>Benefit design</p>	<ul style="list-style-type: none"> • Create minimum creditable coverage that provides a comprehensive set of services, covers 65% of the actuarial value of the covered benefits, limits annual cost-sharing to \$5,950/individual and \$11,900/family, does not impose annual or lifetime limits on coverage, and is not more extensive than the typical employer plan. Require the Secretary to define and annually update the benefit package through a transparent and public process. (See description of benefit categories in Creation of insurance pooling mechanism.) 	<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. 	<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

	Senate Finance Committee America's Healthy Future Act of 2009	Senate HELP Committee Affordable Health Choices Act	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)
Benefit design (continued)	<ul style="list-style-type: none"> Prohibit abortion coverage from being required as part of the minimum benefits package; require segregation of public subsidy funds from private premium payments for plans that choose to cover abortion services beyond Hyde—which allows coverage for abortion services to save the life of the woman and in cases of rape or incest; and require there be no effect on state or federal laws on abortions. 	<ul style="list-style-type: none"> 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. 	<p><i>screening, diagnostic, and treatment (EPSDT) services for children under age 21 be included in the essential benefits package.]</i></p> <p><i>[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.]</i></p> <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"> Impose the same insurance market regulations relating to guarantee issue, premium rating, prohibitions on pre-existing condition exclusions, risk adjustment, and rescissions in the individual market, in the exchange, and in the small group market, phasing in the new rules for small group market over five years. [See new rating and market rules in Creation of insurance pooling mechanism.] Require health plans to report the proportion of premium dollars spent on items other than medical care and require plans to compile information on coverage in a standard format. Require all new policies (except stand-alone dental, vision, and long-term care insurance plans) to comply with one of the four benefit categories, including those offered through the exchanges and those offered outside of the exchanges. Require health plans in the individual and small group markets to at least offer coverage in the silver and gold categories. Existing individual and employer-sponsored plans do not have to meet the new benefit 	<ul style="list-style-type: none"> Impose the same insurance market regulations relating to guarantee issue, premium rating, prohibitions on pre-existing condition exclusions, and prohibitions on insurance plan rescissions in the individual and group markets and in the American Health Benefit Gateways. [See new rating and market rules in Creation of insurance pooling mechanism]. Require health insurers to report their medical loss ratio. Require health insurers to provide financial incentives to providers to better coordinate care through case management and chronic disease management, promote wellness and health improvement activities, improve patient safety, reduce medical errors, and provide culturally and linguistically appropriate care. Provide dependent coverage for children up to age 26 for all individual and group policies. Require insurers and group plans to notify enrollees if coverage does not meet minimum qualifying coverage standards for purposes of satisfying the individual mandate for coverage. 	<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. <i>[E&L Committee amendment: Limit health plans' medical loss ratio to at least 85%.]</i> 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.

Senate Finance Committee America's Healthy Future Act of 2009	Senate HELP Committee Affordable Health Choices Act	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)
<p>Changes to private insurance (continued)</p>	<ul style="list-style-type: none"> standards. (See description of benefit categories in Creation of insurance pooling mechanism.) Require small employers to provide a plan with a deductible that does not exceed \$2,000 for individuals and \$4,000 for families unless contributions are offered that offset deductible amounts above these limits. This deductible limit will not affect the actuarial value of bronze plans and does not apply to "young invincible" plans. (See description of benefit categories in Creation of insurance pooling mechanism.) Allow states the option of merging the individual and small group markets. Create a temporary reinsurance program to help stabilize premiums during the first three years of operation of the exchanges when the risk of adverse selection due to enforcement of the new rating rules and market changes is greatest. Finance the reinsurance program through mandatory contributions by health insurers. Allow insurers to offer a national health plan with a uniform benefits package in the states in which they are licensed. National plans would be required to offer plans with silver and gold benefit packages and would be exempt from state benefit requirements. Allow states to opt out of the national plan. Permit states to form health care choice compacts and allow insurers to sell policies in any state participating in the compact. Insurers selling policies through a compact would only be subject to the laws and regulations of the state where the policy is written or issued. 	<ul style="list-style-type: none"> Permit licensed health insurers to sell health insurance policies outside of the Gateway. States will regulate these outside-the-Gateway plans: Adopt standards for financial and administrative transactions to promote administrative simplification. Create the Health Choices Administration to establish the qualifying health benefits standards, establish the Exchange, administer the affordability credits, and enforce the requirements for qualified health benefit plan offering entities, including those participating in the Exchange or outside the Exchange.

