Side-by-Side Comparison of Major Health Care Reform Proposals

This interactive side-by-side compares the leading comprehensive reform proposals across a number of key characteristics and plan components. Included in this side-by-side are proposals for moving toward universal coverage that have been put forward by the President and Members of Congress. In an effort to capture the most important proposals, we have included those that have been formally introduced as legislation as well as those that have been offered as draft proposals or as policy options. It will be regularly updated to reflect changes in the proposals and to incorporate major new proposals as they are announced. This side-by-side offers a summary of the major components of these proposals; detailed descriptions of provisions relating to Medicare and Medicaid are also available online.

Instructions:
1. Select one or more proposals.
2. Select one or more topics. The Generate Comparison button will appear on the right, just above the proposals. Click for results.
3. Your results will appear with the options to Print the Comparison, or Create a Different Comparison.

Download a printable version of the House Leadership Bill (.pdf)
Download a printable version of the three Congressional authorizing committee proposals (.pdf)
Download a printable side-by-side comparison of all proposals and topics (.pdf)

	House Leadership Bill Affordable Health Care for America Act (H.R. 3962)	Senate HELP Committee Affordable Health Choices Act (S. 1679)	Senate Finance Committee America's Healthy Future Act of 2009
Date Plan Announced	October 29, 2009	June 9, 2009 (passed by Committee July 15, 2009)	September 16, 2009 (as amended by Committee during mark-up)
Overall approach to expanding access to coverage	Require individuals to have health insurance. Create a Health Insurance Exchange through which individuals and smaller employers can purchase health coverage, with premium and cost-sharing credits available to individuals/families with incomes up to 400% of the federal poverty level (or $73,240 for a family of three in 2009). Require employers to provide coverage to employees or pay into a Health Insurance Exchange Trust Fund, with exceptions for certain small employers, and provide certain small employers a credit to offset the costs of providing coverage. Impose new regulations on plans participating in the Exchange and in the small group insurance market. Expand Medicaid to 150% of the poverty level.	Require individuals to have health insurance. Create state-based American Health Benefit Gateways through which individuals and small businesses can purchase health coverage, with subsidies available to individuals/families with incomes up to 400% of the federal poverty level (or $73,240 for a family of three in 2009). Require employers to provide coverage to their employees or pay an annual fee, with exceptions for small employers, and provide certain small employers a credit to offset the costs of providing coverage. Impose new regulations on the individual and small group insurance markets. Expand Medicaid to all individuals with incomes up to 150% of the federal poverty level.	Require most U.S. citizens and legal residents to have health insurance. Create state-based health insurance exchanges through which individuals can purchase coverage, with premium and cost-sharing credits available to individuals/families with income between 100-400% of the federal poverty level (the poverty level is $18,310 for a family of three in 2009) and create separate exchanges through which small businesses can purchase coverage. Assess a fee on certain employers that do not offer coverage for each employee who receives a tax credit for health insurance through an exchange, with exceptions for small employers. Impose new regulations on health plans in the exchange and in the individual and small group markets. Expand Medicaid to all individuals with incomes up to 133% of the federal poverty level.
Individual mandate	■ Require all individuals to have "acceptable health coverage". Those without coverage pay a penalty of 2.5% of their adjusted income above the filing threshold up to the cost of the average national premium for self-only or family coverage under a basic plan in the Health Insurance Exchange. Exceptions granted for those with incomes below the filing threshold (in 2009 the threshold for taxpayers under age 65 is $9,350 for singles and $18,700 for couples), religious objections and financial hardship. (Effective January 1, 2013)	■ Require individuals to have qualifying health coverage. Enforced through a minimum tax penalty of $750 per individual per year (maximum penalty per family of 4 times the individual penalty). Exemptions to the individual mandate will be granted to residents of states that do not establish an American Health Benefit Gateway, members of Indian tribes, those for whom affordable coverage is not available, those without coverage for fewer than 90 days, and those with incomes below 150% FPL.	■ Require U.S. citizens and legal residents to have qualifying health coverage. Enforced through a tax penalty of $750 per adult per year. The penalty will be phased-in according to the following schedule: $0 in 2013; $200 in 2014; $400 in 2015; $600 in 2016; and $750 in 2017. Exemptions will be granted for financial hardship, religious objections, American Indians, and if the lowest cost plan option exceeds 8% of an individual's income or if the individual has income below 133% of the poverty level.

Employer requirements	■ Require employers to offer coverage to their employees and contribute at least 72.5% of the premium cost for single coverage and 65% of the premium cost for family coverage of the lowest cost plan that meets the essential benefits package requirements or pay 8% of payroll into the Health Insurance Exchange Trust Fund. (Effective January 1, 2013) ■ Eliminate or reduce the pay or play assessment for small employers with annual payroll of less than $750,000: ■ Annual payroll less than $500,000: exempt ■ Annual payroll between $500,000 and $585,000: 2% of payroll; ■ Annual payroll between $585,000 and $670,000: 4% of payroll; ■ Annual payroll between $670,000 and $750,000: 6% of payroll. (Effective January 1, 2013) ■ Require employers that offer coverage to automatically enroll into the employer's lowest cost premium plan any individual who does not elect coverage under the employer plan or does not opt out of such coverage. (Effective January 1, 2013) ■ Require a government study of the impact of employer responsibility requirements and recommend to Congress whether an employer hardship exemption is appropriate. (Report due January 1, 2012)	■ Require employers to offer health coverage to their employees and contribute at least 60% of the premium cost or pay $750 for each uninsured full-time employee and $375 for each uninsured part-time employee who is not offered coverage. For employers subject to the assessment, the first 25 workers are exempted. ■ Exempt employers with 25 or fewer employees from the requirement to provide coverage.	■ Assess employers with more than 50 employees that do not offer coverage a fee for each employee who receives a tax credit for health insurance through an exchange. The penalty is the lesser of a flat dollar amount equal to the average national tax credit for each full-time employee receiving a tax credit or $400 times the total number of full-time employees in the firm. ■ Exempt employers with 50 or fewer employees from the penalty. ■ Require employers with 200 or more employees to automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of coverage if they have coverage from another source.
Expansion of public programs	■ Expand Medicaid to all individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 150% FPL. Provide Medicaid coverage for all newborns who lack acceptable coverage and provide optional Medicaid coverage to low-income HIV-infected individuals (with enhanced matching funds) until 2013 and for family planning services to certain low-income women. In addition, increase Medicaid payment rates for primary care providers to 100% of Medicare rates by 2012. Require states to submit a state plan amendment specifying the payment rates to be paid under the state's Medicaid program. The coverage expansions (except the optional expansions) and the enhanced provider payments will be financed with 100% federal financing through 2014 and 91% federal financing beginning in year 2015. (Effective January 1, 2013) ■ Repeal the Children's Health Insurance Program (CHIP) and require CHIP enrollees with incomes above 150% FPL to obtain coverage through the Health Insurance Exchange beginning in 2014. CHIP enrollees with incomes between 100% and 150% FPL would be transitioned to Medicaid and states would receive the CHIP enhanced match rate for children above current levels and up to 150% FPL. Require a report to Congress with recommendations to ensure that coverage in the Health Insurance Exchange is comparable to coverage under an average CHIP plan and that there are procedures to transfer CHIP enrollees into the exchange without interrupting coverage or with a written plan of treatment. (Report due by December 31, 2011)	■ Expand Medicaid to all individuals (children, pregnant women, parents, and adults without dependent children) with incomes up to 150% FPL. Individuals eligible for Medicaid will be covered through state Medicaid programs and will not be eligible for credits to purchase coverage through American Health Benefit Gateways. ■ Grant individuals eligible for the Children's Health Insurance Program (CHIP) the option of enrolling in CHIP or enrolling in a qualified health plan through a Gateway.	■ Expand Medicaid to all individuals (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL (to be implemented in 2014). Adults with incomes between 100-133% FPL will have the option of obtaining coverage through Medicaid or with federal subsidies through the exchange. All newly eligible adults will be guaranteed a benchmark benefit package that at least meets the minimum creditable coverage standards. Require states to provide premium assistance to any Medicaid beneficiary with access to employer-sponsored insurance if it is cost-effective for the state. To finance the coverage for the newly eligible (those who were not previously eligible for a full benchmark benefit package or who were eligible for a capped program but were not enrolled), states will receive an increase in the federal medical assistance percentage (FMAP). Initially, the percentage point increase in the FMAP will be 27.3 for states that already cover adults with incomes above 100% FPL and 37.3 for other states. These percentage point increases will be adjusted over time so that by 2019, all states will receive an FMAP increase of 32.3 percentage points for the newly eligible. High need states—those with total Medicaid enrollment that is below the national average for enrollment as a percentage of the state population and unemployment rates of 12% or higher for August 2009—will receive full federal funding for the newly eligible for five years. ■ Require states to maintain current income eligibility levels for children in Medicaid and the Children's Health Insurance Program (CHIP) until 2019. CHIP benefit package and cost-sharing rules will continue as under current law. Beginning in 2014, states will receive a 23 percentage point increase in the CHIP match rate up to a cap of 100% and a .15 percentage point increase in the Medicaid match rate. CHIP-eligible children who are unable to enroll in the program due to enrollment caps will be eligible for tax credits in the state exchanges.
Premium and cost-sharing subsidies to individuals	■ Provide affordability premium credits to eligible individuals and families with incomes up to 400% FPL to purchase insurance through the Health Insurance Exchange. The premium credits will be based on the average cost of the three lowest cost basic health plans in the area and will be set on a sliding scale such that the premium contributions are limited to the following percentages of income for specified income tiers: ■ 133-150% FPL: 1.5 - 3% of income ■ 150-200% FPL: 3 – 5.5% of income ■ 200-250% FPL: 5.5 - 8% of income ■ 250-300% FPL: 8 - 10% of income ■ 300-350% FPL: 10 - 11% of income ■ 350-400% FPL: 11 - 12% of income (Effective January 1, 2013) ■ Index the affordability premium credits after 2013 to maintain the ratio of government to	■ Provide premium credits on a sliding scale basis to individuals and families with incomes up to 400% FPL to purchase coverage through the Gateway. The premium credits will be based on the average cost of the three lowest cost qualified health plans in the area, but will be such that individuals with incomes less than 400% FPL pay no more than 12.5% of income and individuals with incomes less than 150% FPL pay 1% of income, with additional limits on cost sharing. ■ Limit availability of premium credits through the Gateway to U.S. citizens and lawfully residing immigrants who meet income limits and are	■ Provide refundable and advanceable premium credits to individuals and families with incomes between 133-400% FPL in 2013, and including individuals and families with incomes between 100-133% FPL in 2014, to purchase insurance through the health insurance exchanges. The premium credits will be tied to the second lowest-cost silver plan in the area and will be provided on a sliding scale basis from 2% of income for those at 100% FPL to 12% of income for those between 300-400% FPL. ■ Exclude individuals with incomes below 100% FPL from eligibility for the premium credits. These individuals will be eligible for coverage through the Medicaid program. ■ Provide cost-sharing subsidies to eligible individuals and families with incomes between 100-200% FPL. For those with incomes between 100-150% FPL, the cost-sharing subsidies will result in coverage for 90% of the benefit costs of the plan. For those with incomes between 150-200%, the cost-sharing subsidies will result in coverage for 80% of the benefit costs of the plan. ■ Limit availability of premium credits and cost-sharing subsidies through the exchanges to U.S. citizens and legal immigrants who meet income limits. Employees who are offered coverage

