THE COMPREHENSIVE CONGRESSIONAL HEALTH REFORM BILLS OF 2009: A LOOK AT HEALTH INSURANCE, DELIVERY SYSTEM, AND FINANCING PROVISIONS

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ABSTRACT: This report provides an overview of key provisions of the two comprehensive health reform bills passed by the House of Representatives and the Senate. While the general frameworks of the bills are very similar—both include provisions intended to improve and expand coverage and all would create a comprehensive and coherent strategy for improving health care quality—they differ in a few key respects. Most important, the Senate bill does not include a requirement that employers offer coverage or create a public health insurance plan; the House bill includes both features.

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THE COMPREHENSIVE CONGRESSIONAL HEALTH REFORM BILLS OF 2009: A LOOK AT HEALTH INSURANCE, DELIVERY SYSTEM, AND FINANCING PROVISIONS

INTRODUCTION

This year, policymakers in Washington have risen to the challenge posed by the faltering U.S. health care system and placed reform at the top of the nation's agenda. The five committees with jurisdiction over health care in the U.S. Senate and House of Representatives have now voted to pass major reform bills. In the House, jurisdiction is shared among three committees—Ways and Means, Education and Labor, and Energy and Commerce. All three committees worked in concert to pass similar bills by July 31, 2009, and on November 7, the House passed the Affordable Health Care for America Act, H.R. 3962. In the Senate, the Health, Education, Labor, and Pensions (HELP) Committee passed its bill in July and the Finance Committee passed its bill on October 13. On December 24, the Senate passed a bill blended from the committee bills, the Patient Protection and Affordable Care Act, H.R. 3590.

This report provides an overview of the key provisions of the Senate and House bills that are critical to achieving a high performance health system, as well as more detailed descriptions of these provisions in Appendix A and Appendix B. It also discusses estimates prepared by the Congressional Budget Office and the Joint Committee on Taxation of the number of people potentially covered under the bills and the projected effect on the federal budget. Accompanying Commonwealth Fund reports analyze the coverage and affordability provisions, as well as the delivery system reform provisions, of the House and Senate bills in more depth.[1]

THE GOALS OF HEALTH CARE REFORM

President Obama has stressed three major goals of health reform: 1) ensuring stability and security of health insurance coverage for those who have it; 2) providing insurance for those who do not have it; and 3) slowing the rise in health care costs for employers, families, and government.[2] The Obama administration's aim is to pursue an integrated, systems-based approach to reform that will propel American health care to higher levels of performance. Largely because of the economic downturn and the economic stimulus package passed in early 2009, the administration was committed to enacting health reform that was "deficit-neutral"—that is, reform that would not add to the size of the federal budget deficit—and vowed to veto any legislation that was not so.[3,4] Creating deficit-neutral legislation to reform the U.S. health system has been a guiding principle for the two congressional committees with the authority to raise revenue: the House Ways and Means Committee and the Senate Finance Committee (see sidebar).

Congressional Jurisdiction for Health Care Legislation

While the task of passing comprehensive reform legislation is shared among five committees of jurisdiction in the United States Congress, the responsibility for identifying sources of funding, or "offsets," for reform lies with the two committees with the authority to raise revenue: the House Ways and Means Committee and the Senate Finance Committee. The jurisdiction of the key health committees is as follows:

Senate Finance Committee
The Senate Finance Committee's jurisdiction is defined by subject matter, ranging from taxes to health programs, under the Social Security Act. The Subcommittee on Health oversees matters relating to Medicare and Medicaid, which are entitlement programs established by the Social Security Act. The Finance Committee has authority to make substantive changes to these programs, including changing the populations that are eligible for coverage under these programs and changing the way providers are reimbursed. The committee can raise revenue through taxation to pay for such changes.

Senate Health, Education, Labor, and Pensions (HELP) Committee
The Senate HELP Committee's jurisdiction includes a wide range of subjects, including health, public welfare, occupational health and safety, and public health. The committee oversees legislation relating to these matters but does not have authority over programs like Medicare and Medicaid nor does it have the authority to raise revenue.

House Energy and Commerce Committee
The Energy and Commerce Committee is the oldest legislative standing committee in the U.S. House of Representatives. It has served as the principal guide for the House in matters relating to the promotion of commerce and to the public's health and marketplace interests. In particular, the Energy and Commerce Committee has jurisdiction over health and certain health facilities, biomedical research and development, and public health and quarantine. The Subcommittee on Health oversees many of these issues and health protection in general, including Medicaid and national health insurance, food and drugs, and drug abuse.

House Ways and Means Committee
The House Ways and Means Committee has jurisdiction over taxes, the authority of the federal government to borrow money, trade and tariff legislation, and national social security programs, specifically Medicare. The Subcommittee on Health has jurisdiction over programs providing payments for health care, health delivery systems, or health research. More specifically, the jurisdiction of the subcommittee includes bills and matters that relate to the health care programs of the Social Security Act and, concurrent with the full committee, tax credit and deduction provisions of the Internal Revenue Code that deal with health insurance premiums and health care costs.

House Education and Labor Committee
The House Education and Labor Committee has jurisdiction over federal programs and initiatives dealing with education at all levels, and over workforce initiatives aimed at strengthening health care, job training, and retirement security for workers. The Subcommittee on Health, Employment, Labor, and Pensions oversees employment-related retirement security, including pension, health, and other employee benefits. The Education and Labor Committee does not have authority over the Medicare and Medicaid programs, nor does it have the authority to raise revenue.

The president has stressed the urgent need for action. In September, the Census Bureau reported that 46.3 million people lacked health insurance in 2008, an increase of 8 million people since 2000.[5] While the uninsured rate for children reached its lowest point since 1987—a direct result of expansions in Medicaid and the Children's Health Insurance Program (CHIP)—the number of working-age adults without insurance has climbed steadily in the last decade. In addition, The Commonwealth Fund estimates that in 2007, 25 million insured working-age adults had such high out-of-pocket costs relative to income that they could be considered underinsured—an increase of 9 million adults since 2003.[6] Both these trends have had serious financial and health consequences for U.S. families. An estimated 72 million adults under age 65, both with and without health insurance, reported problems paying their medical bills in 2007. Eighty million adults reported a time that they did not get needed health care because of costs.[7] The relentless growth in health care costs, combined with the severe downturn in the economy, has deepened the health insurance crisis facing families across the country, with little future. relief. If current cost trends continue, the average family premium for employer plans is expected to nearly double by 2020.[8]

Despite devoting more resources to its health system than other industrialized countries, there is substantial evidence that the United States is not reaping the kind of value expected with such an investment and is failing to keep pace with the gains in health outcomes achieved by other countries. For example, the U.S. is now in last place, behind 18 other nations, on "mortality amenable to health care" before age 75—deaths that are potentially preventable with timely, effective health care or with early efforts to screen and prevent the onset of disease.[9] The gap between the U.S. and the countries with the lowest mortality rates is equivalent to 100,000 premature, potentially preventable deaths each year. In addition, U.S. adults are far more likely than adults in other industrialized countries to experience a medical error resulting from a delay in hearing about a diagnostic test, to receive duplicative care or have a gap in the coordination of their care, and to lack rapid access to primary care or care after business hours.[10]

OVERALL APPROACH OF THE CONGRESSIONAL HEALTH REFORM BILLS

Health Insurance Reforms

The bills passed by the House and the Senate aim to provide near-universal health coverage by building on the strongest aspects of the current insurance system—large-employer insurance, Medicaid, and CHIP. At the same time, they would reorganize and regulate the weakest parts of the system—the individual and small-group insurance markets, where so many people and small businesses are hurt by high premiums, high administrative costs, underwriting, and a lack of transparency regarding the content of

benefit packages (Figure 1 and Table 1). This common framework, based on our mixed private–public system of financing, represents a multifaceted strategy for ensuring affordable health insurance coverage, improving quality of care, and slowing growth in health care costs.

Figure 1. Insurance Reform Proposals as of December 2009

	Senate (H.R. 3590) 12/24/09	House of Representatives (H.R. 3962) 11/7/09
Insurance market regulations	GI, adjusted CR 3:1; in 2011: meet 80 or 85% medical loss ratio depending on group size; in 2010 uninsured eligible for high risk pools; no lifetime limits or rescissions, prohibitions on annual limits, dependent coverage to 26	GI, adjusted CR 2:1; in 2010: meet 85% medical loss ratio; uninsured eligible for high-risk pools, no annual or lifetime limits or rescissions, dependent coverage to 27
Individual mandate	Penalty: Greater of $750/year per adult in household or 2% of income in 2016 up to a cap of national average bronze plan premium, phased in at $95 in 2014, $350 in 2015; exempts premiums >8% of income	Penalty: 2.5% of the difference between MAGI and the tax filing threshold up to the average national premium of the "basic" benefit package
Exchange	Regional, state, or substate	National or state
Plans offered	Private, co-op, multi-state plans with at least one non-profit plan offered under contract with OPM	Private, public, and co-op
Eligibility for exchange	Individuals and small businesses 50–100, 100 by 2015, 100+ at state option	Individuals and small businesses <25 in 2013; <50 by 2014; <100 by 2015: 100+ after 2015
Minimum benefit standard, tiers	Essential health benefits 60%–90% actuarial value, Four tiers; catastrophic policy for young adults <30 and those exempt from individual mandate	Essential health benefits 70%–95% actuarial value, four tiers
Premium/cost-sharing assistance	Sliding scale 2%–9.8% of income up to 300% FPL/ flat cap at 9.8% 300%–400% FPL; cost-sharing subsidies for 100%–200% FPL	Sliding scale 1.5%–12% of income up to 400% FPL; cost-sharing credits 133%–350% FPL
Medicaid/CHIP expansion	Up to 133% FPL	Up to 150% FPL
Shared responsibility/ Employer pay-or-play	Firms >50 FTEs pay uncovered worker fee of $750; small employer tax credit; young adults can stay on parent's health plan to age 26	Play or pay; firms >$500,000 payroll 72.5% + prem. contribution for indiv./65% + for families; sliding scale phased-in from 2% to 8% of payroll at $750,000; small employer tax credit; young adults can stay on parent's health plan to age 27

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Note: GI = guaranteed issue; CR = community rating.
Source: Commonwealth Fund analysis of proposals.

Insurance Market Regulation

Both bills would establish new federal rules that require all insurance carriers selling policies in all markets to accept every individual and employer that applied for coverage (known as guaranteed issue) and prevent carriers from setting premiums based on health status. Premiums could reflect age (with a maximum rate variance between age bands of 2:1 in the House and 3:1 in the Senate bill) and family structure. The House bill would require qualified health benefits plans to meet a medical-loss ratio standard of 85 percent. The Senate bill would require carriers to report medical-loss ratios and, beginning in 2011, refund enrollees for non-claims costs that exceed 15 percent in the large group market and 20 percent in the small group and individual markets.