Senate Finance Committee America's Healthy Future Act of 2009	Senate HELP Committee Affordable Health Choices Act	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)	
<p>State role</p>	<ul style="list-style-type: none"> Require states to create health insurance exchanges for individuals and small businesses and require state insurance commissioners to provide oversight of health plans with regard to the new insurance market regulations, consumer protections, rate reviews, solvency, reserve fund requirements, and premium taxes, and to define rating areas. Require states to enroll newly eligible Medicaid beneficiaries into state Medicaid programs, coordinate enrollment with the new exchanges, and implement other specified changes to the Medicaid program. Require states to maintain current Medicaid and CHIP eligibility levels for children until 2019. States must also maintain current Medicaid eligibility levels for adults above 133% FPL until 2013 and until 2014 for those with incomes at or below 133% FPL. A state is exempt from the maintenance of effort requirement for non-disabled adults with incomes above 133% FPL from January 2011 if the state certifies that it is experiencing a budget deficit or will experience a deficit in the following year. Require states to establish an ombudsman office to serve as an advocate for people with private coverage in the individual and small group markets. Permit states to obtain a waiver of certain new health insurance requirements if the state can demonstrate that it provides health coverage to all residents that is at least as comprehensive as the coverage required under an exchange plan and that the state plan is budget-neutral to the federal government over 10 years. 	<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.

**Senate Finance Committee
America's Healthy Future Act of 2009**

**Senate HELP Committee
Affordable Health Choices Act**

**House T-1 Committee
America's Affordable Health Choices Act of 2009
(H.R. 3200)**

Cost containment

- Restructure payments to Medicare Advantage plans to base payments on plan bids with bonus payments for quality, performance improvement, and care coordination. Grandfather the extra benefits in MA plans in areas where plan bids are at or below 75% of traditional fee-for-service Medicare (these plans are required to participate in the new competitive bidding process). Provide transitional extra benefits for MA beneficiaries in certain areas if they experience a significant reduction in extra benefits under competitive bidding.
- Reduce annual market basket updates for inpatient hospital, home health, skilled nursing facility, hospice and other Medicare providers, and adjust for productivity.
- Freeze the threshold for income-related Medicare Part B premiums through 2019, and reduce the Medicare Part D premium subsidy for those with incomes above \$85,000/individual and \$170,000/couples.
- Establish an independent Medicare Commission to submit proposals for reducing excess Medicare cost growth by targeted amounts. Proposals submitted by the Commission must be acted on by Congress and if a legislative package with the targeted level of Medicare savings is not enacted, the Commission's proposal will go into effect automatically. The Commission would be prohibited from submitting proposals that would ration care, increase revenues or change benefits, eligibility or Medicare beneficiary cost sharing (including Parts A and B premiums), but would not be prohibited from making recommendations to reduce premium subsidies for Medicare Advantage or stand-alone Part D prescription drug plans. Hospitals and hospices would not be subject to cost reductions proposed by the Commission. Beginning January 1, 2019, the growth target for Medicare spending would be set at GDP per capita plus one percent.

- 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.

- 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:
 - Modify market basket updates to account for productivity improvements for inpatient hospital, home health, skilled nursing facility, and other Medicare providers; and
 - Reduce payments for potentially preventable hospital readmissions.
- Restructure payments to Medicare Advantage plans, phasing to 100% of fee-for-services payments, with bonus payments for quality.
- Increase the Medicaid drug rebate percentage and extend the prescription drug rebate to Medicaid managed care plans. Require drug manufacturers to provide drug rebates for dual eligibles enrolled in Part D plans.
- *[E&C Committee amendment: Require the Secretary to negotiate directly with pharmaceutical manufacturers to lower drug prices for Medicare Part D plans and Medicare Advantage Part D plans.]*
- *[E&C Committee amendment: Authorize the Food and Drug Administration to approve generic versions of biologic drugs and grant biologics manufacturers 12 years of exclusive use before generics can be developed.]*
- Reduce Medicaid DSH payments by \$6 billion in 2019, imposing the largest percentage reductions in state DSH allotments in states with the lowest uninsured rates and those that do not target DSH payments.