	enrollee shares of the premiums over time. ■ Provide affordability cost-sharing credits to eligible individuals and families with incomes up to 400% FPL. The cost-sharing credits reduce the cost-sharing amounts and annual cost-sharing limits and have the effect of increasing the actuarial value of the basic benefit plan to the following percentages of the full value of the plan for the specified income tier: ■ 133-150% FPL: 97% ■ 150-200% FPL: 93% ■ 200-250% FPL: 85% ■ 250-300% FPL: 78% ■ 300-350% FPL: 72% ■ 350-400% FPL: 70% (Effective January 1, 2013) ■ Lower the out-of-pocket spending limits established in the essential benefits package ($5,000/individual and $10,000/family) for eligible individuals and families with incomes up to 400% FPL to the following amounts: ■ 133-150% FPL: $500/individual; $1,000/family ■ 150-200% FPL: $1,000/individual; $2,000/family ■ 200-250% FPL: $2,000/individual; $4,000/family ■ 250-300% FPL: $4,000/individual; $8,000/family ■ 300-350% FPL: $4,500/individual; $9,000/family ■ 350-400% FPL: $5,000/individual; $10,000/family (Effective January 1, 2013) ■ Limit availability of premium and cost-sharing credits to US citizens and lawfully residing immigrants who meet the income limits and are not enrolled in qualified or grandfathered employer or individual coverage, Medicare, Medicaid (except those eligible to enroll in the Exchange), TRICARE, or VA coverage (with some exceptions). Individuals with access to employer-based coverage are eligible for the premium and cost-sharing credits if the cost of the employee premium exceeds 12% of the individuals' income. ■ Require verification of both income and citizenship status in determining eligibility for the federal premium and cost-sharing credits.	not eligible for employer-based coverage that meets minimum qualifying criteria and affordability standards, Medicare, Medicaid, TRICARE, or the Federal Employee Health Benefits Program. Individuals with access to employer-based coverage are eligible for the premium credits if the cost of the employee premium exceeds 12.5% of the individuals' income.	by an employer are not eligible for premium credits unless the employer plan does not have an actuarial value of at least 65% or if the employee share of the premium exceeds 10% of income. ■ Require verification of both income and citizenship status in determining eligibility for the federal premium credits.
Premium subsidies to employers	■ Provide small employers with fewer than 25 employees and average wages of less than $40,000 with a health coverage tax credit for up to two years. The full credit of 50% of premium costs paid by employers is available to employers with 10 or fewer employees and average annual wages of $20,000 or less. The credit phases-out as firm size and average wage increases and is not permitted for employees earning more than $80,000 per year. (Effective January 1, 2013) ■ Create a temporary reinsurance program for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare. Program will reimburse employers for 80% of retiree claims between $15,000 and $90,000. Payments from the reinsurance program will be used to lower the costs for enrollees in the employer plan. Appropriate $10 billion over ten years for the reinsurance program. (Effective 90 days after enactment)	■ Provide qualifying small employers with a health options program credit. To qualify for the credit, employers must have fewer than 50 full-time employees, pay an average wage of less than $50,000, and must pay at least 60% of employee health expenses. The credit is equal to $1,000 for each employee with single coverage and $2,000 for each employee with family coverage, adjusted for firm size (phasing out as firm size increases) and number of months of coverage provided. Bonus payments are given for each additional 10% of employee health expenses above 60% paid by the employer. Employers may not receive the credit for more than three consecutive years. Self-employed individuals who do not receive premium credits for purchasing coverage through the Gateway are eligible for the credit. ■ Create a temporary reinsurance program for employers providing health insurance coverage to retirees ages 55 to 64. Program will reimburse employers for 80% of retiree claims between $15,000 and $90,000. Program will end when the state Gateway is	■ Provide small employers with fewer than 25 employees and average annual wages of less than $40,000 that purchase health insurance for employees with a tax credit. ■ *Phase I* : For tax years 2011 and 2012, provide a tax credit of up to 35% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost or 50% of a benchmark premium. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than $20,000. Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 25% of the employer's contribution toward the employee's health insurance premium. ■ *Phase II* : For tax years 2013 and later, for eligible small businesses that purchase coverage through the state exchange, provide a tax credit of up to 50% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost or 50% of a benchmark premium. The credit will be available for two years. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than $20,000. Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 35% of the employer's contribution toward the employee's health insurance premium. ■ Create a temporary reinsurance program for employers providing health insurance coverage to retirees ages 55 to 64. Program will reimburse employers or insurers for 80% of retiree claims between $15,000 and $90,000. Appropriate $5 billion to finance the program.