Insurance Market Exchange

Both bills would create a new health insurance exchange—an organized marketplace, managed and regulated by the government, where eligible individuals and businesses could choose from among private or public health plans (House bill only) that meet the requirements of participation set by the exchange.[11] Participants in the exchange would be eligible, according to a sliding scale based on income, for subsidies to offset the cost of plan premiums. A minimum standard benefit package, with varying levels of cost-sharing, would set a floor for plans offered through the exchange. Cost-sharing subsidies in the House and Senate bills would lower out-of-pocket costs for lower-income families.

Initially, the exchange would be open to small businesses and to individuals without access to employer coverage, although the phasing schedule and size of firms that would be eligible differ somewhat between the House and Senate versions. The House bill calls for federal operation of the exchange, with an option for states to create an exchange, subject to strong federal guidelines. The Senate bill call for states or regions to create and operate exchanges within federal guidelines.

Choice of plan. The House bill would include a public plan ("public option") in the exchange, in addition to private plans. The Senate bill would allow multistate plans offered by private insurance carriers under contract with the federal office of personnel management, and would require that at least one of the multistate plans be nonprofit. Both bills would allow for new nonprofit, private insurance cooperatives. The House bill would direct the secretary of health and human services (HHS) to negotiate provider payment rates within a range between Medicare and commercial rates. The secretary could use innovative payment methods in the public plan, including: incentives for providers to establish medical homes for their patients; accountable care organizations that are responsible for patient outcomes and the costs of care; value-based purchasing; bundling of payments; differential payment rates; and performance-based payment.

Essential benefits. An essential standard benefit package with cost-sharing tiers would set a floor for plans offered through the exchange. Benefits would be comprehensive, including hospital, physician, and preventive care, prescription drugs, and pediatric dental and vision services, among others. Determination of the exact benefit package would be delegated to executive branch officials. While keeping the benefit package constant, plans would be offered in four tiers, each varying by their actuarial value, or the average share of medical expenses covered. Cost-sharing would be greater for lower-tier plans, which would therefore have lower actuarial values. The House bill specifies four tiers, with actuarial values ranging from .70 to .95, meaning that the plans

would cover 70 to 95 percent of expected costs. In the Senate bill, actuarial values are .60 to .90.

Financial assistance for people with low to moderate incomes. Subsidies would be available on a sliding scale to offset the premium costs of plans purchased through the exchange. The House bill stipulates no premiums for plan enrollees living below 133 percent of the federal poverty level. Above that income level, premium contributions would be capped at no more than 1.5 percent of income for those living at 133 percent of poverty to no more than 12 percent of income for those at 400 percent of poverty. The Senate bill requires families above the poverty level to contribute no more than 2 percent of income, a share that increases to no more than 9.8 percent of income for those at three to four times the poverty level.

In addition to premium subsidies, both bills would provide lower-income families who obtain coverage through the exchange with cost-sharing credits that would effectively raise the actuarial value of the lowest-tier plans. In the House bill, cost-sharing credits would be available to those earning between 133 percent and 350 percent of poverty. The Senate bill would provide cost-sharing credits for people earning between 100 percent and 200 percent of poverty and would lower out-of-pocket maximums for those earning up to 400 percent of poverty.

Medicaid Expansion

Coverage under Medicaid would be expanded up to 150 percent of the federal poverty level (about $33,000 for a family of four) under the House bill. The Senate bill would raise eligibility to 133 percent of poverty (about 29,000 for a family of four).

The House bill provides 100 percent federal financing of Medicaid expansions through 2014, then 91 percent financing beginning in 2015. The Senate bill provides 100 percent federal financing of Medicaid expansions in 2014 to 2016. In 2017, states will share in the cost of expanded coverage.

Individual Responsibility

Americans would be required to have health insurance coverage. Under the House bill, adults who do not obtain insurance would pay 2.5 percent of the difference between their modified adjusted gross income (modified to include tax-exempt interest and certain other sources of income) and the tax-filing threshold, up to the cost of the average national premium for the “basic” benefit plan. The Senate bill would require the greater of either a flat penalty of $750 per person per year or 2 percent of income in 2016 up to a

cap of the national average bronze plan premium. The penalty would be phased in at $95 in 2014, increase to $495 in 2015, and rise to $750 in 2016. Hardship exemptions are provided in the Senate bill for those individuals for whom the premium would exceed 8 percent of income. There are unspecified exceptions for financial hardship in the House bill.

Employer Shared Responsibility

Under the House bill, large employers would be required to either offer health insurance coverage that meets standards or contribute a specified share of the cost of their employees' insurance. The Senate bill requires employers to contribute to the cost of coverage of uninsured workers who receive premium subsidies through the exchange. Specifically, the House bill would require employers to: 1) offer coverage to their employees and contribute at least 72.5 percent of the premium cost for single coverage and 65 percent of the premium cost for family coverage of the lowest-cost plan that meets the bill's qualified health benefits plan requirements; or 2) pay 8 percent of payroll into a health insurance exchange trust fund. The House bill requires employers (and all other health plans) to include dependents up to age 27.

The Senate bill requires firms with 50 or more full-time employees who do not offer coverage to pay $750 per employee to a trust fund if at least one employee obtains subsidized coverage through the exchange. If firms with 50 or more full-time employees offer coverage that is deemed unaffordable or does not meet the minimum benefit standard, they must pay the lesser of $3,000 for each full-time worker receiving a tax credit or $750 for each worker. There are also per-worker penalties for firms that impose waiting periods. Employers with more than 200 employees must automatically enroll new full-time employees in coverage. The bill also requires employers to include dependents up to age 26.

Small businesses. Small businesses are exempt from these requirements and some are eligible for assistance with paying for workers' coverage. The House bill exempts small businesses with payrolls of less than $500,000, with contributions phasing up gradually to 8 percent for those firms with payrolls above $750,000. As noted above, the Senate bill exempts firms with fewer than 50 employees from any obligations to provide or contribute to coverage.

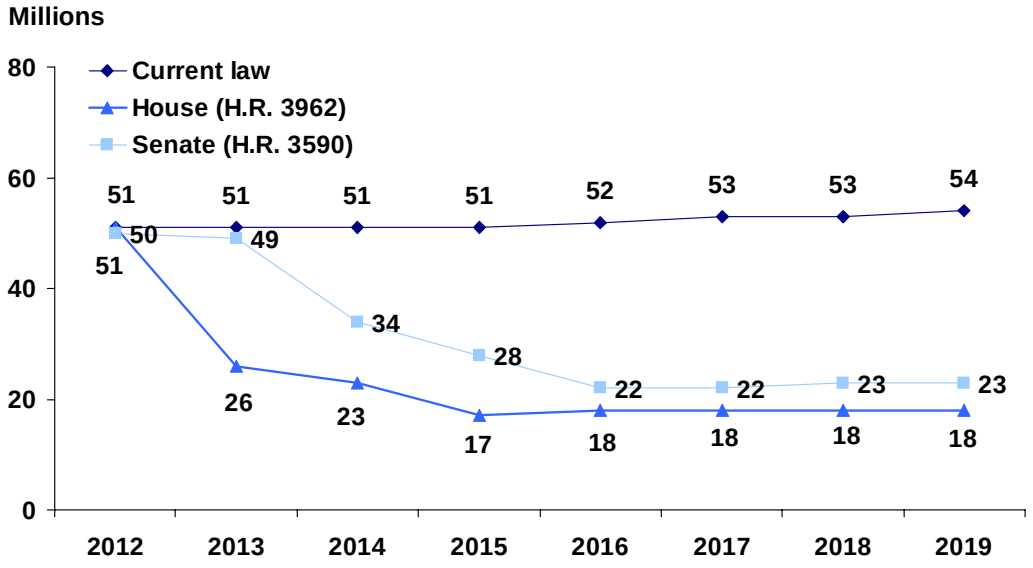
In addition, the House bill provides a tax credit equal to 50 percent of the premium contribution paid by small low-wage firms that are in compliance with the requirement to offer health insurance for up to two years. The Senate bill provides limited

subsidies (35 percent of employer premium contribution) in the start-up years of 2010 to 2013 for firms that contribute at least 50 percent of their employees' premiums, and then provides tax credits up to 50 percent of the employer premium contribution for small, low-wage employers for up to two years. Small nonprofit organizations are also eligible for employer premium contribution subsidies of 25 percent in 2010-2013 and then 35 percent.

Impact on Coverage

In the absence of health reform, the Congressional Budget Office estimates that the number of uninsured Americans will rise to 54 million by 2019 (Figure 2). Under the House bill, the number of people without coverage is projected to decline by 36 million people in 2019. When unauthorized immigrants, who are not eligible for coverage under the bill's provisions, are excluded from the analysis, the proposal would cover 96 percent of uninsured legal residents under age 65. Under the Senate bill, the number of people uninsured is projected to decline by 31 million people, or about 94 percent of legal residents.

Figure 2. Trend in the Number of Uninsured Nonelderly, 2012–2019 Under Current Law and Senate and House Bills



Note: The uninsured includes unauthorized immigrants. With unauthorized immigrants excluded from the calculation, nearly 94% and 96% of legal nonelderly residents are projected to have insurance under the Senate and House proposals, respectively.
Data: Estimates by The Congressional Budget Office.

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Health System Reforms

Both the House and the Senate bills propose reforms aimed at improving health outcomes and quality of care, increasing efficiency in the delivery and administration of care, and slowing the growth in total health care costs (Figure 3 and Table 2). The House and Senate provisions have more similarities than differences. The bills include key provisions for: investing in primary care; increasing funding for prevention and wellness programs; launching rapid-cycle pilots of innovative methods for paying providers, including medical homes, accountable care organizations, and bundled hospital payments; containing costs; and fostering quality improvement.

Figure 3. System Improvement Provisions of National Health Reform Proposals, 2009

	Senate (H.R. 3590) 12/24/09	House of Representatives (H.R. 3962) 11/7/09
Exchange standards and plans	State, substate, or regional exchanges; private and co-op plans offered, multi-state plans offered under contract with federal OPM; essential health benefits 60%–90% actuarial value, four tiers plus catastrophic policy; insurers must meet medical loss ratio in 2011	National or state exchanges; private, public or co-op plans offered; essential health benefits 70%–95% actuarial value, four tiers; insurers must meet specified medical loss ratio
Primary care	10% Medicare bonus payments for PCPs and general surgeons practicing in shortage areas for 5 years	Increase Medicare payments for PCPs by 5%; bring Medicaid PCPs up to Medicare level
Prevention and wellness	Provide annual wellness visit including health risk assessment for Medicare beneficiaries; Create a National Prevention, Health Promotion and Public Health Council to establish a national prevention and health promotion strategy; establish a Prevention and Public Health Investment Fund; remove cost-sharing for proven preventive services, grants to support employer wellness programs	Develop a national prevention and wellness strategy; establish a Prevention and Wellness Trust Fund; remove cost-sharing for proven preventive services; grants to support employer wellness programs
Innovative payment pilots: medical homes, accountable care organizations, bundled hospital and post-acute care	Allow Medicaid beneficiaries to designate medical home; ACOs to share savings in Medicare; Adopt medical homes, ACOs, and bundled payments on large scale if pilot programs prove successful; Center for Medicare and Medicaid Innovation	Adopt medical homes, ACOs, and bundled payments on large scale if pilot programs prove successful; Center for Medicare and Medicaid Innovation
Productivity improvements	Modify market-basket updates to account for productivity improvements	Modify market basket updates to account for productivity improvements
Comparative effectiveness	Create Patient-Centered Outcomes Research Institute	Establish Center for Comparative Effectiveness Research within AHRQ
Quality improvement	Direct HHS to develop national quality strategy, public reporting; establish an interagency working group to coordinate federal activities	Establish the Center for Quality Improvement to identify, develop, evaluate, disseminate, and implement best practices; develop national priorities for performance improvement and quality measures

Source: Commonwealth Fund analysis of health reform proposals.