	Senate Finance Committee America's Healthy Future Act of 2009	Senate HELP Committee Affordable Health Choices Act	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)
<p>Cost containment (continued)</p>	<ul style="list-style-type: none"> • Reduce Medicare DSH payments by an amount proportional to the percentage point decrease in the uninsured for the period evaluated. • Eliminate the Medicare Improvement Fund. • Allow providers organized as accountable care organizations (ACOs) that voluntarily meet quality thresholds to share in the cost-savings they achieve for the Medicare program. To qualify as an ACO, organizations must agree to be accountable for the overall care of their Medicare beneficiaries, have adequate participation of primary care physicians and specialists, define processes to promote evidence-based medicine, report on quality and costs measure, and coordinate care. Create a chronic care coordination pilot program to provide the highest cost Medicare beneficiaries with primary care services in their home and allow participating teams of health professionals to share in any savings if they achieve quality outcomes, patient satisfaction, and cost savings. • Create an Innovation Center within the Centers for Medicare and Medicaid Services to test, evaluate, and expand in Medicare, Medicaid, and CHIP different payment structures and methodologies to foster patient-centered care, improve quality, and slow Medicare costs growth. Payment reform models that improve quality and reduce the rate of costs could be expanded throughout the Medicare, Medicaid, and CHIP programs. • Reduce payments for preventable hospital readmissions in Medicare: for hospitals with readmission rates above a certain threshold reduce payments by 20% if a patient is re-hospitalized with a preventable readmission within seven days and by 10% if a patient is re-hospitalized with a preventable readmission within 15 days, and reduce payments by 1% to hospitals with the highest rates of hospital acquired conditions. 		<ul style="list-style-type: none"> • 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.

<p>Cost containment (continued)</p>	<ul style="list-style-type: none"> • Increase the Medicaid drug rebate percentage for brand name drugs to 23.1, increase the Medicaid rebate for non-innovator, multiple source drugs to 13% of average manufacturer price, and extend the drug rebate to Medicaid managed care plans. • Reduce a state's Medicaid DSH allotment by 50% (25% for low DSH states) once the uninsured rate decreases by at least 50%. DSH allotments will be further reduced, not to fall below 35% of the total allotment in 2012 if states' uninsured rates continue to decrease. Exempt any portion of the DSH allotment used to expand Medicaid eligibility through a section 1115 waiver. • Establish demonstration projects in Medicaid and CHIP to allow pediatric medical providers organized as accountable care organizations to share in cost-savings. • Prohibit federal payments to states for Medicaid services related to health care acquired conditions. • Eliminate fraud, waste, and abuse in public programs through more intensive screening of providers, the development of the "One PI database" to capture and share data across federal and state programs, increased penalties for submitting false claims, and increase funding for anti-fraud activities. 	<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 	<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. <i>IE&C Committee amendment: Prohibit use of comparative effectiveness research findings to deny or ration care or to make coverage decisions in Medicare.]</i>
<p>Improving quality/health system performance</p>	<ul style="list-style-type: none"> • Simplify health insurance administration by adopting a single set of operating rules for eligibility verification, claims status, claims payment, and the electronic transfer of funds. • Establish a non-profit Patient-Centered Outcomes Research Institute to identify research priorities and conduct research that compares the clinical effectiveness of medical treatments. The Institute will be overseen by an appointed multi-stakeholder Board of Governors and will be assisted by expert advisory panels. 	<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 	<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. <i>IE&C Committee amendment: Prohibit use of comparative effectiveness research findings to deny or ration care or to make coverage decisions in Medicare.]</i>

Improving quality/health system performance (continued)	Senate Finance Committee <i>America's Healthy Future Act of 2009</i>	Senate HELP Committee <i>Affordable Health Choices Act</i>	House Tri-Committee <i>America's Affordable Health Choices Act of 2009</i> (H.R. 3200)
	<ul style="list-style-type: none"> • Encourage states to develop and test alternatives to the current civil litigation system as a way to improve patient safety, reduce medical errors, increase the availability of a prompt and fair resolution of disputes, and improve access to liability insurance, while preserving an individual's right to seek redress in court. Recommend that Congress consider establishing a state demonstration project to evaluate alternatives to the current litigation system. • Establish a national Medicare pilot program to develop and evaluate paying a bundled payment for acute, inpatient hospital services and post-acute care services for an episode of care that begins three days prior to a hospitalization and spans 30 days following discharge. If the pilot program achieves stated goals, develop a plan for making the pilot a permanent part of the Medicare program. • Establish a hospital value-based purchasing program in Medicare to pay hospitals based on performance on quality measures and extend the Medicare physician quality reporting initiative beyond 2010. • Improve care coordination for dual eligibles by creating a new office within the Centers for Medicare and Medicaid services, the Federal Coordinated Health Care Office, to align Medicare and Medicaid benefits, administration, oversight rules, and policies for dual eligibles. • Develop a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health. Create processes for the development of quality measures involving input from multiple stakeholders and for selecting quality measures to be used in reporting to and payment under federal health programs. Establish the Medicaid Quality Measurement Program to establish priorities for the development and advancement of quality measures for adults in Medicaid. 	<ul style="list-style-type: none"> • 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. • 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. 	<ul style="list-style-type: none"> • 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: <i>Adopt accountable care organization, bundled payment, and medical home models on a large scale if pilot programs prove successful at reducing costs.</i>] [E&C Committee amendment: <i>Conduct accountable care organization pilot programs in Medicaid.</i>] • [E&C Committee amendment: <i>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.</i>] • [W&M Committee amendment: <i>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.</i>] • 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
America's Healthy Future Act of 2009**