		established. Payments from the reinsurance program will be used to lower the costs for enrollees in the employer plan.	
Tax changes related to health insurance and to financing health reform	■ Impose a tax on individuals without acceptable health care coverage of 2.5% of adjusted income above the filing threshold up to the cost of the average national premium for self-only or family coverage under a basic plan in the Health Insurance Exchange . (Effective January 1, 2013) ■ Permit only prescribed drugs to be reimbursable through a health savings account, Archer medical savings account, health reimbursement arrangement, or flexible spending arrangement for medical expenses. (Effective January 1, 2011) ■ Increase the tax on distributions from a health savings account that are not used for qualified medical expenses to 20% (from 10%) of the disbursed amount. (Effective January 1, 2011) ■ Limit the amount of contributions to a flexible spending arrangement for medical expenses to $2,500 per year. (Effective January 1, 2013) ■ Impose a tax of 2.5% of the price on the first taxable sale of any medical device. (Effective January 1, 2013) ■ Impose a tax of 5.4% on individuals with modified adjusted gross income exceeding $500,000 and families with modified adjusted gross income exceeding $1,000,000. (Effective January 1, 2011)	■ Impose a minimum tax on individuals without qualifying health care coverage of $750 per individual per year (maximum family penalty of 4 times the individual penalty).	■ Impose a tax on individuals without qualifying coverage of $750 per adult per year to be phased-in beginning in 2014. ■ Impose an excise tax in 2013 on insurers of employer-sponsored health plans with aggregate values that exceed $8,000 for individual coverage and $21,000 for family coverage (these threshold values will be indexed to the consumer price index for urban consumers (CPI-U) plus 1%). The threshold amounts will be increased for retired individuals age 55 and up and for employees engaged in high-risk professions by $1,850 for individual coverage and $5,000 for family coverage. In the 17 states with the highest health care costs, the threshold amount is increased by 20% initially; this premium increase is subsequently reduced by half each year until it is phased out in 2015. The tax is equal to 40% of the value of the plan that exceeds the threshold amounts and is imposed on the issuer of the health insurance policy, which in the case of a self-insured plan is the plan administrator or, in some cases, the employer. The aggregate value of the health insurance plan includes reimbursements under a flexible spending account for medical expenses (health FSA) or health reimbursement arrangement (HRA), employer contributions to a health savings account (HSA), and coverage for dental, vision, and other supplementary health insurance coverage. ■ Conform the definition of medical expenses for purposes of employer provided health coverage (including HRAs and health FSAs), HSAs, and Archer medical savings accounts to the definition for purposes of the itemized deduction for medical expenses. This change will exclude the costs for over-the-counter drugs not prescribed by a doctor from being reimbursed through an HRA or health FSA and from being reimbursed on a tax-free basis through an HSA or Archer MSA. ■ Increase the tax on distributions from a health savings account that are not used for qualified medical expenses to 20% (from 10%) of the disbursed amount. ■ Limit the amount of contributions to a flexible spending account for medical expenses to $2,500 per year. ■ Increase the threshold for the itemized deduction for unreimbursed medical expenses from 7.5% of adjusted gross income to 10% of adjusted gross income for regular tax purposes. Individuals age 65 and older are exempt from the increased threshold. ■ Impose new fees on segments of the health care sector: ■ $2.3 billion annual fee on the pharmaceutical manufacturing sector; ■ $4 billion annual fee on the medical device manufacturing sector; and ■ $6.7 billion annual fee on the health insurance sector.
Creation of insurance pooling mechanisms	■ Create a National Health Insurance Exchange, through which individuals and employers (phasing-in eligibility for employers starting with smallest employers) can purchase qualified insurance, including from private health plans and the public health insurance option. ■ Restrict access to coverage through the Exchange to individuals who are not enrolled in qualified or grandfathered employer or individual coverage, Medicare, Medicaid, TRICARE, or VA coverage. ■ Create a new public health insurance option to be offered through the Health Insurance Exchange that must meet the same requirements as private plans regarding benefit levels, provider networks, consumer protections, and cost-sharing. Require the public plan to offer basic, enhanced, and premium plans, and permit it to offer premium plus plans. Finance the costs of the public plan through revenues from premiums. Require the public health insurance option to negotiate rates with providers so that the rates are not lower than Medicare rates and not higher than the average rates paid by other qualified health benefit plan offering entities. Health care providers participating in Medicare are considered participating providers in the public plan unless they opt out. Permit the public plan to develop innovative payment mechanisms, including medical home and other care management payments, value-based purchasing, bundling of services, differential payment rates, performance based payments, or partial capitation and modify cost-sharing and payment rates to encourage use of high-value services. ■ Create four benefit categories of plans to be offered through the Exchange: ■ *Basic plan* includes essential benefits	■ Create state-based American Health Benefit Gateways, administered by a governmental agency or non-profit organization, through which individuals and small employers can purchase qualified coverage. States may form regional Gateways or allow more than one Gateway to operate in a state as long as each Gateway serves a distinct geographic area. ■ Restrict access to coverage through the Gateways to individuals who are not incarcerated and who are not eligible for employer-sponsored coverage that meets minimum qualifying criteria and affordability standards, Medicare, Medicaid, TRICARE, or the Federal Employee Health Benefits Program ■ Create a community health insurance option to be offered through state Gateways that complies with the requirements of being a qualified health plan and meets the same requirements as other plans relating to guarantee issue and renewability, insurance rating rules, quality improvement and reporting, solvency standards, licensure, and benefit plan information. Require the community health insurance	■ Provide immediate assistance until the new insurance market rules go into effect for those with pre-existing conditions by creating a temporary high-risk pool. Individuals who have been denied health coverage due to a pre-existing medical condition and who have been uninsured for at least six months will be eligible to enroll in the high-risk pool and receive subsidized premiums. The high-risk pool will exist until 2013. ■ Create state-based exchanges for the individual market and small business health options program (SHOP) exchanges for the small group market. Allow small businesses with up to 100 employees to purchase coverage through the SHOP exchanges beginning in 2015 and permit states to allow businesses with more than 100 employees to purchase coverage in the SHOP exchange beginning in 2017. ■ Restrict access to coverage through the exchanges to U.S. citizens and legal immigrants. ■ Create the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of non-profit, member-run health insurance companies in all 50 states and District of Columbia. To be eligible to receive funds, organizations must not be an existing organization, substantially all of its activities must consist of the issuance of qualified health benefit plans in each state in which it is licensed, governance of the organization must be subject to a majority vote of its members, must operate with a strong consumer focus, and any profits must be used to lower premiums, improve benefits, or improve the quality of health care delivered to its members. Require CO-OPs to meet the same requirements as private insurance plans in the exchanges related to solvency, licensure, provider payments, network adequacy, and any applicable state premium assessments. ■ Require all state-licensed insurers in the individual and small group markets to participate in the exchanges. ■ Require guarantee issue and renewability and allow rating variation based only on age (limited to 4 to 1 ratio), tobacco use (limited to 1.5. to 1 ratio) , family composition, and geography in the non-group and the small group market (new rules for small group market will be phased-in over five years). Require risk adjustment in the individual and small group markets and prohibit insurers from rescinding coverage. ■ Require the exchanges to develop a standardized format for

package and covers 70% of the benefit costs of the plan;
  - *Enhanced plan* includes essential benefits package, reduced cost-sharing compared to the basic plan, and covers 85% of benefit costs of the plan;
  - *Premium plan* includes essential benefits package with reduced cost-sharing compared to the enhanced plan and covers 95% of the benefit costs of the plan;
  - *Premium plus* plan is a premium plan that provides additional benefits, such as oral health and vision care.
- Require guarantee issue and renewability; allow rating variation based only on age (limited to 2 to 1 ratio), premium rating area, and family enrollment.
- Require plans participating in the Exchange to be state licensed, report data as required, implement affordability credits, meet network adequacy standards, provide culturally and linguistically appropriate services, contract with essential community providers and Indian health care providers, and participate in risk pooling. Require participating plans to offer one basic plan for each service area and permit them to offer additional plans. Require plans to provide information related to end-of-life planning to individuals and provide the option to establish advance directives and physician's order for life-sustaining treatment.
- Require risk adjustment of participating Exchange plans.
- Provide information to consumers and small employers to enable them to choose among plans in the Exchange, including establishing a telephone hotline and maintaining a website, and provide information on open enrollment periods and how to enroll.
- Prohibit plans participating in the Exchange from discriminating against any provider because of a willingness or unwillingness to provide abortions.
- Create a Consumer Operated and Oriented Program (CO-OP) to facilitate the establishment of non-profit, member-run health insurance cooperatives to provide insurance through the Exchange. (Effective six months following enactment)
- Allow states to operate state-based exchanges if they demonstrate the capacity to meet the requirements for administering the exchange.
- Unless otherwise noted, provisions relating to the Health Insurance Exchange are effective January 1, 2013.