Primary Care

The House bill provides for a 5 percent increase in fees for primary care services, and a 10 percent increase in areas with shortages. The Senate bill calls for a 10 percent increase in primary care fees, as well as for general surgeons practicing in areas with shortages. In addition, both bills promote reform in graduate medical education to expand and improve training opportunities in primary care.

Prevention and Wellness

The House and Senate bills provide for coverage of preventive services that have been proven effective, without cost-sharing requirements for Medicare beneficiaries and for people under age 65 who are in private plans, and provide grants to support small and mid-size employer wellness programs. In addition, the bills establish a fund (called the Prevention and Wellness Trust Fund in the House bill and the Prevention and Public Health Investment Fund in the Senate bill) to provide funding for community-based prevention programs, childhood obesity programs, and other similar public health programs. Finally, the bills create a task force on clinical preventive services and community preventive services to develop, update, and disseminate evidence-based recommendations for prevention services. The Senate bill creates a new annual wellness visit, including a health risk assessment and personalized prevention plan, for Medicare beneficiaries. Both bills call for a national strategy to improve prevention and public health. Under the Senate bill, this strategy would be developed by a newly created National Prevention, Health Promotion, and Public Health Council.

Innovative Payment Pilots

Both the House and Senate bills call for the creation of a center for Medicare and Medicaid innovation within the Centers for Medicare and Medicaid Services to test new methods of payment for medical homes, accountable care organizations, and bundled hospital and post-acute care. The secretary of health and human services has broad authority to spread successful payment methods in Medicare and, in the House bill, to incorporate these methods in a new public health insurance plan.

Productivity Improvements

In response to a hospital industry agreement, both the House and Senate bills slow the update in payment rates for all providers, other than physicians, annually to account for productivity improvements.

Cost Containment and Budget Savings

The House bill calls for negotiating pharmaceutical prices and requires a review of health insurance plan premiums. In addition the commissioner of the exchange would establish a process to obtain bids from private carriers, negotiate and enter into contracts with qualified plans. The Senate bill requires state insurance commissioners to provide data on premium trends and to make recommendations to the HHS secretary about whether certain insurance carriers should be excluded from the exchange based on a pattern of excessive premium increases. In addition, states and the secretary are instructed to monitor premium increases inside and outside the exchange beginning in 2014. Both the

House and Senate bills reduce the current overpayment of Medicare private plans, although the methods differ. As the number of people without coverage declines, reductions are made in Medicare and Medicaid disproportionate share hospital payments to those hospitals serving low-income and uninsured patients. The Senate bill creates an Independent Payment Advisory Board (IPAB) to identify areas of savings within the Medicare program to meet an expenditure target, as well as a process for rapid approval by Congress or substitution of an alternative that achieves the same objective in years that spending is expected to be above the target.

Quality Improvement

The House bill establishes a Center for Quality Improvement and the Senate bill directs the secretary of health and human services to develop a national quality strategy. In addition, the Senate bill requires the president to convene an interagency working group to coordinate and streamline federal quality activities. Both bills include processes for developing standard quality measures to facilitate performance improvement and enhance data collection.

Impact on the Federal Budget

The cost-containment and budget-savings provisions are estimated to generate $483 billion in savings between 2010 and 2019 in the Senate bill and $456 billion in the House bill (Figure 4). Most of these savings come from the productivity improvement changes to provider updates, from the reduction in disproportionate share hospital payments, and from leveling the playing field between Medicare private plans and the Medicare fee-for-service program. Although earlier versions of both the House and Senate used a portion of these savings to finance the cost of a one-year or permanent change to the Medicare physician fee update formula known as the sustainable growth rate (SGR), neither bill addressed the SGR in its final form. In the House, a companion bill passed on November 19 (H.R. 3961) would replace the current methodology and prevent the cuts to physician fees expected under current law. Senate Majority Leader Harry Reid has indicated that the Senate will address the SGR separately early in 2010.

Figure 4. Senate and House Payment and System Reform Savings, 2010–2019

Dollars in billions

	CBO estimate of Senate bill (H.R. 3590)	CBO estimate of House bill (H.R. 3962)
Total Savings from Payment and System Reforms	**–$483**	**–$456**
• Productivity improvement/provider payment updates	–151	–177
• Medicare Advantage reform	–136	–170
• Primary care, geographic adjustment	6	–6
• Payment innovations	–8	–2
• Hospital readmissions	–7	–9
• Disproportionate share hospital adjustment	–43	–20
• Prescription drugs	6	–75
• Home health	–39	–55
• Independent Payment Advisory Board	–28	—
• Other improvements and interactions	–83	58

Source: The Congressional Budget Office Cost Estimate of the Patient Protection and Affordable Care Act, Dec. 19, 2009, http://www.cbo.gov/doc.cfm?index=10868. The Congressional Budget Office Analysis of H.R. 3962, The Affordable Health Care for America Act, Nov. 20, 2009, http://www.cbo.gov/doc.cfm?index=10741.

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Paying for Reform: Revenue Sources and Financing

The Congressional Budget Office has estimated that the net cost of coverage expansion in the Senate bill would total $763 billion, while coverage expansion efforts in the House bill would total $891 billion over 2010–2019 (Figure 5).[12] While there are differences between the House and Senate approaches to financing health reform, both include a mixture of new revenue sources and savings from within the health system in order to develop comprehensive reform legislation that is deficit neutral (Figure 6). In the Senate bill, the largest new revenue source is an excise tax of 40 percent on insurers that write policies costing more than $8,500 for an individual or $23,000 for a family (Figure 7). In the House bill, the marginal income tax rate for very-high-income families is increased, with a tax surcharge on individuals with incomes over $500,000 and families with incomes over $1,000,000.

Figure 5. Major Sources of Savings and Revenues Compared with Projected Spending, Net Cumulative Effect on Federal Deficit, 2010–2019

Dollars in billions

	CBO estimate of Senate bill (H.R. 3590)	CBO estimate of House bill (H.R. 3962)
Total Net Impact on Federal Deficit, 2010–2019	**–$132**	**–$138**
Total Federal Cost of Coverage Expansion and Improvement	**$763**	**$891**
Gross Cost of Coverage Provisions	***$871***	***$1,052***
• Medicaid/CHIP outlays	395	425
• Exchange subsidies	436	602
• Small employer subsidies	40	25
Offsetting Revenues and Wage Effects	***–$108***	***–$162***
• Payments by uninsured individuals	–15	–33
• Play-or-pay payments by employers	–28	–135
• Associated effects on taxes and outlays	–65	6
Total Savings from Payment and System Reforms	**–$483**	**–$456**
• Productivity updates/provider payment changes	–151	–177
• Medicare Advantage reform	–136	–170
• Other improvements and savings	–196	–109
Total Revenues	**–$413**	**–$574**
• Excise tax on high premium insurance plans	–149	—
• Surtax on wealthy individuals and families	—	–461
• Other revenues	–264	–113

Note: Totals do not reflect net impact on deficit because of rounding.
Source: The Congressional Budget Office Cost Estimate of the Patient Protection and Affordable Care Act, Dec. 19, 2009, http://www.cbo.gov/doc.cfm?index=10868. The Congressional Budget Office Analysis of H.R. 3962, The Affordable Health Care for America Act, Nov. 20, 2009, http://www.cbo.gov/doc.cfm?index=10741.

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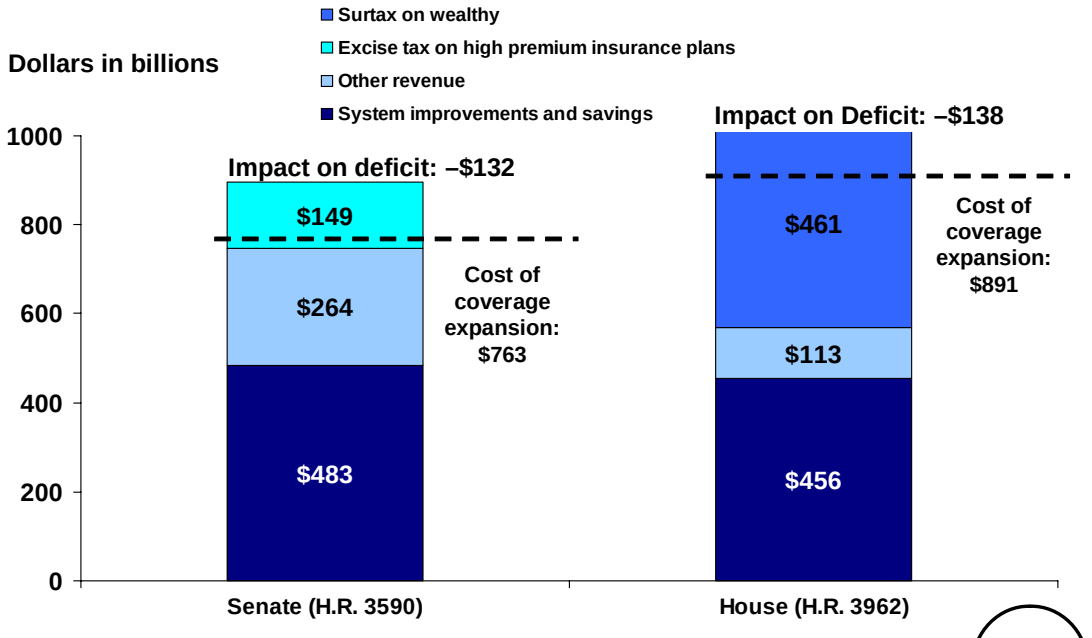
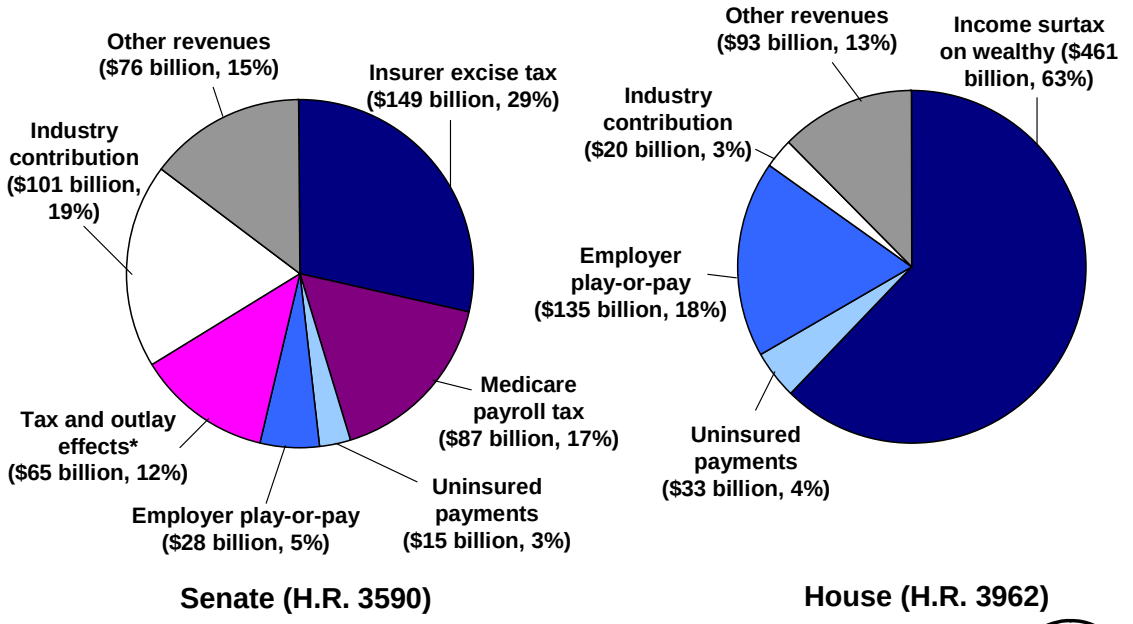
Figure 6. Proportions of System Savings and New Revenue in Senate and House Bills