**Senate HELP Committee
Affordable Health Choices Act**

**House Tri-Committee
America's Affordable Health Choices Act of 2009
[H.R. 3200]**

<p>Improving quality/health system performance (continued)</p>	<ul style="list-style-type: none"> 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"> 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. <i>[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.]</i>
<p>Prevention/wellness</p>	<ul style="list-style-type: none"> Provide Medicare beneficiaries access to a comprehensive health risk assessment and creation of a personalized prevention plan, eliminate cost-sharing for certain preventive services in Medicare. Cover only proven preventive services in Medicare and Medicaid and provide incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs. Require Medicaid coverage for tobacco cessation services for pregnant women, and for states that provide coverage for and remove cost-sharing for preventive services recommended by the US Preventive Services Task Force and recommended immunizations, provide a one percentage point increase in the FMAP for these services and for the tobacco cessation services. Create a new Medicaid state plan option to permit Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a health home. Provide states taking up the option with 90% FMAP for two years. 	<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. 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"> 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. 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.

<p>Prevention/wellness (continued)</p>	<ul style="list-style-type: none"> • Prohibit insurance plans (except existing grandfathered plans and those that use a value-based insurance design) from charging cost-sharing for preventive services. • Allow insurers to vary premium rates based on tobacco use. Any insurer that rates based on tobacco use must provide coverage for comprehensive tobacco cessation programs, including counseling and pharmacotherapy. • Provide grants to small businesses to establish comprehensive, evidence-based workplace wellness programs. • Permit employers to offer employees rewards of up to 30% of the cost of coverage for participating in a wellness program. Rewards may be in the form of premium discounts, waivers of cost-sharing requirements, or benefits that would otherwise not be provided. Rewards may be increased to 50% of the cost of coverage if a report finds the increase appropriate. Establish 10-state pilot programs in 2014 to permit participating states to apply similar rewards for participating in wellness programs in the individual market. 		
<p>Long-term care</p>	<ul style="list-style-type: none"> • Extend the Medicaid Money Follows the Person Rebalancing Demonstration program through September 2016 and allocate \$10 million per year for five years to continue the Aging and Disability Resource Center initiatives. • Provide states that undertake reforms to increase nursing home diversions and access to home and community-based services in their Medicaid programs with a targeted increase in the federal matching rate for five years. • Establish the Community First Choice Option in Medicaid to provide community-based attendant supports and services to individuals with disabilities who require an institutional level of care. Provide states with an enhanced federal matching rate of an additional six percentage points for reimbursable expenses in the program. Sunset the option after five years. 	<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.

Long-term care (continued)	Senate Finance Committee <i>America's Healthy Future Act of 2009</i>	Senate HELP Committee <i>Affordable Health Choices Act</i>	House Tri-Committee <i>America's Affordable Health Choices Act of 2009</i> (H.R. 3200)
<p>Other Investments</p>	<ul style="list-style-type: none"> • Improve transparency of information about skilled nursing facilities (SNF) and nursing homes, enforcement of SNF and nursing home standards and rules, and training of SNF and nursing home staff. 	<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. [E&C Committee amendment: <i>Support the development of interdisciplinary mental and behavioral health training programs.</i>] [E&C Committee amendment: <i>Establish a training program for oral health professionals.</i>] • Provide grants to each state health department to address core public health infrastructure needs.
<ul style="list-style-type: none"> • Make improvements to the Medicare program: <ul style="list-style-type: none"> – Provide a 50% discount on brand-name prescriptions filled in the Medicare Part D coverage gap for enrollees, other than those who receive low-income subsidies and those with incomes above \$95,000/individual and \$170,000/couples; – Make Part D cost-sharing for full-benefit dual eligible beneficiaries receiving home and community-based care services equal to the cost-sharing for those who receive institutional care; and – Provide a one-year increase in physician payments under Medicare to prevent a reduction in fees that would otherwise take effect, with 10% bonus payments for primary care. Provide general surgeons and primary care physicians practicing in health professional shortage areas with a 10% Medicare bonus. • Establish a multi-stakeholder Workforce Advisory Committee to develop a national workforce strategy for recruiting, training, and retaining a health care workforce that meets current and projected health care needs. • Increase the number of Graduate Medical Education (GME) training positions by redistributing currently unused slots, with priorities given to primary care and general surgery and to states with the lowest resident physician-to-population ratios; and increase flexibility in laws and regulations that govern GME funding to promote training in outpatient settings, and ensure the availability of residency programs in rural and underserved areas. Establish Teaching Health Centers, defined as community-based, ambulatory 			