plan to provide the essential benefits package and offer coverage at all cost-sharing tiers. Require that the costs of the community health insurance plan be financed through revenues from premiums, require the plan to negotiate payment rates with providers, and contract with qualified nonprofit entities to administer the plan. Permit the plan to develop innovative payment policies to promote quality, efficiency, and savings to consumers. Require each State to establish a State Advisory Council to provide recommendations on policies and procedures for the community health insurance option.
- Require guarantee issue and renewability of health insurance policies in the individual and small group markets; prohibit pre-existing condition exclusions; prohibit insurers from rescinding coverage except in cases of fraud; and allow rating variation based only on family structure, geography, the actuarial value of the health plan benefit, tobacco use (limited to 1.5 to 1 ratio), and age (limited to 2 to 1 ratio).
- Require plans participating in the Gateway to provide coverage for at least the essential health care benefits, meet network adequacy requirements, and make information regarding plan benefits service area, premium and cost sharing, and grievance and appeal procedures available to consumers.
- Create three benefit tiers of plans to be offered through the Gateways based on the percentage of allowed benefit costs covered by the plan:
  - Tier 1: includes the essential health benefits, covers 76% of the benefit costs of the plan, and limits out-of-pocket costs to the Health Savings Account (HSA) current law limit ($5,950 for individuals and $11,900 for families in 2010);
  - Tier 2: includes the essential health benefits, covers 84% of the benefit costs of the plan, and limits out-of-pocket costs to 50% of the HSA limit ($2,975 for individuals and $5,950 for families); and
  - Tier 3: includes the essential health benefits, covers 93% of the benefit costs of the plan, and limits out-of pocket costs to 20% of the HSA limit ($1,190 for individuals and $2,380 for families).
- Require states to adjust payments to health plans based on the actuarial risk of plan enrollees using methods established by the Secretary.
- Require the Gateway to certify participating health plans, provide consumers with information allowing them to choose among plans (including through a centralized website), contract with navigators to presenting insurance options, create a web portal to help consumers find insurance, maintain a call center for customer service, and establish procedures for enrolling individuals and businesses and for determining eligibility for tax credits. Permit exchanges to contract with state Medicaid agencies to determine eligibility for tax credits in the exchanges.
- Create four benefit categories of plans plus a separate "young invincible plan" to be offered through the exchange, and in the individual and small group markets:
  - *Bronze plan* represents minimum creditable coverage and would cover 65% of the benefit costs of the plan, with an out-of-pocket limit equal to the Health Savings Account (HSA) current law limit ($5,950 for individuals and $11,900 for families in 2010);
  - *Silver plan* includes minimum benefits, covers 70% of the benefit costs of the plan, with the HSA out-of-pocket limits;
  - *Gold plan* includes the minimum benefits, covers 80% of the benefit costs of the plan, with the HSA out-of-pocket limits;
  - *Platinum plan* includes the minimum benefits, covers 90% of the benefit costs of the plan, with the HSA out-of-pocket limits;
  - *Young Invincible plan* available to those 25 years old and younger and provides catastrophic coverage only with the coverage level set at the HSA current law levels except that prevention benefits would be exempt from the deductible.
- Reduce the out-of-pocket limits for those with incomes up to 400% FPL to the following levels:
  - 100-200% FPL: one-third of the HSA limits ($1,983/individual and $3,967/family);
  - 200-300% FPL: one-half of the HSA limits ($2,975/individual and $5,950/family);
  - 300-400% FPL: two-thirds of the HSA limits ($3,987/individual and $7,973/family).
- Permit states the option of creating a Basic Health Plan for uninsured individuals with incomes between 133-200% FPL. States opting to provide this coverage will contract with multiple private plans to provide coverage at the level of plans in the exchanges. They are encouraged to include innovative features in the contracts, such as care coordination and incentives for using preventive services and should seek to contract with managed care plans that meet specific performance measures. States will receive 85% of the funds that would have been paid as federal premium and cost-sharing subsidies for eligible individuals in the state with incomes between 133-200% FPL to establish the Basic Health Plan. Individuals with incomes between 133-200% FPL in states creating Basic Health Plans will not be eligible for subsidies in the exchanges.
- Require that at least one plan in the exchanges provide coverage for abortions beyond those for which federal funds are permitted and require that at least one plan in the exchange does not provide coverage for abortions beyond those for which federal funds are permitted (in cases of rape or incest or to save the life of the woman). Prohibit plans participating in the exchanges from discriminating against any provider because of a willingness or unwillingness to provide, pay for, provide coverage of, or refer for abortions.

		conduct outreach and enrollment assistance, create a single point of entry for enrolling in coverage through the Gateway or through Medicaid, CHIP or other federal programs, and assist consumers with the purchase of long-term care services and supports. ■ Prohibit plans participating in the Gateways from discriminating against any provider because of a willingness or unwillingness to provide abortions. ■ Following initial federal support, the Gateway will be funded by a surcharge of no more than 4% of premiums collected by participating health plans.	
Benefit design	■ Create an essential benefits package that provides a comprehensive set of services, covers 70% of the actuarial value of the covered benefits, limits annual cost-sharing to $5,000/individual and $10,000/family, does not require cost-sharing for preventive services, and does not impose annual or lifetime limits on coverage. The Health Benefits Advisory Council, chaired by the Surgeon General, will make recommendations on specific services to be covered by the essential benefits package as well as cost-sharing levels. Prohibit abortion coverage from being required as part of the essential benefits package; require segregation of public subsidy funds from private premiums payments for plans that choose to cover abortion services beyond those for which public funding is permitted (public funding of abortions is permitted to save the life of the woman and in cases of rape or incest); and require there be no effect on state or federal laws on abortions. (Health Benefits Advisory Council report due one year following enactment; essential benefits package becomes effective January 1, 2013) ■ All qualified health benefits plans, including those offered through the Exchange and those offered outside of the Exchange (except certain grandfathered individual and employer-sponsored plans) must provide at least the essential benefits package. (Effective January 1, 2013) ■ Require a report on including oral health benefits in the essential benefits package. (Report due one year following enactment)	■ Create the essential health care benefits package that provides a comprehensive array of services and prohibits inclusion of lifetime or annual limits on the dollar value of the benefits. The essential health benefits must be included in all qualified health plans and must be equal to the scope of benefits provided by a typical employer plan. Create a temporary, independent commission to advise the Secretary in the development of the essential health benefit package. ■ Specify the criteria for minimum qualifying coverage for purposes of meeting the individual mandate for coverage, and an affordability standard such that coverage is deemed unaffordable if the premium exceeds 12.5% of an individual's adjusted gross income.	■ Create minimum creditable coverage that provides a comprehensive set of services, covers 65% of the actuarial value of the covered benefits, limits annual cost-sharing to $5,950/individual and $11,900/family, does not impose annual or lifetime limits on coverage, and is not more extensive than the typical employer plan. Require the Secretary to define and annually update the benefit package through a transparent and public process. (See description of benefit categories in Creation of insurance pooling mechanism.) ■ Prohibit abortion coverage from being required as part of the minimum benefits package; require segregation of public subsidy funds from private premium payments for plans that choose to cover abortion services beyond Hyde—which allows coverage for abortion services to save the life of the woman and in cases of rape or incest; and require there be no effect on state or federal laws on abortions.
Changes to Private Insurance	■ Establish a temporary national high-risk pool to provide health coverage to individuals (and spouses and dependents) with pre-existing medical conditions. Individuals who have been denied coverage, offered unaffordable coverage, have an eligible medical condition or who have been uninsured for at least six months will be eligible to enroll in the national high-risk pool. Premiums for the high-risk pool will be set at not higher than 125% of the prevailing rate for comparable coverage in the state and could vary by no more than 2:1 due to age; annual deductibles will be limited to $1,500 for an individual; and maximum cost-sharing will be limited to $5,000 for individuals. (Effective January 1, 2010 and until the Health Insurance Exchange is established) ■ Individuals eligible for COBRA continuation coverage may retain COBRA coverage until the Exchange is established or they obtain acceptable coverage. (Effective upon enactment) ■ Limit health plans' medical loss ratio to not less than 85% to be enforced through a rebate back to consumers and prohibit plans from imposing aggregate dollar lifetime limits on coverage. (Effective January 1, 2010) Prohibit insurers from rescinding coverage except in cases of fraud. (Effective July 1, 2010) ■ Adopt standards for financial and administrative transactions to promote administrative simplification. (Effective upon enactment)	■ Impose the same insurance market regulations relating to guarantee issue, premium rating, prohibitions on pre-existing condition exclusions, and prohibitions on insurance plan rescissions in the individual and group markets and in the American Health Benefit Gateways. (See new rating and market rules in Creation of insurance pooling mechanism). ■ Require health insurers to report their medical loss ratio. ■ Require health insurers to provide financial incentives to providers to better coordinate care through case management and chronic disease management, promote wellness and health improvement activities, improve patient safety, reduce medical errors, and provide culturally and linguistically appropriate care. ■ Provide dependent coverage for children up to age 26 for all individual and group policies. ■ Require insurers and group plans to notify enrollees if	■ Impose the same insurance market regulations relating to guarantee issue, premium rating, prohibitions on pre-existing condition exclusions, risk adjustment, and rescissions in the individual market, in the exchange, and in the small group market, phasing in the new rules for small group market over five years. (See new rating and market rules in Creation of insurance pooling mechanism.) ■ Require health plans to report the proportion of premium dollars spent on items other than medical care and require plans to compile information on coverage in a standard format. ■ Require all new policies (except stand-alone dental, vision, and long-term care insurance plans) to comply with one of the four benefit categories, including those offered through the exchanges and those offered outside of the exchanges. Require health plans in the individual and small group markets to at least offer coverage in the silver and gold categories. Existing individual and employer-sponsored plans do not have to meet the new benefit standards. (See description of benefit categories in Creation of insurance pooling mechanism.) ■ Require small employers to provide a plan with a deductible that does not exceed $2,000 for individuals and $4,000 for families unless contributions are offered that offset deductible amounts above these limits. This deductible limit will not affect the actuarial value of bronze plans and does not apply to "young invincible" plans. (See description of benefit categories in Creation of insurance pooling mechanism.) ■ Allow states the option of merging the individual and small group markets. ■ Create a temporary reinsurance program to help stabilize premiums during the first three years of operation of the exchanges when the risk of adverse selection due to enforcement of the new rating rules and market changes is greatest. Finance the reinsurance program through mandatory contributions by health insurers. ■ Allow insurers to offer a national health plan with a uniform benefits package in the states in which they are licensed.