Note: Totals do not reflect net impact on deficit because of rounding.
Source: The Congressional Budget Office Cost Estimate of the Patient Protection and Affordable Care Act, Dec. 19, 2009, http://www.cbo.gov/doc.cfm?index=10868, and The Joint Committee on Taxation Estimated Revenue Effects of the Revenue Provisions in the "Patient Protection and Affordable Care Act", December 19, 2009, JCX-61-09. The Congressional Budget Office Analysis of H.R. 3962, The Affordable Health Care for America Act, As Passed by the House of Representatives, November 20, 2009, http://www.cbo.gov/doc.cfm?index=10741.

THE COMMONWEALTH FUND

Figure 7. Sources of New Revenue in Senate and House Bills



Note: Numbers may not sum to 100% due to rounding. In addition, taxes and outlay effects are excluded from the sources of revenue for H.R. 3962 because taxes and outlay effects are estimated to result in an additional $6 billion in federal spending over the 2010-2019 period.
Source: The Congressional Budget Office Cost Estimate of the Patient Protection and Affordable Care Act, Dec. 19, 2009, http://www.cbo.gov/doc.cfm?index=10868, and The Joint Committee on Taxation Estimated Revenue Effects of the Revenue Provisions in the "Patient Protection and Affordable Care Act", Dec. 19, 2009, JCX-61-09. The Congressional Budget Office Analysis of H.R. 3962, The Affordable Health Care for America Act, As Passed by the House of Representatives, November 20, 2009, http://www.cbo.gov/doc.cfm?index=10741.

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In the Senate, the total net impact on the federal budget deficit in the 10-year period 2010 to 2019 is a reduction of $132 billion (Figure 8). This figure reflects the net federal costs of expanding coverage ($763 billion), offset by reductions in health system spending ($483 billion) as well as new revenues ($413 billion) (Figure 4 and Appendix A).

Under the House bill, the total net impact on the federal budget deficit in the 10-year period 2010 to 1019 is a reduction of $138 billion (Figure 8).[13] This figure reflects the net federal costs of expanding coverage of $891 billion, offset by reductions in health system spending of $456 billion and by increased total revenue of $574 billion (Figure 4 and Appendix B).

Figure 8. Proposals' Impact on Insurance Coverage and Costs, 2019

	Senate (H.R. 3590) 12/24/09	House of Representatives (H.R. 3962) 11/7/09
Formerly uninsured now covered, 2019	31 million	36 million
Additionally covered by Medicaid/CHIP, 2019	15 million	15 million
Covered in exchange, 2019	30 million	30 million
Net cost of coverage expansion, 2010–2019	$763 billion	$891 billion
Net impact on federal deficit, 2010–2019	–$132 billion	–$138 billion

Source: The Congressional Budget Office Cost Estimate of the Patient Protection and Affordable Care Act, Dec. 19, 2009, http://cbo.gov/doc.cfm?index=10868. The Congressional Budget Office Analysis of H.R. 3962, The Affordable Health Care for America Act, As Passed by the House of Representatives, November 20, 2009, http://www.cbo.gov/doc.cfm?index=10741.

THE COMMONWEALTH FUND

COMPARING THE BILLS: SIMILARITIES AND DIFFERENCES

Conceptually, the Senate and House bills are similar in many ways (Figure 9). Both include a number of provisions intended to improve and expand coverage: an individual mandate, insurance exchanges, premium subsidies, increased oversight of the insurance market, minimum benefit standards, and an expansion of Medicaid and CHIP. In addition, the bills create a comprehensive and coherent strategy for improving health care quality in the United States. Both would create a center for payment innovation for rapid-cycle testing of innovative payment methods. The bills also include provisions to create a national quality strategy, improve primary care reimbursement, create a center for comparative effectiveness research, and develop pilot programs to improve prevention and wellness in the workplace and in communities. Though both bills would establish an insurance exchange, the House bill would include the choice of a public option in the exchange, while the Senate bill would require the Office of Personnel Management to contract with private insurers to offer at least two multistate plans in each exchange, including at least one non-profit plan. In addition, both bills provide for a Consumer Operated and Oriented Plan program to foster the creation of non-profit, member-run health insurance companies to offer health insurance plans in the exchange.

Figure 9. Major Areas of Similarities and Differences Between Bills

Similarities between bills	Differences between bills
❖ Individual mandate	❖ Employer shared responsibility
❖ Insurance exchange	❖ Independent Payment Advisory Board to extend Medicare solvency, slow Medicare cost growth and increase quality of care
❖ Premium and cost-sharing subsidies	❖ Sources of revenue: surcharges on higher income vs. excise tax on high cost health plans
❖ Insurance market regulations	❖ Choice of public plan in exchange
❖ Essential standard benefit package standard	❖ Nationally- vs. State-based exchanges
❖ Medicaid / CHIP expansion	
❖ Center for Payment Innovation; pilot programs for rapid cycle testing of innovative payment methods	
❖ Creating a national quality improvement strategy	
❖ Improving primary care reimbursement	
❖ Center for Comparative Effectiveness Research	
❖ Create and expand wellness and prevention programs	

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Source: Commonwealth Fund analysis of health reform proposals.

While the general frameworks of the two bills are very similar, they differ in a few key areas, namely: a requirement for employers to share financial responsibility for coverage; a new independent Payment Advisory Board that will make recommendations to contain Medicare spending; the existence of a public health insurance option in the exchange; and sources of revenue to finance the proposal. The Senate bill does not include a requirement for standards of employer coverage or shared employer responsibility for paying premiums or create a public health insurance option—whereas the House bill does. The Senate bill gives great authority to a new Payment Advisory Board, whose proposals would go into effect unless Congress passes an alternative that achieves the same cost savings. Finally, both the House and the Senate bills look to finance the cost of reform through a mix of system savings and new revenues. The largest new revenue raiser in the House bill is a tax on high-income earners, while the Senate bill includes a new tax on high-cost insurance plans.

NOTES

[1] S. R. Collins, K. Davis, J. L. Nicholson, S. D. Rustgi, and R. Nuzum, The Health Insurance Provisions of the 2009 Congressional Health Reform Bills: Implications for Coverage, Affordability, and Costs (New York: The Commonwealth Fund, forthcoming); K. Davis, S. Guterman, S. R. Collins, K. Stremikis, S. D. Rustgi, and R. Nuzum, *Starting on the Path to a High Performance Health System: Analysis of Health System Reform Provisions of Reform Bills in the House of Representatives and Senate* (New York: The Commonwealth Fund, Dec. 2009).

[2] Office of Management and Budget, *A New Era of Responsibility: Renewing America's Promise* (Washington, D.C.: OMB, Feb. 2009), http://www.whitehouse.gov/omb/assets/fy2010_new_era/a_new_era_of_responsibility2.pdf.

[3] American Recovery and Reinvestment Act of 2009, P.L. 111-5.

[4] Remarks by the President to a Joint Session of Congress, Sept. 9, 2009.

[5] C. DeNavas-Walt, B. D. Proctor, and J. C. Smith, *Income, Poverty, and Health Insurance Coverage in the United States: 2008* (Washington, D.C.: U.S. Census Bureau, Sept. 2009).

[6] C. Schoen, S. R. Collins, J. L. Kriss, and M. M. Doty, "How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007," *Health Affairs* Web Exclusive, June 10, 2008:w298–w309. Underinsured adults are insured all year and report spending 10 percent or more of their income (5 percent if their incomes are under 200 percent of the poverty level) on out-of-pocket health costs, excluding premiums, or report that their deductibles amount to 5 percent or more of income.

[7] S. R. Collins, J. L. Kriss, M. M. Doty, and S. D. Rustgi, *Losing Ground: How the Loss of Adequate Health Insurance Is Burdening Working Families: Findings from the Commonwealth Fund Biennial Health Insurance Surveys, 2001–2007* (New York: The Commonwealth Fund, Aug. 2008).

[8] C. Schoen, J. L. Nicholson, and S. D. Rustgi, *Paying the Price: How Health Insurance Premiums Are Eating Up Middle-Class Incomes—State Health Insurance Premium Trends and the Potential of National Reform* (New York: The Commonwealth Fund, Aug. 2009).

[9] E. Nolte and C. M. McKee, "Measuring the Health of Nations: Updating an Earlier Analysis," *Health Affairs*, Jan./Feb. 2008 27(1):58–71.

[10] C. Schoen, R. Osborn, S. K. H. How, M. M. Doty, and J. Peugh, "In Chronic Condition: Experiences of Patients with Complex Health Care Needs, in Eight Countries, 2008," *Health Affairs* Web Exclusive, Nov. 13, 2008:w1–w16.

[11] P. B. Ginsburg, "Employment-Based Health Benefits Under Universal Coverage," *Health Affairs*, May/June 2008 27(3):675–85.

[12] Under the Congressional Budget Act of 1974, the Congressional Budget Office (CBO) is directed to score the effect that legislation has on the federal deficit relative to federal baseline projections. Under the law, the Joint Committee on Taxation (JCT) is also required to estimate the effect on revenues when legislation involves the tax code and CBO is required to incorporate JCT estimates into its analysis. All estimates in this description are in billions, unless otherwise noted, and refer to cumulative savings over the 10-year window, 2019–2019.

[13] Although the individually listed costs, savings, and revenue sum to $139 billion, the CBO estimate lists the reduction in the federal deficit as $138 billion. This is likely because of rounding.