	Senate Finance Committee <i>America's Healthy Future Act of 2009</i>	Senate HELP Committee <i>Affordable Health Choices Act</i>	House Tri-Committee <i>America's Affordable Health Choices Act of 2009</i> (H.R. 3200)
<p>Other investments (continued)</p>	<p>patient care centers, including federally-qualified health centers and other federally-funded health centers, that are eligible for Medicare payments for the expenses associated with operating primary care residency programs.</p> <ul style="list-style-type: none"> • Establish a graduate nurse education demonstration program to provide Medicare reimbursement to hospitals for costs associated with training advance practice nurses. • Impose additional requirements on non-profit hospitals to conduct a community needs assessment every three years and adopt an implementation strategy to meet the identified needs, adopt and widely publicize a financial assistance policy that indicates whether free or discounted care is available and how to apply for the assistance, limit charges to patients who qualify for financial assistance to the amount generally billed to insured patients, and make reasonable attempts to inform patients about the financial assistance policy before undertaking extraordinary collection actions. 		
<p>Financing</p>	<p>CBO estimates the cost of the coverage components of the Chairman's Mark, as amended during mark-up, to be \$829 billion over ten years. These costs are financed through a combination of savings from Medicare and Medicaid and new taxes and fees. The net savings from Medicare and Medicaid are estimated to be \$404 billion over ten years and the primary sources of these savings include incorporating productivity improvements into Medicare market basket updates, reducing payments to Medicare Advantage plans, creating the Medicare Commission charged with finding savings in the program, changing the Medicaid drug rebate provisions, and cutting Medicaid and Medicare DSH payments. [See descriptions of cost savings provisions in Cost containment.]</p>	<p>The Congressional Budget Office estimates this proposal will cost \$645 billion over 10 years. Because the Senate HELP Committee does not have jurisdiction over the Medicare and Medicaid programs or revenue raising authority, mechanisms for financing the proposal will be developed in conjunction with the Senate Finance Committee.</p>	<p>The Congressional Budget Office estimates the net cost of the proposal (less payments from employers and uninsured individuals) to be \$1.042 trillion over ten years. Approximately half of the cost of the plan is financed through savings from Medicare and Medicaid, including incorporating productivity improvements into Medicare market basket updates, reducing payments to Medicare Advantage plans, changing drug rebate provisions, reducing potentially preventable hospital readmissions, and cutting Medicaid DSH payments. The remaining costs are financed through a surcharge imposed on families with incomes above \$350,000 and individuals with incomes above \$280,000. The surcharge is equal to 1% for families with modified adjusted gross income between</p>

	Senate Finance Committee America's Healthy Future Act of 2009	Senate HELP Committee Affordable Health Choices Act	House Tri-Committee America's Affordable Health Choices Act of 2009 (H.R. 3200)
Financing (continued)	The largest source of new revenue will come from an excise tax on high cost insurance, which CBO estimates will raise \$201 billion over ten years. Additional revenue provisions will generate \$196 billion over the same time period. (See Tax changes related to health insurance.) CBO estimates the proposal will reduce the deficit by \$81 billion over ten years.		\$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	http://www.finance.senate.gov/sitepages/baucus.htm	http://help.senate.gov/	Ways and Means Committee: http://waysandmeans.house.gov/MoreInfo.asp?Section=52 Energy and Commerce Committee: http://energycommerce.house.gov/index.php?option=com_content&view=article&id=1687&catid=156&Itemid=55 Education and Labor Committee: http://edlabor.house.gov/newsroom/2009/07/led-labor-approves-historic-hea.shtml

THE HENRY J. KAISER FAMILY FOUNDATION

Headquarters: 2400 Sand Hill Road, Menlo Park, CA 94025 650.854.9400 Fax: 650.854.4800

Washington Offices and Barbara Jordan Conference Center: 1330 G Street, NW Washington, DC 20005-202347 Fax: 202-347-5274

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.