	■ Require review of increases in health insurance premiums prior to implementation of the increases. (Effective upon enactment) ■ Provide dependent coverage for children up to age 27 for all individual and group policies. (Effective January 1, 2010) ■ Limit pre-existing condition exclusions for group policies prior to implementation of the insurance market reforms by shortening the period plans can look back for pre-existing conditions from six months to 30 days and shortening the period plans can exclude coverage of certain benefits from 12 months to three months. (Effective January 1, 2010) ■ Prohibit reductions to retiree benefits unless reductions also apply to current employees. (Effective upon enactment) ■ Prohibit coverage purchased through the individual market from qualifying as acceptable coverage for purposes of the individual mandate unless it is grandfathered coverage. Individuals can purchase a qualifying health benefit plan through the Health Insurance Exchange. (Effective January 1, 2013) ■ Impose the same insurance market regulations relating to guarantee issue, premium rating, and prohibitions on pre-existing condition exclusions in the insured group market and in the Exchange. (See creation of insurance pooling mechanisms). (Effective January 1, 2013) ■ Improve consumer protections by establishing uniform marketing standards, requiring fair grievance and appeals mechanisms and accurate and timely disclosure of plan information. (Effective January 1, 2013) ■ Create the Health Choices Administration to establish the qualifying health benefits standards, establish the Exchange, administer the affordability credits, and enforce the requirements for qualified health benefit plan offering entities, including those participating in the Exchange or outside the Exchange. ■ Permit states to form Health Care Choice Compacts to facilitate the purchase of individual insurance across state lines. (Effective January 1, 2015) ■ Remove the anti-trust exemption for health insurers and medical malpractice insurers. (Effective upon enactment)	coverage does not meet minimum qualifying coverage standards for purposes of satisfying the individual mandate for coverage. ■ Permit licensed health insurers to sell health insurance policies outside of the Gateway. States will regulate these outside-the-Gateway plans.	National plans would be required to offer plans with silver and gold benefit packages and would be exempt from state benefit requirements. Allow states to opt out of the national plan. ■ Permit states to form health care choice compacts and allow insurers to sell policies in any state participating in the compact. Insurers selling policies through a compact would only be subject to the laws and regulations of the state where the policy is written or issued.
State role	■ Implement the Medicaid eligibility expansions and the specified changes with respect to provider payment rates, benefit enhancements, quality improvement, and program integrity. ■ Maintain Medicaid and CHIP eligibility standards, methodologies, or procedures that were in place as of June 16, 2009 as a condition of receiving federal Medicaid or CHIP matching payments. End CHIP maintenance of eligibility at the end of 2013. ■ Establish a Memorandum of Understanding with the Health Insurance Exchange to coordinate enrollment of individuals in Exchange-participating health plans and under the state's Medicaid program. ■ May determine eligibility for affordability credits through the Health Insurance Exchange.	■ Establish American Health Benefit Gateways meeting federal standards and adopt individual and small group market regulation changes. ■ Implement Medicaid eligibility expansions and adopt federal standards and protocols for facilitating enrollment of individuals in federal and state health and human services programs. ■ Create temporary "RightChoices" programs to provide uninsured individuals with immediate access to preventive care and treatment for identified chronic conditions. States will receive federal grants to finance these programs.	■ Require states to create health insurance exchanges for individuals and small businesses and require state insurance commissioners to provide oversight of health plans with regard to the new insurance market regulations, consumer protections, rate reviews, solvency, reserve fund requirements, and premium taxes, and to define rating areas. ■ Require states to enroll newly eligible Medicaid beneficiaries into state Medicaid programs, coordinate enrollment with the new exchanges, and implement other specified changes to the Medicaid program. Require states to maintain current Medicaid and CHIP eligibility levels for children until 2019. States must also maintain current Medicaid eligibility levels for adults above 133% FPL until 2013 and until 2014 for those with incomes at or below 133% FPL. A state is exempt from the maintenance of effort requirement for non-disabled adults with incomes above 133% FPL from January 2011 if the state certifies that it is experiencing a budget deficit or will experience a deficit in the following year. ■ Require states to establish an ombudsman office to serve as an advocate for people with private coverage in the individual and small group markets. ■ Permit states to obtain a waiver of certain new health insurance requirements if the state can demonstrate that it provides health coverage to all residents that is at least as comprehensive as the coverage required under an exchange plan and that the state plan is budget-neutral to the federal government over 10 years.
Cost containment	■ Simplify health insurance administration by adopting standards for financial and administrative transactions, including timely and transparent claims and denial management processes and use of standard electronic transactions. (Effective upon enactment) ■ Reduce market basket updates in Medicare payment rates for providers and incorporate adjustment for expected productivity gains. (Effective dates vary) ■ Reduce Medicare payments for potentially preventable hospital readmissions. (Effective	■ Establish a Health Care Program Integrity Coordinating Council, a Fraud, Waste, and Abuse Commission, and two new federal department positions to oversee and coordinate policy, program development, and oversight of health care fraud, waste, and abuse in public and private coverage. ■ Simplify health insurance administration by adopting	■ Restructure payments to Medicare Advantage plans to base payments on plan bids with bonus payments for quality, performance improvement, and care coordination. Grandfather the extra benefits in MA plans in areas where plan bids are at or below 75% of traditional fee-for-service Medicare (these plans are required to participate in the new competitive bidding process). Provide transitional extra benefits for MA beneficiaries in certain areas if they experience a significant reduction in extra benefits under competitive bidding. ■ Reduce annual market basket updates for inpatient hospital, home health, skilled nursing facility, hospice and other Medicare providers, and adjust for productivity. ■ Freeze the threshold for income-related Medicare Part B