Table 1. Congressional Health Reform Bills: Coverage, as of 12/24/2009

Features	Senate Introduced 11/18/09, with manager's amendment 12/19/09, passed by the Senate 12/24/09[14]	House of Representatives Introduced 10/29/09, Passed by the House 11/7/09[15]
Insurance Market Regulations	National regulations apply inside and outside the exchange. Guaranteed issue; Rating based on age (max 3:1), tobacco use (max 1.5:1), family composition, participation in a health promotion program, and geography; no health rating; prohibits health insurers from excluding coverage of preexisting conditions for children beginning immediately; 5-year phase-in for small group; lifetime and unreasonable annual limits on benefits will be eliminated beginning in 2010; all annual limits will be prohibited beginning in 2014. Prohibits rescissions by insurance companies beginning in 2010. Health plans required to report the proportion of premiums spent on items other than medical care beginning in 2010; Beginning in 2011, health plans (including grandfathered plans) required to refund enrollees for non-claims costs that exceed 15 percent in the large group market and 20 percent in the small group and individual markets. Uninsured people who have been denied coverage because of a preexisting condition eligible for subsidized coverage through a national high-risk pool program beginning in 2010. Insurers and employers must cover dependents to age 26 beginning in 2010. Provides $30 million in grant funds to states in 2010 for consumer assistance or ombudsman programs. Establishes in 2010 an internet portal to help people choose insurance plans.	National regulations apply inside and outside the exchange. Guaranteed issue; no health rating; rating based on age (2:1), family composition, and geography; no annual or lifetime limits on benefits beginning in 2010. Prohibits rescissions by insurance companies except in cases of fraud, effective July 1, 2010. Insurers must meet a medical loss ratio of 85%, effective January 1, 2010. Repeals exemption of insurance companies from anti-trust laws. Establishes annual review process for premium increases by HHS Secretary and States beginning in 2010. Insurers must cover dependents to age 27 beginning in 2010. Enacts a temporary national high-risk pool insurance program with financial assistance for those who have been uninsured for several months or denied a policy because of preexisting conditions.
Insurance Exchange	State, regional, or substate; each state would be required to establish an American Health Benefit Exchange by 2014 for individuals and a Small Business Health Options Program (SHOP) exchange for small employers; states can opt to provide just one exchange for individuals and small employers; does not replace individual market; federal government provides grants to states to establish exchanges; by 2015, exchanges must be self-sustaining and may charge assessments or fees on carriers.	National or state; no competing sub-state exchanges; replaces individual market but not small group market. Commissioner of exchange accepts carrier bids for contracts and negotiates premiums. The bill allows the commissioner to consider applications by states or groups of states to establish state-based exchanges, but requires that there be only be one exchange per state, that

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Features	Senate Introduced 11/18/09, with manager's amendment 12/19/09, passed by the Senate 12/24/09[14]	House of Representatives Introduced 10/29/09, Passed by the House 11/7/09[15]
	States would be able to opt out of federal requirements through a waiver in 2017 if they could demonstrate that they could offer all residents coverage at least as comprehensive and affordable as that required by the bill. In 2010, the Secretary of HHS and states will establish a process for annual review of premium increases and determination of participation in exchange based on premium increases.	the exchange operate under the same rules and requirements established for the national exchange, and that it not result in a net increase in expenditures to the federal government.
Eligibility to purchase through exchange	Individuals and small businesses with up to 100 employees. Until 2016, states could opt to limit enrollment to companies with 50 or fewer employees. States would have the option to allow companies with more than 100 employees to purchase coverage in 2017. Requires the offering of only qualified health plans through Exchanges to members of Congress and their staff.	Individuals without access to employer coverage that is in compliance with the employer mandate and who are not eligible for Medicaid; employers with 25 or fewer employees in 2013; 50 or fewer employees in 2014; 100 or fewer in 2015; 100+ after 2015.
Minimum benefit standard; tiered standards; content	Essential health benefits, equal in scope to a typical employer plan, would range from 60% to 90% actuarial value; Four tiers: bronze actuarial value 60%; silver actuarial value 70%; gold actuarial value 80%; platinum actuarial value 90%; for each tier out-of-pocket spending would be limited to the HSA level of $5,950 for individual policies and $11,900 for family policies; no cost-sharing for preventive services. Deductibles of greater than $2,000 for individuals and $4,000 for families would be prohibited in the small group market. Young adult catastrophic policy would be available for those younger than 30, would include essential health benefits, 3 primary care visits and cost sharing to HSA out-of-pocket limits; people who cannot find a plan that is 8% or less of their income would be able to purchase the young adult policy as well. All insurance plans in the individual and small-group market would be required to offer coverage in the silver and gold categories, at a minimum. Most reforms apply to all non-grandfathered plans, but some apply only to exchanges/individual/small group markets including the essential benefit package. Exchange plans must	As specified by new Health Benefits Advisory Council, all plans, including employers, must provide at least the basic package inside and outside the exchange. Four benefit tiers: essential health benefits basic plan covers 70% of costs, enhanced plan covers 85%, premium plan covers 95%, premium plus covers 95% and adds additional benefits including oral health and vision care. Annual out-of-pocket spending in the essential benefits package limited to $5,000 for an individual and $10,000 for a family; no cost-sharing for preventive services. Coverage purchased on individual market does not qualify unless grandfathered. The bill would require that health plans participating through the exchange meet the standards set for "qualified health benefits plans." In addition, plans would have to at least offer the basic benefit plan through the exchange. Offering higher tiers of health plans would be optional, but a carrier could not offer a higher tier plan without offering the basic plan.

Table 1. Congressional Health Reform Bills: Coverage, as of 12/24/2009

Features	Senate Introduced 11/18/09, with manager's amendment 12/19/09, passed by the Senate 12/24/09[14]	House of Representatives Introduced 10/29/09, Passed by the House 11/7/09[15]
	be qualified health plans and must meet a number of other requirements, including QI strategies with market-based incentives. Non-qualified health plans can be sold outside the exchange.	All non-grandfathered plans, inside and outside exchange, must be qualified health benefits plans and must comply with insurance reforms.
Premium subsidies to individuals	Sliding-scale premium credits would be based on second lowest-cost silver plan in the area where the individual resides such that premium contributions are no greater than 2% of income for 100% FPL or less to 9.8% of income for 300%–400% FPL; no subsidies for those with employer-based coverage with an actuarial value of 60% or higher or employee coverage contribution that is <9.8% of income.	Sliding scale premium credits would be based on the average of the three lowest premiums for the "basic" plan in the local market area up to 400% FPL for purchasing through exchange; capping premiums at no more than 1.5% of income for those earning 133% FPL and phasing out at 12% of income for those earning 400% FPL; no subsidies for those with employer-based coverage that meets minimum qualifying criteria and affordability standards (premiums must be <12% of income).
Cost-sharing subsidies/credits	Cost-sharing subsidies limit cost-sharing, thus increasing actuarial value of essential benefits to: 100%–150% FPL: 90% 150%–200% FPL: 80% Out-of-pocket limit for 100%–200% FPL is one-third HSA limit, or $1,983 for individuals and $3,967 for families; for 200%–300% FPL is one-half HSA limit, or $2,975 for individuals and $5,950 for families; for 300%–400% FPL is two-thirds HSA limit, or $3,967 for individuals and $7,933 for families.	Cost-sharing credits reduce limits on cost-sharing, thus increasing actuarial value of basic plan to: 133%–150% FPL: 97%; 150%–200% FPL: 93% 200%–250% FPL: 85% 250%–300% FPL: 78% 300%–350% FPL: 72% Out-of-pocket maximums vary by income from $500 individual and $1000 family at 133-150% FPL up to $5,000/$10,000 at 350-400% FPL.
Plans offered	Private, co-op, multistate plans offered by private insurance carriers, at least one of the new multistate plans must be non-profit, multistate plans will be offered under contract with the Federal office of personnel management (OPM). The secretary would establish a Basic Health Program for people with incomes between 133% and 200% of poverty. Under the program, states would have the option of contracting with and negotiating premiums with "standard" health plans as long as premium and cost sharing requirements were not greater than plans offered through the exchange. Standard plans would be required to have a medical loss ratio of at least 85%.	Private, public and co-op. Public plan to pay providers at rates negotiated between providers and HHS health care providers participating in Medicare will be considered participating providers in the public plan unless they opt out. Providers have a year to decide whether to participate and there are no penalties for opting out. New payment initiatives such as incentives for providers to establish medical homes, accountable care organizations, value-based purchasing, bundling of payment, differential payment rates, and performance-based payment, would be pursued by the secretary through the public plan.

Table 1. Congressional Health Reform Bills: Coverage, as of 12/24/2009

Features	Senate Introduced 11/18/09, with manager's amendment 12/19/09, passed by the Senate 12/24/09[14]	House of Representatives Introduced 10/29/09, Passed by the House 11/7/09[15]
Insurance administrative simplification	Facilitate administrative simplification beginning in 2010; Accelerate adoption of uniform standards and operating rules for the electronic transactions that occur between providers and health plans, including eligibility verification, prior authorization, and electronic funds transfer payments; Establish a process to regularly update the standards and operating rules for electronic transactions; Insurance company administrative expenditures would be capped beginning in 2010.	Simplify health insurance administration by adopting standards for financial and administrative transactions.
Risk adjustment for plans	The bill includes two temporary and one permanent risk-equalization programs: a state transitional reinsurance pool, a temporary federal risk corridor program, and a permanent state risk-adjustment program. All states are required to establish a nonprofit reinsurance entity for 2014, 2015, and 2016 that would collect payments from all insurers in the individual and group markets and make payments to insurers in the individual market that cover high-risk individuals. Requires the secretary of HHS to establish and administer a risk-corridor program for qualified health plans offered in the individual and small-group markets in 2014, 2015, and 2016. Under the permanent program, states are required to develop methods with the secretary by which they would require payments from health plans offered in the individual and small group markets that had lower health risks among enrollees compared with all plans (excluding self-insured plans). In addition, the states would pay those health plans with higher risks (also excluding self-insured plans). The risk adjustment would apply to plans in individual and small-group markets but not grandfathered plans.	The commissioner would establish a mechanism whereby premium amounts paid to qualifying health plans offering plans through exchange would be adjusted to account for differences in risk characteristics of individuals and employers enrolled under different plans.

Table 1. Congressional Health Reform Bills: Coverage, as of 12/24/2009

Features	Senate Introduced 11/18/09, with manager's amendment 12/19/09, passed by the Senate 12/24/09[14]	House of Representatives Introduced 10/29/09, Passed by the House 11/7/09[15]
Medicaid/CHIP Expansion	In 2014, expansion up to 133% FPL for all nonelderly individuals; full federal funding would be provided for expansion populations for 2014, 2015, and 2016; newly eligible beneficiaries would receive "benchmark" coverage with at least essential benefits, plus coverage for prescription drugs and mental health services. Beginning in April 2010, states can opt to expand Medicaid to adults up to 133% FPL and receive current law FMAP. States will be required to maintain existing income eligibility levels for all Medicaid populations through 2013 for adults, and through September 30, 2019 for children currently in Medicaid or CHIP; Extends the current reauthorization period of CHIP for two years, through September 30, 2015; Between 2016 and 2019, states will receive a 23 percentage point increase in the CHIP federal match rate, subject to a 100% cap; In 2017, states that initially covered at least some of the newly-eligible population will receive an initial increase in the federal medical assistance percentage (FMAP) of 30.3 percentage points, and states that initially covered less of the newly-eligible population will receive an initial increase of 34.3 percentage points; increases will be adjusted over time so that by 2019 all states will receive an FMAP increase of 32.3 percentage points. States that had already expanded Medicaid to adults with incomes above 133% FPL and are not eligible for the new federal funding; will receive a 2.2 percentage point increase in their FMAP for parents and childless adults who are not newly eligible for 2014 through 2019, or a 0.5 percentage point increase in FMAP for 2014 through 2016. Individuals will be able to apply for and enroll in Medicaid, CHIP, and the Exchange through state-run websites. Medicaid, CHIP programs, and the Exchange will coordinate enrollment procedures to provide seamless enrollment for all programs. Requires states to offer Medicaid to all individuals below age 26 who were in foster care for at least 6 months beginning in 2014.	Expansion up to 150% FPL; people enrolled in Medicaid are not allowed to purchase coverage through the exchange. The bill would require State Medicaid programs to cover non-disabled, childless adults under age 65 who are not eligible for Medicare with incomes at or below 150% of poverty. The federal government would pay 100% of the costs of Medicaid coverage for this population in 2013 and 2014, then 91% in 2015 and beyond. The bill would also require State Medicaid programs to cover children, parents, and individuals with disabilities under age 65 with income at or below 150% of poverty. For individuals in these categories with incomes between the levels in effect in the state as of June 16, 2009 and 150% of poverty, the federal government would pay 100% of the costs of Medicaid coverage in 2013 and 2014 and 91% in 2015 and beyond.

Table 1. Congressional Health Reform Bills: Coverage, as of 12/24/2009

Features	Senate Introduced 11/18/09, with manager's amendment 12/19/09, passed by the Senate 12/24/09[14]	House of Representatives Introduced 10/29/09, Passed by the House 11/7/09[15]
Individual Mandate	Yes; penalty is greater of $750 per year per adult in household or 2% of income in 2016, phased in at $95 in 2014, $495 in 2015, and $750 in 2016, up to a cap of the national average bronze plan premium; family penalty is capped at $2,250; exemption if premium of lowest cost option is >8% of income and allows these individuals to purchase a young adult catastrophic policy regardless of age; exemptions for those below 100% FPL, and certain other groups.	Yes; penalty is 2.5% of the difference between modified adjusted gross income and the tax filing threshold, up to a cap of the national average premium for the "basic" benefit plan offered through the insurance exchange; exceptions for financial hardship; and certain other groups.
Shared Responsibility/ Employer Pay-or-Play	Firms with >50 FTEs that do not offer coverage and have at least one worker receiving an exchange tax credit must pay an uncovered worker fee of $750 per FTE; firms with >50 FTEs that offer coverage that is deemed unaffordable or does not meet the minimum benefit standard must pay the lesser of $3,000 for each full-time worker receiving a tax credit or $750 for each worker; employers with more than 200 employees must automatically enroll new full-time employees in coverage. Large employers will pay $600 for each full-time worker in a waiting period of more than 60 days. Employers that offer coverage and make a contribution are required to offer "free choice vouchers" to employees with incomes below 400% FPL to purchase health plans through exchange. The voucher must be equal to the contribution that the employer would have made to its own plan. Employees qualify if their required contribution under the employer's plan would be between 8 and 9.8 percent of their income. Free choice vouchers are excluded from taxation and voucher recipients are not eligible for tax credits.	Required to provide at least 72.5% premium contribution for individuals, 65% for families or pay 8% of payroll; small firms with <$500,000 payroll exempted and tax phased in up to firms with payrolls of $750,000.

Table 1. Congressional Health Reform Bills: Coverage, as of 12/24/2009

Features	Senate Introduced 11/18/09, with manager's amendment 12/19/09, passed by the Senate 12/24/09[14]	House of Representatives Introduced 10/29/09, Passed by the House 11/7/09[15]
Small Business Tax Credits	Temporary program (2010–13): Tax credit up to 35% of employer premium contribution (must be at least 50% of premium) for employers with fewer than 25 employees with average wages below $50,000; full amount of credit is available to employers with 10 or fewer FTEs and average wages of $25,000 and phases out to firms with 25 FTEs and $50,000 average wages. Permanent program (beginning 2014): Tax credit up to 50% of employer premium contribution (must be at least 50% of premium) for up to two years for employers with fewer than 25 employees with average wages below $50,000 who buy plans through the exchange. The full amount of the credit is available for employers with 10 or fewer FTEs and average wages below $25,000; credit phases out for firms with up to 25 employees (at rate of 6% of base credit percentage for each employee above 10) and average wages $25,000–$50,000 (at rate of 5% for each $1,000 increase of average wages above $25,000). Tax-exempt organizations are eligible for the small business tax credits, though they are somewhat lower: 25% of employer contribution to premium in the first phase (2010–13) (compared with 35% for other companies) and 35% in the second phase beginning in 2014 (compared with 50% for other companies).	50% of amount paid by a small employer in compliance with mandate (provide at least 72.5% premium contribution for individuals, 65% for families) (phased out for 10–25 employees or average wage of $20,000–$40,000 annually); credits could not be used to cover coverage expenses of employees earning more than $80,000.

Sources: Kaiser Family Foundation Side-by-Side Comparison of Major Health Care Reform Proposals, updated 12/23/09; Commonwealth Fund analysis of proposals; Health Policy R&D analysis of proposals.

[14] S. Amendment 2786 and S. Amendment 3276 in the nature of a substitute to H.R. 3590, The Patient Protection and Affordable Care Act, Introduced November 18, 2009, Manager's Amendment December 19, Passed December 24, 2009, 111th Congress, 1st session, available at. http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3590eas.txt.pdf; Democratic Policy Committee, Short Summary, Detailed Summary and Section-by-Section analysis of the Patient Protection and Affordable Care Act, available at http://dpc.senate.gov/dpcdoc-sen_health_care_bill.cfm.

[15] H.R. 3962 Affordable Health Care for America Act, October 29, 2009, 111th Congress, 1st session, available at http://www.gpo.gov/fdsys/pkg/BILLS-111hr3962IH/pdf/BILLS-111hr3962IH.pdf; Affordable Health Care for America Act, Section-by-Section Analysis, Committees on Energy and Commerce, Ways and Means, and Education and Labor Nov. 1, 2009, available at http://energycommerce.house.gov/Press_111/health_care/hr3962_Section_by_Section.pdf; Topline Changes from Introduced Bill to Blended Bill, Committees on Energy and Commerce, Ways and Means, and Education and Labor, October 29, 2009, available at http://energycommerce.house.gov/Press_111/health_care/hr3962_TOPLINE.pdf; H.R. 3200 America's Affordable Health Choices Act of 2009, July 14, 2009, 111th Congress, 1st session, Energy and Commerce Committee amendments, Education and Labor Committee amendments, Ways and Means Committee amendments; An American Solution: Quality Affordable Health Care, The House Tri-Committee Health Reform Discussion Draft Summary, Committees on Ways and Means, Energy and Commerce, and Education and Labor, July 14, 2009, available at http://energycommerce.house.gov/Press_111/20090714/hr3200_summary.pdf.

Table 2. Congressional Health Reform Bills: System Reform, as of 12/24/2009

Features	Senate Introduced 11/18/09, with manager's amendment 12/19/09, passed 12/24/09[16]	House of Representatives Introduced 10/29/09, passed 11/7/09[17]
Primary Care	Strengthen primary care by providing primary care physicians a 10% Medicare payment bonus for primary care services for five years beginning in 2011. General surgeons providing care in a designated Health Professional Shortage Area (HPSA) also would be eligible for a 10% bonus on payments for major procedures. Increase the number of graduate medical education (GME) training positions by redistributing currently unused slots, with priorities given to primary care and general surgery, increase flexibility in laws and regulations that govern Medicare GME funding to promote training in outpatient settings, and ensure the availability of residency programs in rural and underserved areas. 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. Create a home-based chronic care management program pilot project to bring primary care services to the highest-cost Medicare beneficiaries with multiple chronic conditions in their home. Establish a National Health Care Work Force Commission to review health care workforce and projected workforce needs. Provide comprehensive, unbiased information to lawmakers on how to align resources with national need. Establish grant program to states to plan and implement activities leading to health care workforce development strategies. Create a grant program to states to support providers who treat a high percentage of medically underserved populations.	Strengthen primary care and care coordination by increasing Medicaid payments for eligible primary care providers to Medicare levels by 2012, providing Medicare bonus payments of 5% to primary care practitioners (with 10% bonuses paid to primary care practitioners serving in HPSAs). Retain federal matching rate for costs of increasing Medicaid primary care payment rates to Medicare levels at 100% through 2014; reduced to 91 in 2015 and beyond. Department of Health and Human Services (HHS) secretary will periodically identify primary care services that are potentially misvalued and adjust their values. Reform graduate medical education to increase training of primary care providers by redistributing residency positions, promote training in outpatient settings, and support the development of primary care training programs. Increase federal payments to states to pay for increased costs of Medicaid primary care reimbursement, and provide additional funds to states with high unemployment.
Prevention/Wellness	Create a National Prevention, Health Promotion and Public Health Council to establish a national prevention and health promotion strategy and develop interagency working relationships to implement the strategy. Create a Prevention and Public Health Investment Fund to expand and sustain funding for prevention and public health programs.	Develop a national strategy to improve the nation's health through evidence-based clinical and community-based prevention and wellness activities. Create a Prevention and Wellness Trust Fund to provide $34 billion in mandatory funding over the next 10 years, for community-based prevention programs, child obesity program and others.

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	Provide Medicare beneficiaries access to an annual wellness visit, including a comprehensive health risk assessment and creation of a personalized prevention plan, with no copayment or deductible. Eliminate cost-sharing for evidence-based preventive services under Medicare and eligible private plans. States that expand Medicaid coverage to include preventive services approved by the US Preventive Services Task Force and immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) with no cost-sharing will receive an increased FMAP contribution for these services. Cover only proven preventive services in Medicare and Medicaid and provide incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs. Prohibit insurance plans (except existing grandfathered plans and those that use a value-based insurance design) from charging cost-sharing for preventive services. HHS to offer grants to states to provide incentives to Medicaid beneficiaries to enlist in comprehensive and proven wellness programs. Require coverage of tobacco cessation programs for pregnant women under Medicaid free of cost-sharing. Encourage employers to provide wellness programs by conducting targeted educational campaigns to raise awareness of the value of these programs and by increasing from 20 percent to 30 percent the allowable premium discount for employees who participate in these programs. Provide reasonable alternatives for employees for whom it is unreasonably difficult or inadvisable to meet the standard. Provide grants for small and mid-sized employers to implement and strengthen qualified wellness programs. Require CDC to study, evaluate and provide technical assistance to small businesses to implement effective employer-sponsored wellness programs.	Expand and improve coordination of task forces on clinical preventive services and community preventive services to develop, update, and disseminate evidence-based recommendations on the use of clinical and community prevention services, with an emphasis on health disparities. Improve prevention by covering only proven preventive services in Medicare and Medicaid; cover vaccines under Medicare Part B rather than Part D. Eliminate any cost-sharing for preventive services in Medicare and Medicaid and private plans and increase Medicare payments for certain preventive services to 100% of actual charges or fee schedule rates. Provide grants for small and mid-sized employers to implement and strengthen qualified wellness programs. Provide funds for research and inclusion of proven healthy behaviors in the essential health benefits package and in community wellness programs.