	October 1, 2011) ■ Restructure payments to Medicare Advantage plans (except for PACE plans), phasing down to equal 100% of fee-for-services payments by 2013, with bonus payments for higher-quality and improved-quality plans in qualifying counties. (Effective FY 2011). ■ Increase the Medicaid drug rebate percentage to 23.1% 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 to help close the Part D coverage gap. (Effective January 1, 2010) ■ Require the Secretary to negotiate drug prices directly with pharmaceutical manufacturers for Medicare Part D plans. (Effective upon enactment; applies to drug prices beginning on January 1, 2011) ■ Reduce Medicaid DSH allotments by a total of $10 billion ($1.5 billion in 2017; $2.5 billion in 2018; and $6 billion in 2019), imposing the largest percentage reductions in state DSH allotments in states with the lowest uninsured rates and those that do not target DSH payments. Reduce Medicare DSH payments to account for reductions in the national rate of uninsurance as a result of the Act, based on recommendation by the Secretary. (Medicare DSH reductions effective 2017) ■ Require the Institute of Medicine to conduct a study on geographic variation in health care spending across all providers and recommend changes to Medicare payments that promote high-value care; require the Secretary to develop an implementation plan and issue regulations to implement the Medicare payment changes unless Congress acts to stop implementation. (Report due April 15, 2011; final implementation plan due 240 days following receipt of report; regulations issued by May 31, 2012) ■ Authorize the Food and Drug Administration to approve generic versions of biologic drugs and grant biologics manufacturers 12 years of exclusive use before generics can be developed. (Effective upon enactment) ■ Enhance competition in the pharmaceutical market by stopping agreements between brand name and generic drug manufacturers that limit, delay, or otherwise prevent competition from generic drugs. (Effective upon enactment) ■ Require hospitals and ambulatory surgical centers to report on health care-associated infections to the Centers for Disease Control and Prevention (effective one year following enactment) and refuse Medicaid payments for certain health care-associated conditions. (Effective January 1, 2010) ■ Reduce waste, fraud, and abuse in public programs by allowing provider screening, enhanced oversight periods, and enrollment moratoria in areas identified as being at elevated risk of fraud in all public programs, and by requiring Medicare and Medicaid program providers and suppliers to establish compliance programs. (Effective dates vary)	standards for financial and administrative transactions, including timely and transparent claims and denial management processes and use of standard electronic transactions.	premiums through 2019, and reduce the Medicare Part D premium subsidy for those with incomes above $85,000/individual and $170,000/couples. ■ Establish an independent Medicare Commission to submit proposals for reducing excess Medicare cost growth by targeted amounts. Proposals submitted by the Commission must be acted on by Congress and if a legislative package with the targeted level of Medicare savings is not enacted, the Commission's proposal will go into effect automatically. The Commission would be prohibited from submitting proposals that would ration care, increase revenues or change benefits, eligibility or Medicare beneficiary cost sharing (including Parts A and B premiums), but would not be prohibited from making recommendations to reduce premium subsidies for Medicare Advantage or stand-alone Part D prescription drug plans. Hospitals and hospices would not be subject to cost reductions proposed by the Commission. Beginning January 1, 2019, the growth target for Medicare spending would be set at GDP per capita plus one percent. ■ Reduce Medicare DSH payments by an amount proportional to the percentage point decrease in the uninsured for the period evaluated. ■ Eliminate the Medicare Improvement Fund. ■ Allow providers organized as accountable care organizations (ACOs) that voluntarily meet quality thresholds to share in the cost-savings they achieve for the Medicare program. To qualify as an ACO, organizations must agree to be accountable for the overall care of their Medicare beneficiaries, have adequate participation of primary care physicians and specialists, define processes to promote evidence-based medicine, report on quality and costs measure, and coordinate care. Create a chronic care coordination pilot program to provide the highest cost Medicare beneficiaries with primary care services in their home and allow participating teams of health professionals to share in any savings if they achieve quality outcomes, patient satisfaction, and cost savings. ■ Create an Innovation Center within the Centers for Medicare and Medicaid Services to test, evaluate, and expand in Medicare, Medicaid, and CHIP different payment structures and methodologies to foster patient-centered care, improve quality, and slow Medicare costs growth. Payment reform models that improve quality and reduce the rate of costs could be expanded throughout the Medicare, Medicaid, and CHIP programs. ■ Reduce payments for preventable hospital readmissions in Medicare: for hospitals with readmission rates above a certain threshold reduce payments by 20% if a patient is re-hospitalized with a preventable readmission within seven days and by 10% if a patient is re-hospitalized with a preventable readmission within 15 days, and reduce payments by 1% to hospitals with the highest rates of hospital acquired conditions. ■ Increase the Medicaid drug rebate percentage for brand name drugs to 23.1, increase the Medicaid rebate for non-innovator, multiple source drugs to 13% of average manufacturer price, and extend the drug rebate to Medicaid managed care plans. ■ Reduce a state's Medicaid DSH allotment by 50% (25% for low DSH states) once the uninsured rate decreases by at least 50%. DSH allotments will be further reduced, not to fall below 35% of the total allotment in 2012 if states' uninsured rates continue to decrease. Exempt any portion of the DSH allotment used to expand Medicaid eligibility through a section 1115 waiver. ■ Establish demonstration projects in Medicaid and CHIP to allow pediatric medical providers organized as accountable care organizations to share in cost-savings. ■ Prohibit federal payments to states for Medicaid services related to health care acquired conditions. ■ Eliminate fraud, waste, and abuse in public programs through more intensive screening of providers, the development of the "One PI database" to capture and share data across federal and state programs, increased penalties for submitting false claims, and increase funding for anti-fraud activities.
Improving quality / health system performance	■ Support comparative effectiveness research by establishing a Center for Comparative Effectiveness Research within the Agency for Healthcare Research and Quality to conduct, support, and synthesize research on outcomes, effectiveness, and appropriateness of health care services and procedures. An independent CER Commission will oversee the activities of the Center. Provides that comparative effectiveness research findings may not be construed as mandates for payment, coverage, or treatment or used to deny or ration care. Establish the Comparative Effectiveness Research Trust Fund. (Effective FY 2010) ■ Provide incentive payments to states that enact alternative medical liability laws that make the medical liability system more reliable through the prevention of or prompt and fair resolution of disputes, encourage the disclosure of health care errors, and maintain access to affordable liability insurance.	■ Develop a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health. Publish an annual national health care quality report card. Create an inter-agency Working Group on Health Care Quality to coordinate and streamline federal quality activities related to the national quality strategy. ■ Develop, through a multi-stakeholder process, quality measures that allow assessments of health outcomes; continuity and coordination of care; safety, effectiveness and timeliness	■ Simplify health insurance administration by adopting a single set of operating rules for eligibility verification, claims status, claims payment, and the electronic transfer of funds. ■ Establish a non-profit Patient-Centered Outcomes Research Institute to identify research priorities and conduct research that compares the clinical effectiveness of medical treatments. The Institute will be overseen by an appointed multi-stakeholder Board of Governors and will be assisted by expert advisory panels. ■ Encourage states to develop and test alternatives to the current civil litigation system as a way to improve patient safety, reduce medical errors, increase the availability of a prompt and fair resolution of disputes, and improve access to liability insurance, while preserving an individual's right to seek redress in court. Recommend that Congress consider establishing a state demonstration project to evaluate alternatives to the current litigation system. ■ Establish a national Medicare pilot program to develop and evaluate paying a bundled payment for acute, inpatient hospital services and post-acute care services for an episode of care that begins three days prior to a hospitalization and spans