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	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. Create a medication management grant program to support provision of services by local providers. Permit insurers to create incentives for health promotion and disease prevention practices. Create a temporary high risk health insurance pool program to provide uninsured adults with access to preventive services until the exchanges are operational in 2014. Expand and improve coordination of task forces on clinical preventive services and community preventive services to develop, update, and disseminate evidence-based recommendations on the use of clinical and community prevention services, with an emphasis on health disparities.	
Medical Home/ Coordinated Care	Provide grants for improving health system efficiency, including grants that will establish community health teams to support a medical home model, implement medication management services, and design and implement regional emergency care and trauma systems. Create state option to allow Medicaid beneficiaries with chronic conditions, including serious and persistent mental health conditions, to designate a provider as a health home. Qualified providers would be required to report applicable quality data.	Conduct pilot programs in Medicare and Medicaid to assess the feasibility of reimbursing qualified patient-centered medical homes. Include both Patient-Centered Medical Home model and Community-Based Medical Home model. Require HHS to set specific benchmarks for expansion of pilot programs and test them in a variety of settings and regions. If successful, HHS must continue to expand them on a larger scale.
Quality Measurement, Reporting, and Improvement	Direct HHS to develop a National Strategy to Improve Health Care Quality that includes priorities to improve the delivery of health care services, patient health outcomes, and population health. Create an Interagency Working Group to coordinate and streamline federal quality activities, as directed by the President. 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. These quality measures shall include outcome measures for providers and hospitals (measures of acute and chronic diseases, and primary and preventive care).	Establish a Center for Quality Improvement led by AHRQ 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, informed by National Priorities for Performance Improvement and Key Health Indicators developed by HHS. Create HHS position of assistant secretary for health information to oversee and coordinate health information initiatives, particularly the development and measurement of key health indicators, and to facilitate and coordinate analyses of health disparities.

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	Establish the Medicaid Quality Measurement Program to establish priorities for the development and advancement of quality measures for adults in Medicaid. Implement quality measure reporting programs for long-term care hospitals, inpatient rehabilitation facilities, cancer hospitals, hospice providers by 2014. Requires HHS to develop a "Physician Compare" website where Medicare beneficiaries can compare scientifically-sound measures of physician quality and patient experience measures Authorizes release of Medicare claims data to measure performance of providers and suppliers in a way that protects patient privacy Improve transparency of information about skilled nursing facilities. Improve public reporting of quality and performance information that includes making information available on a user-friendly web site. 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. Provide an additional 0.5 percent Medicare bonus payment to physicians who successfully report quality measures to CMS via a qualified Maintenance of Certification program Provide grants to assist in development of community-based collaborative care networks, or integrated health care delivery systems, to service low-income or medically underserved communities. Screen providers and suppliers before granting Medicare billing privileges. Provide Technical Assistance and Process Implementation grants to local providers to promote teaching and implementation of quality improvement best practices.	Provide grants to assist in development of community-based collaborative care networks, or integrated health care delivery systems, to service low-income or medically underserved communities.

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Health Goals and Priorities for Performance Improvement	Develop a national strategy to improve health care quality that includes priorities to improve the delivery of health care services, patient health outcomes, and population health and to establish an Interagency Working Group on health care quality.	Develop national priorities for performance improvement and quality measures for the delivery of health care services, informed by national priorities for performance improvement and key health indicators developed by HHS.
New Payment Approaches	Establish new Center for Medicare and Medicaid Innovation within CMS to test new provider payment models; if successful, implement models in Medicare, Medicaid, and CHIP programs. Requires secretary to focus on models that both improve quality and reduce costs. Direct HHS to develop a national, voluntary pilot program encouraging hospitals, doctors, and post-acute care providers to improve patient care and achieve savings for the Medicare program through bundled payment models spanning 3 days before and 30 days after a hospitalization. Requires the Secretary to establish this program by January 1, 2013 for a period of five years. Before January 1, 2016, the Secretary is also required to submit a plan to Congress to expand the pilot program if doing so will improve patient care and reduce spending. Establish demonstration projects in Medicaid to pay bundled payments for episodes of care that include hospitalizations. Adjust Medicare hospital payments for potentially preventable readmissions for the three conditions that are currently endorsed by the National Quality Forum. Also, provides HHS authority to expand the policy to additional conditions in future years and directs the Secretary to calculate and make publicly available information on all patient hospital readmission rates for certain conditions. Prohibit federal payments for Medicaid services related to hospital-acquired conditions. Create Community-based Care Transitions Program to fund eligible hospitals and community-based organizations that provide patient-centered, evidence-based transitional care services to Medicare beneficiaries at highest risk of preventable rehospitalization. Establish a hospital value-based purchasing program to pay hospitals based on performance on quality measures; develop a similar plan to create a value-based purchasing program for Ambulatory Surgical Centers.	Establish a Center for Medicare and Medicaid Innovation to evaluate effectiveness and efficiency of alternative 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. Modify hospital payments under Medicare to reflect percentage of potentially preventable hospital readmissions. Require hospitals and clinics to report on health care-associated infections to the Centers for Disease Control and Prevention (CDC) and refuse Medicaid payments for certain health care-associated conditions. Conduct Medicare pilot programs to test payment incentive models for accountable care organizations and bundling of post-acute care payments. Require HHS to set specific benchmarks for expansion of pilot programs and test them in a variety of settings and regions. If successful, HHS must continue to expand them on a larger scale. Require HHS to periodically assess diseases and conditions that are or could become the most cost-intensive for Medicare. Provide information to help inform prevention and treatment research priorities. Improve payment accuracy for imaging services in Medicare.

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	Establish a physician value-based purchasing program. Reward providers who participate in 2011 up to 2014, penalize eligible providers who do not participate by 2014, expand Medicare physician feedback program, and prepare reports comparing physicians who use significantly more resources to their peers. Establish Medicaid global payments demonstration project to fund large safety-net hospitals in five states to alter payment from fee-for-service to capitated, global payment structure. Establish Medicaid emergency psychiatric care demonstration project to expand the number of emergency inpatient psychiatric care beds available. Create new demonstration program for chronically ill Medicare beneficiaries to test payment incentive and service delivery system that utilizes physician and nurse practitioner directed home-based primary care teams to reduce costs and improve health outcomes (see also in primary care). Establish a pay-for-performance pilot program for eligible Medicare providers; pilot program must not create additional expenditures. Program to be expanded after 2018 if it reduces spending and quality of care is improved or remains the same. Such a program cannot deny or limit provision of benefits under Medicare.	
Accountable Care Organizations (ACOs)	Allow providers organized as ACOs that meet quality-of-care targets and reduce costs relative to a spending benchmark to share in savings they generate for Medicare; allows secretary to use payment systems currently in place in private sector. Establish demonstration project to allow pediatric providers to organize as ACOs and partake in federal and state cost-saving generated under Medicaid.	Conduct Medicare pilot programs to test payment incentive models for accountable care organizations and bundling of post-acute care payments. Require HHS to set specific benchmarks for expansion of pilot programs and test them in a variety of settings and regions. If successful, HHS must continue to expand them on a larger scale.
Adjust Payment for Productivity Improvement	Modify market basket updates to provider payments under Medicare to account for productivity improvements for inpatient hospital, home health, skilled nursing facility, and other Medicare providers.	Modify provider payments under Medicare by expanding productivity adjustments to market basket updates for hospital outpatient departments, ambulatory surgical centers, ambulances, clinical laboratories, and durable medical equipment not competitively bid.

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Physician Payment Update Formula—Sustainable Growth Rate (SGR)	No provision.	No provision.
Other Payment Reforms	Require HHS to apply physician payment modifier to Medicare fee-for-service payment to pay physicians differentially based on quality and costs of care. Publish measures in 2012; phase in modifier from 2015 to 2017. Directs the Secretary to regularly review Medicare fee schedule rates for physician services, including services that have experienced high growth rates. Strengthens the Secretary's authority to adjust fees schedule rates that are found to be misvalued or inaccurate. Require HHS secretary to submit plan to Congress to implement current CMS value-based purchasing models pilot program for Medicare Home Health Agency and Skilled Nursing Facilities. Reduce Medicare payments to hospitals in top 25th percentile of rates of certain hospital-acquired conditions by 1% beginning 2015. Improve payment accuracy of home health payments starting in 2013. Improve payment accuracy of Medicare hospice payment system starting in 2013. Limit FSA contributions to $2,500 annually; beginning 2012, this limit is indexed to inflation.	Require MedPAC to undertake a study to examine variation in Medicare margins among home health agencies. Includes patient characteristics, agency characteristics and types of services provided. Limit FSA contributions to $2,500 annually; beginning 2012, this limit is indexed to inflation.
Geographic Disparities	Extend the 1.00 floor for the Geographic Practice Cost Index (GPCI) for physician work through December 2010. Adjust the GPCI for practice expense by blending local and national averages for below-average cost areas. Requires the HHS secretary to submit a plan by the end of 2011 to reform the Medicare hospital wage index system.	Provide 5% bonus to physicians and other providers of services covered under Medicare Part B in lowest-cost areas. Require the Institute of Medicine to conduct two studies; the first on geographic variation in health care spending and recommend strategies for addressing this variation by promoting high-value care and the second to report on the validity of geographic adjusters that apply to Medicare payment rates. CMS shall implement changes as appropriate.