	(Effective upon enactment) ■ Strengthen primary care and care coordination by increasing Medicaid payments for primary care providers to 100% of Medicare rates (phased-in beginning in 2010 through 2012) and providing Medicare bonus payments to primary care practitioners (with larger bonuses paid to primary care practitioners serving in health professional shortage areas) beginning January 1, 2011. ■ Require the Secretary to develop a plan to reform Medicare payments for post-acute services, including bundled payments, to improve the coordination, quality and efficiency of such services and improve outcomes. (Effective January 1, 2011) ■ Conduct Medicare and Medicaid pilot program to test payment incentive models for accountable care organizations and to assess the feasibility of reimbursing qualified patient-centered medical homes. Adopt these models on a large scale if pilot programs prove successful at reducing costs. (Implementation of medical home pilots upon enactment; implementation of accountable care organization pilots by January 1, 2012) ■ Establish the Center for Medicare and Medicaid Innovation to test payment and service delivery models to improve quality and efficiency. Evaluate all models and expand those models that improve quality without increasing spending or reduce spending without reducing quality, or both. (Effective January 1, 2011) ■ Require the Institute of Medicine to conduct a study on geographic adjustment factors in Medicare and require the Secretary to issue regulations to revise the geographic adjustment factors based on the recommendations. (Report due one year following enactment; proposed regulations issued following submission of report) ■ Require the Secretary to improve coordination of care for dual eligibles through a new office or program within the Centers for Medicare and Medicaid Services. (Report of activities due within one year of enactment) ■ Establish the Center for Quality Improvement to identify, develop, evaluate, disseminate, and implement best practices in the delivery of health care services. Develop national priorities for performance improvement and quality measures for the delivery of health care services. (Effective dates vary) ■ Establish the Community-based Collaborative Care Network Program to support consortiums of health care providers to coordinate and integrate health care services, manage chronic conditions, and reduce emergency department use for low-income uninsured and underinsured populations. (Funds appropriated for five years beginning FY 2011) ■ 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. (Effective March 2011) ■ Reduce racial and ethnic disparities by conducting a study on the feasibility of developing Medicare payment systems for language services, providing Medicare demonstration grants to reimburse culturally and linguistically appropriate services and developing standards for the collection of data on race, ethnicity, and primary language. (Report due to Congress one year following enactment)	of care; health disparities; and appropriate use of health care resources. Require public reporting on quality measures through a user-friendly website. ■ Create a Center for Health Outcomes Research and Evaluation within the Agency for Healthcare Research and Quality to conduct and support research on the effectiveness of health care services and procedures to provide providers and patients with information on the most effective therapies for preventing and treating health conditions. The Center will be overseen by an appointed multi-stakeholder advisory council. ■ Provide grants for improving health system efficiency, including grants to establish community health teams to support a medical home model; to implement medication management services for treatment of chronic conditions; to design and implement regional emergency care and trauma systems. ■ Require hospitals to report preventable readmission rates; hospitals with high re-admission rates will be required to work with local patient safety organizations to improve their rates. ■ Create a Patient Safety Research Center charged with identifying, evaluating, and disseminating information on best practices for improving health care quality. ■ Develop interoperable standards for using HIT to enroll individuals in public programs and provide grants to states and other governmental entities to adopt and implement enrollment technology. ■ Require enhanced collection and reporting of data on race, ethnicity, gender, geographic location, primary language, and underserved rural and frontier populations.	30 days following discharge. If the pilot program achieves stated goals, develop a plan for making the pilot a permanent part of the Medicare program. ■ Establish a hospital value-based purchasing program in Medicare to pay hospitals based on performance on quality measures and extend the Medicare physician quality reporting initiative beyond 2010. ■ Improve care coordination for dual eligibles by creating a new office within the Centers for Medicare and Medicaid services, the Federal Coordinated Health Care Office, to align Medicare and Medicaid benefits, administration, oversight rules, and policies for dual eligibles. ■ Develop a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health. Create processes for the development of quality measures involving input from multiple stakeholders and for selecting quality measures to be used in reporting to and payment under federal health programs. Establish the Medicaid Quality Measurement Program to establish priorities for the development and advancement of quality measures for adults in Medicaid. ■ 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.
Prevention / Wellness	■ Develop a national strategy to improve the nation's health through evidenced-based clinical and community-based prevention and wellness activities. Create task forces on Clinical Preventive Services and Community Preventive Services to develop, update, and disseminate evidenced-based recommendations on the use of clinical and community prevention services. ■ Improve prevention by covering only proven preventive services and eliminating cost-sharing for preventive services in Medicare and Medicaid. (Effective July 1, 2010) Increase Medicare payments for certain	■ Develop a national prevention and health promotion strategy that sets specific goals for improving health. Create a prevention and public health investment fund to expand and sustain funding for prevention and public health programs. ■ Award competitive grants to state and local governments and community-based organizations to implement and evaluate proven	■ Provide Medicare beneficiaries access to a comprehensive health risk assessment and creation of a personalized prevention plan, eliminate cost-sharing for certain preventive services in Medicare. Cover only proven preventive services in Medicare and Medicaid and provide incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs. ■ Require Medicaid coverage for tobacco cessation services for pregnant women, and for states that provide coverage for and remove cost-sharing for preventive services recommended by the US Preventive Services Task Force and recommended immunizations, provide a one percentage point increase in the FMAP for these services and for the tobacco cessation services.

	preventive services to 100% of actual charges or fee schedule rates. (Effective January 1, 2011) ■ Provide wellness grants for up to three years to small employers for up to 50% of costs incurred for a qualified wellness program. (Effective July 1, 2010) ■ Establish a grant program to support the delivery of evidence-based and community-based prevention and wellness services aimed at reducing health disparities. Train community health workers to promote positive health behaviors in medically underserved communities. Provide grants to plan and implement programs to prevent obesity among children and their families. (Funds appropriated for five years beginning FY 2011) ■ Require chain restaurants and food sold from vending machines to disclose the nutritional content of each item. (Proposed regulations issued within one year of enactment)	community preventive health activities to reduce chronic disease rates and address health disparities. ■ Prohibit insurance plans from charging cost-sharing (except minimal cost-sharing) for preventive services. Permit insurers to create incentives for health promotion and disease prevention practices. ■ Permit employers to offer employees rewards—in the form of premium discounts, waivers of cost-sharing requirements, or benefits that would otherwise not be provided—of up to 30% of the cost of coverage for participating in a wellness program and meeting certain health-related standards. Employers must offer an alternative standard for individuals for whom it is unreasonably difficult or inadvisable to meet the standard. The limit may be increased to 50% of the cost of coverage if deemed appropriate. Encourage employers to provide wellness programs by conducting targeted educational campaigns to raise awareness of the value of these programs. ■ Provide grants to states to create temporary Right Choices Programs to provide uninsured adults with incomes below 350% FPL access to a one-time health risk appraisal, referrals for preventive services, and referrals to safety net providers for treatment of diagnosed illnesses. ■ Establish a 5-year national public education campaign focused on preventing oral disease and award grants to demonstrate the effectiveness of research-based dental caries disease management activities.	■ Create a new Medicaid state plan option to permit Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a health home. Provide states taking up the option with 90% FMAP for two years. ■ Prohibit insurance plans (except existing grandfathered plans and those that use a value-based insurance design) from charging cost-sharing for preventive services. ■ Allow insurers to vary premium rates based on tobacco use. Any insurer that rates based on tobacco use must provide coverage for comprehensive tobacco cessation programs, including counseling and pharmacotherapy. ■ Provide grants to small businesses to establish comprehensive, evidence-based workplace wellness programs. ■ Permit employers to offer employees rewards of up to 30% of the cost of coverage for participating in a wellness program. Rewards may be in the form of premium discounts, waivers of cost-sharing requirements, or benefits that would otherwise not be provided. Rewards may be increased to 50% of the cost of coverage if a report finds the increase appropriate. Establish 10-state pilot programs in 2014 to permit participating states to apply similar rewards for participating in wellness programs in the individual market.
Long-term Care	■ Establish a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program). Following a five-year vesting period, the program will provide individuals with functional limitations a cash benefit of not less than an average of $50 per day to purchase non-medical services and supports necessary to maintain community residence. The program is financed through voluntary payroll deductions: all working adults will be automatically enrolled in the program, unless they choose to opt-out. (Effective 2010) ■ Establish a three-year demonstration program in four states to evaluate the effectiveness of recommended core competencies for personal and home care aides and training curriculum and methods to provide long-term services and supports. (Demonstration program established within 180 days of issuance of recommendations) ■ Improve transparency of information about skilled nursing facilities and nursing facilities. (Disclosure reporting regulations issued within two years of enactment; reporting of information required 90 days after regulations are issued)	■ Establish a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program). The program will provide individuals with functional limitations a cash benefit to purchase non-medical services and supports necessary to maintain community residence. The program is financed through voluntary payroll deductions: all working adults will be automatically enrolled in the program, unless they choose to opt-out.	■ Extend the Medicaid Money Follows the Person Rebalancing Demonstration program through September 2016 and allocate $10 million per year for five years to continue the Aging and Disability Resource Center initiatives. ■ Provide states that undertake reforms to increase nursing home diversions and access to home and community-based services in their Medicaid programs with a targeted increase in the federal matching rate for five years. ■ Establish the Community First Choice Option in Medicaid to provide community-based attendant supports and services to individuals with disabilities who require an institutional level of care. Provide states with an enhanced federal matching rate of an additional six percentage points for reimbursable expenses in the program. Sunset the option after five years. ■ Improve transparency of information about skilled nursing facilities (SNF) and nursing homes, enforcement of SNF and nursing home standards and rules, and training of SNF and nursing home staff.
Other investments	■ Make improvements to the Medicare program: ■ Modify the initial coverage limit and catastrophic thresholds to reduce the coverage gap by $500 in 2010 and eventually eliminate the Medicare Part D coverage gap by 2019; require drug manufacturers to provide a 50% discount on brand-name prescriptions filled in the	■ Establish a National Health Care Workforce Commission to make recommendations and disseminate information on health workforce priorities, goals, and policies including education and training, workforce supply and demand, and retention	■ Make improvements to the Medicare program: ■ Provide a 50% discount on brand-name prescriptions filled in the Medicare Part D coverage gap for enrollees, other than those who receive low-income subsidies and those with incomes above $85,000/individual and $170,000/couples; ■ Make Part D cost-sharing for full-benefit dual eligible beneficiaries receiving home and community-based care services equal to the cost-sharing for those who receive institutional care; and