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Medicare Advantage (MA)	Restructure payments to MA plans using new benchmarks computed from weighted average of plan bids, phased in from 2012 to 2015, with bonus payments for quality, performance improvement, care coordination, and efficiency. Grandfather Medicare Advantage plans with bids at 75% or below of fee-for-service rates. Make extra benefits plans can offer more consistent across plans and ensure cost-sharing does not exceed that in traditional Medicare FFS. Provide additional transitional benefits through 2019 to beneficiaries who experience a reduction in benefits under competitive bidding.	Restructure payments to Medicare Advantage plans, phasing to 100% of fee-for-service payments in three years, with bonus payments for quality. Require MA plans to maintain medical loss ratio of at least 85% beginning in 2014. Limit cost-sharing to no greater than cost-sharing in traditional Medicare.
Prescription Drugs	Provide a 50% discount on brand-name drugs purchased by enrollees who are subject to the Medicare Part D coverage gap, other than those with high incomes. The undiscounted price would be counted as out-of-pocket costs for purposes of determining when the catastrophic coverage threshold is reached. Reduce the Medicare Part D premium subsidy for high-income beneficiaries. Increase the Medicaid drug rebate percentage; increase the Medicaid rebate for non-innovator, multiple source drugs; and extend the prescription drug rebate to Medicaid managed care plans. Authorize the Food and Drug Administration (FDA) to approve generic versions of biologic drugs and grant biologics manufacturers 12 years of exclusive use before generics can be developed. 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.	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. Require the HHS secretary to negotiate directly with pharmaceutical manufacturers to lower drug prices for Medicare Part D plans and Medicare Advantage Part D plans. Begin to close Medicare Part D donut hole by $500 and institute a 50 percent discount for brand-name drugs. Phased in by 2019. Authorize the Food and Drug Administration (FDA) to approve generic versions of biologic drugs and grant biologics manufacturers 12 years of exclusive use before generics can be developed. 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.

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Other Medicare/ Medicaid Changes	Freeze threshold for income-related Part B premiums for 10 years and reduce Medicare Part D premium subsidy for those with high incomes. Eliminate the Medicare Improvement Fund. Eliminate fraud, waste, and abuse in public programs through more intensive screening of providers, the development of the "One PI" integrated database to capture and share data across federal and state programs, increased penalties for submitting false claims, and increase funding for anti-fraud activities. Require the HHS secretary to update Medicare hospital payments to better account for hospitals' uncompensated care costs. Beginning 2015, hospitals' Medicare disproportionate share hospital (DSH) payments would be reduced to reflect lower uncompensated care costs relative to increases in the number of insured. Reduce States' Medicaid disproportionate share hospital (DSH) allotments by 50 percent once the rate of uninsurance in a State decreases by 45 percent (low DSH States would receive a 25 percent reduction). As the rate of uninsurance continues to decline, the States' DSH allotments would be reduced by a corresponding amount. At no time could a State's DSH allotment be reduced by more than 65 percent compared to its 2012 allotment. Establish a Federal Coordinated Health Care Office within CMS to more effectively integrate benefits and improve coordination between state and federal governments for individuals eligible for both Medicare and Medicaid. Extend current reauthorization period of CHIP for two years, through 2015, and includes a 23 percentage point increase in FMAP rates from 2016 through 2019. Directs HHS to establish a 3-year demonstration project in States to provide comprehensive health care services to uninsured at reduced fees.	Reduce waste, fraud, and abuse in public programs by improving provider and payment screening, creating new penalties for providers and suppliers that defraud federal health care programs, allowing beneficiary access to plan information and administrative costs, allowing enhanced oversight for Medicare and Medicaid programs at risk of fraud, 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, except physicians and skilled nursing facilities, to establish compliance programs Increase funding for Health Care Fraud and Abuse Control Fund. Increase the asset test for Medicare Savings Program and Part D Low-Income Subsidies to $17,000/$34,000. Provide grants to strengthen capacity in emergency rooms and trauma centers. Require Medicaid Managed Care Organizations to meet a medical loss ratio standard of at least 85%. Provide technical assistance to states for Medicare and Medicaid coordination initiatives for dual eligibles' care. Require the HHS secretary to update Medicare hospital payments to better account for hospitals' uncompensated care costs by 2016. If uninsurance rate falls at least 8 percent between 2012 and 2014, reduce disproportionate share hospital (DSH) payments in 2017 as directed by the secretary. Require HHS secretary to develop method to reduce States' Medicaid disproportionate share hospital (DSH) payments by $10 billion between 2017 and 2019, with largest reductions in states with lowest uninsurance rates or least effective targeting of funds to DSH hospitals.

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Medicare Commission	Create a new 15-member Independent Payment Advisory Board tasked with presenting Congress with comprehensive proposals to reduce excess cost growth and improve quality of care for Medicare beneficiaries. In years when Medicare costs are projected to be unsustainable, the Board's proposals will take effect unless Congress passes an alternative measure that achieves the same level of savings. Congress would be allowed to consider an alternative provision on a fast-track basis. The Board would be prohibited from making proposals that ration care, raise taxes or Part B premiums, or change Medicare benefit, eligibility, or cost-sharing standards. Beginning 2014, the Board shall issue an annual public report that provides information on health system costs, utilization, access and quality of care.	
Comparative Effectiveness	Create a private, nonprofit Patient-Centered Outcomes Research Institute to set national research agenda and conduct comparative clinical effectiveness research. The Institute will be governed by a public-private sector Board. Prohibits any findings to be construed as mandates on practice guidelines or coverage decisions and contains patient safeguards to protect against discriminatory coverage decisions by HHS based on age, disability, terminal illness, or an individual's quality of life preference.	Establish a Center for Comparative Effectiveness Research (CER) within AHRQ to conduct, support, and synthesize research on outcomes, effectiveness, and appropriateness of health care services and procedures. Research would seek to improve treatments, decrease costs, and increase the quality of life for patients. An independent CER commission with its own source of funding will oversee the activities of the center. Reports are not considered to be mandates for payment, coverage or reimbursement policies for any public or private payer.
Health Information Technology (HIT)	Develop and update interoperable standards for using HIT to enroll individuals in public programs.	Develop and update standards for electronic administrative transactions.
Public Health	Impose additional requirements on nonprofit 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. 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; and to design and implement regional emergency care and trauma systems. Provide grants to develop and support pilot projects that design, implement, and evaluate regionalized systems for emergency care response.	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. Support the development of interdisciplinary mental, behavioral, and oral health training programs. Provide grants to each state health department to address core public health infrastructure needs. Reauthorize Indian Health Care Improvement Act. Permanently establish an Office of Women's Health in HHS, CDC, AHRQ, FDA, HRSA, and the Substance Abuse and Mental Health Services Administration (SAMHSA).

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	Permanently establish an Office of Women's Health in HHS, CDC, AHRQ, FDA, and the Health Resources and Services Administration (HRSA); provide grants to accomplish goals of HHS Office of Women's Health. Permanently establish an Office of Minority Health in CDC, AHRQ, FDA, CMS, the Health Resources and Services Administration (HRSA), and SAMHSA; provide grants to accomplish goals of Offices of Minority Health. Establish a Community Health Centers and National Health Service Corps Fund to create an expanded and sustained national investment in community health centers. Require HHS to develop a national education campaign for young women and health care professionals about breast health and risk factors for breast cancer. Require HHS and CDC to jointly issue a national Diabetes Report Card, which will include aggregate health outcomes for patients diagnosed with diabetes. These measures will include preventive care practices and quality of care, risk factors and outcomes, with trend analysis over time. HHS shall establish the Cures Acceleration Network to expedite development of drugs, devices and biological products for diagnosis, mitigation, prevention, or treatment from any disease or condition that the NIH determines is a priority; and that the commercial market does not provide sufficient financial incentive for timely development of these products. Provide grants to establish Centers of Excellence for Depressive Disorders that will develop treatments for these diseases. Enhance and expand infrastructure to track epidemiology of congenital heart disease.	Provide grants for infant mortality programs to eligible entities. Provide grants to create health sciences training in secondary schools. Provide grants to community-based collaborative care networks that help low-income patients access health care.

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Malpractice Reform	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. Authorizes grants to States to test alternatives to civil tort litigation. Models required to emphasize patient safety, disclosure of health care errors, and early resolution of disputes. Patients can opt-out. HHS must conduct an evaluation to determine effectiveness of alternatives.	Establish a new voluntary grant program to encourage states to implement alternatives to traditional medical malpractice litigation.
Long-Term Care	Improve the availability of long-term care services by increasing access to home- and community-based services through financial incentives, changes in Medicaid program requirements and through grants to states. 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. Improve transparency of information about skilled nursing facilities (SNF) and nursing homes, enforcement of SNF and nursing home standards and rules, and training of SNF and nursing home staff. Establish national or state background checks on certain employees and providers in long-term care facilities; provide federal matching funds to states to support the checks. Establish a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program). The program will provide active working individuals with functional limitations a cash benefit to purchase nonmedical 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 homes. Require health insurers in the Exchange to provide information about resources available for planning for care near the end of life to enrollees. Establish a national, voluntary, long-term care insurance program for purchasing community living assistance services and supports (CLASS program). The program will provide active working individuals and their nonworking spouses with functional limitations a cash benefit to purchase nonmedical 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.

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New Leadership Councils and Commissions	National Prevention, Health Promotion and Public Health Council. Interagency Working Group to coordinate and streamline federal quality activities Patient-Centered Outcomes Research Institute. Independent Payment Advisory Board. Medicare and Medicaid Innovation Center within CMS. CMS Coordinated Healthcare Office. Task Forces on Clinical Preventive Services and Community Preventive Services. National Health Care Workforce Commission.	Center for Quality Improvement. Assistant Secretary for Health Information. Center for Comparative Effectiveness Research. Comparative Effectiveness Research Commission. Medicare and Medicaid Innovation Center within CMS. Task Forces on Clinical Preventive Services and Community Preventive Services. Advisory Committee on Health Workforce Evaluation and Assessment

Sources: Kaiser Family Foundation Side-by-Side Comparison of Major Health Care Reform Proposals, updated 12/23/09; Commonwealth Fund analysis of proposals; HealthPolicy R&D analysis proposals.

[16] S. Amendment 2786 and S. Amendment 3276 in the nature of a substitute to H.R. 3590, The Patient Protection and Affordable Care Act, Introduced November 18, 2009, Manager's Amendment December 19, Passed December 24, 2009, 111th Congress, 1st session, available at. http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3590eas.txt.pdf; Democratic Policy Committee, Short Summary, Detailed Summary and Section-by-Section analysis of the Patient Protection and Affordable Care Act, available at http://dpc.senate.gov/dpcdoc-sen_health_care_bill.cfm.

[17] H.R. 3962 Affordable Health Care for America Act, October 29, 2009, 111th Congress, 1st session, available at http://www.gpo.gov/fdsys/pkg/BILLS-111hr3962IH/pdf/BILLS-111hr3962IH.pdf; Affordable Health Care for America Act, Section-by-Section Analysis, Committees on Energy and Commerce, Ways and Means, and Education and Labor Nov. 1, 2009, available at http://energycommerce.house.gov/Press_111/health_care/hr3962_Section_by_Section.pdf; Topline Changes from Introduced Bill to Blended Bill, Committees on Energy and Commerce, Ways and Means, and Education and Labor, October 29, 2009, available at http://energycommerce.house.gov/Press_111/health_care/hr3962_TOPLINE.pdf; H.R. 3200 America's Affordable Health Choices Act of 2009, July 14, 2009, 111th Congress, 1st session, Energy and Commerce Committee amendments, Education and Labor Committee amendments, Ways and Means Committee amendments; An American Solution: Quality Affordable Health Care, The House Tri-Committee Health Reform Discussion Draft Summary, Committees on Ways and Means, Energy and Commerce, and Education and Labor, July 14, 2009, available at http://energycommerce.house.gov/Press_111/20090714/hr3200_summary.pdf.