	coverage gap. (Effective January 1, 2010). ■ Increase the asset test threshold for Medicare Savings Program and Part D Low-Income Subsidies to $17,000 per individual and $34,000 per couple. (Effective 2012) ■ Cover through Medicaid the Part B deductible and cost-sharing for Medicare beneficiaries under age 65 with incomes below 150% FPL (and resources at or below two times the SSI level); finance these costs with 100% federal funding in 2013 and 2014 and 91% federal funding in subsequent years. (Effective January 1, 2013) ■ Improve workforce training and development: ■ Establish a multi-stakeholder Advisory Committee on Health Workforce Evaluation and Assessment to develop and implement a national health workforce strategy. (Funds appropriated beginning FY 2011) ■ Reform Graduate Medical Education to increase training of primary care providers by redistributing residency positions and promote training in outpatient settings, including through a Teaching Health Center demonstration project. (Effective July 1, 2011) ■ Support training of health professionals through scholarships and loans; establish a primary care training and capacity building program; establish a loan repayment program for professionals who work in health professions needs areas; establish a public health workforce corps; promote training of a diverse workforce; and provide cultural competence training for health care professionals. Support the development of interdisciplinary mental and behavioral health training programs and establish a training program for oral health professionals. (Funds appropriated beginning FY 2011) ■ Address the projected shortage of nurses and retention of nurses by increasing the capacity for education, supporting training programs, providing loan repayment and retention grants, and creating a career ladder to nursing. ■ Support the development of interdisciplinary health training programs that focus on team-based models, including medical home models and models that integrate physical, mental, and oral health services. (Funds appropriated beginning FY 2011) ■ Establish the Public Health Investment Fund for financing designated public health provisions. (Initial appropriation in FY 2011) ■ Establish a new trauma center program to strengthen emergency department and trauma center capacity and to establish new trauma centers in urban areas with substantial trauma related to violent crimes. Create an Emergency Care Coordination Center within HHS; develop demonstration programs to design, implement, and evaluate innovative models for emergency care systems. (Funds appropriated for five years beginning in FY 2011) ■ Improve access to care by increasing funding by $12 billion over five years for community health centers; establish new programs to support school-based health centers (effective July 1, 2010) and nurse-managed health centers (effective 2011), and set criteria for the certification of federally qualified behavioral health centers. ■ Provide grants to each state health department to address core public health infrastructure needs. (Funds appropriated for five years beginning FY 2011) ■ Reauthorize and amend the Indian Health Care Improvement Act. (Effective dates vary)	practices ■ Increase the supply of health care professionals by increasing loans for nursing students and establishing loan repayment programs for public health workers and pediatric specialists. Expand funding for the National Health Service Corps. ■ Support training of health professionals in direct care, primary care, and dentistry; provide health education and training grants for professionals in geriatric care and mental and behavioral health; and provide prevention, public health, and cultural competence training for health care professionals. ■ Improve access to care by providing additional funding to increase the number of community health centers and school-based health centers and nurse-managed health clinics.	■ Provide a one-year increase in physician payments under Medicare to prevent a reduction in fees that would otherwise take effect, with 10% bonus payments for primary care. Provide general surgeons and primary care physicians practicing in health professional shortage areas with a 10% Medicare bonus. ■ Establish a multi-stakeholder Workforce Advisory Committee to develop a national workforce strategy for recruiting, training, and retaining a health care workforce that meets current and projected health care needs. ■ Increase the number of Graduate Medical Education (GME) training positions by redistributing currently unused slots, with priorities given to primary care and general surgery and to states with the lowest resident physician-to-population ratios, and increase flexibility in laws and regulations that govern GME funding to promote training in outpatient settings, and ensure the availability of residency programs in rural and underserved areas. Establish Teaching Health Centers, defined as community-based, ambulatory patient care centers, including federally qualified health centers and other federally-funded health centers, that are eligible for Medicare payments for the expenses associated with operating primary care residency programs. ■ Establish a graduate nurse education demonstration program to provide Medicare reimbursement to hospitals for costs associated with training advance practice nurses. ■ Impose additional requirements on non-profit hospitals to conduct a community needs assessment every three years and adopt an implementation strategy to meet the identified needs, adopt and widely publicize a financial assistance policy that indicates whether free or discounted care is available and how to apply for the assistance, limit charges to patients who qualify for financial assistance to the amount generally billed to insured patients, and make reasonable attempts to inform patients about the financial assistance policy before undertaking extraordinary collection actions.
Financing	The Congressional Budget Office estimates the net cost of the proposal (less payments from employers and uninsured individuals) to be $894 billion over ten years. These costs are financed through a combination of savings from Medicare and Medicaid and new taxes and fees. The net savings from Medicare and Medicaid are estimated to be $426 billion over ten years and the primary sources of these savings include incorporating productivity improvements into	The Congressional Budget Office estimates this proposal will cost $645 billion over 10 years. Because the Senate HELP Committee does not have jurisdiction over the Medicare and Medicaid programs or revenue raising authority,	CBO estimates the cost of the coverage components of the Chairman's Mark, as amended during mark-up, to be $829 billion over ten years. These costs are financed through a combination of savings from Medicare and Medicaid and new taxes and fees. The net savings from Medicare and Medicaid are estimated to be $404 billion over ten years and the primary sources of these savings include incorporating productivity improvements into Medicare market basket updates, reducing payments to Medicare Advantage plans, creating the Medicare Commission charged with finding savings in the program, changing the Medicaid drug

	Medicare market basket updates, reducing payments to Medicare Advantage plans, changing the Medicaid drug rebate provisions, and cutting Medicaid and Medicare DSH payments. (See descriptions of cost savings provisions in Cost containment.) The largest source of new revenue will come from a 5.4% surcharge imposed on families with incomes above $1,000,000 and individuals with incomes above $500,000, which is projected to raise $461 billion in revenue. Additional revenue provisions will generate $97 billion over the same time period. (See Tax changes related to health insurance.) CBO estimates the proposal will reduce the deficit by $104 billion over ten years.	mechanisms for financing the proposal will be developed in conjunction with the Senate Finance Committee.	rebate provisions, and cutting Medicaid and Medicare DSH payments. (See descriptions of cost savings provisions in Cost containment.) The largest source of new revenue will come from an excise tax on high cost insurance, which CBO estimates will raise $201 billion over ten years. Additional revenue provisions will generate $196 billion over the same time period. (See Tax changes related to health insurance.) CBO estimates the proposal will reduce the deficit by $81 billion over ten years.
Sources of information	Ways and Means Committee http://waysandmeans.house.gov Energy and Commerce Committee: http://energycommerce.house.gov Education and Labor Committee http://edlabor.house.gov/	http://help.senate.gov/	http://www.finance.senate.gov/sitepages/baucus.htm