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

Sara R. Collins, Karen Davis, Rachel Nuzum,
Sheila D. Rustgi, Stephanie Mika, and Jennifer L. Nicholson

October 2009
revised November 4, 2009

ABSTRACT: This report provides an overview of key provisions of the two comprehensive health reform bills passed by the five committees of jurisdiction in the U.S. Congress: the Finance Committee and the Health, Education, Labor, and Pensions (HELP) Committee of the Senate, and the Ways and Means, Education and Labor, and Energy and Commerce committees of the House of Representatives. While the general frameworks of the bills are very similar—all bills 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 Finance Committee bill does not include a public plan option or a requirement that employers offer coverage; the House bill and the Senate HELP bill both include all of these features.

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff. To learn more about new Commonwealth Fund publications when they become available, visit the Fund's Web site and register to receive e-mail alerts. Commonwealth Fund pub. no. 1333.

CONTENTS

LIST OF FIGURES AND TABLES

ABOUT THE AUTHORS

Sara R. Collins, Ph.D., is vice president at The Commonwealth Fund. An economist, she is responsible for survey development, research, and policy analysis, as well as program development and management of the Fund's Affordable Health Insurance program. Prior to joining the Fund, Dr. Collins was associate director/senior research associate at the New York Academy of Medicine, Division of Health and Science Policy. Earlier in her career, she was an associate editor at *U.S. News & World Report,* a senior economist at Health Economics Research, and a senior health policy analyst in the New York City Office of the Public Advocate. She holds an A.B. in economics from Washington University and a Ph.D. in economics from George Washington University. She can be e-mailed at src@cmwf.org.

Karen Davis, Ph.D., is president of The Commonwealth Fund. She is a nationally recognized economist with a distinguished career in public policy and research. In recognition of her work, Ms. Davis received the 2006 AcademyHealth Distinguished Investigator Award. Before joining the Fund, she served as chairman of the Department of Health Policy and Management at The Johns Hopkins Bloomberg School of Public Health, where she also held an appointment as professor of economics. She served as deputy assistant secretary for health policy in the Department of Health and Human Services from 1977 to 1980, and was the first woman to head a U.S. Public Health Service agency. A native of Oklahoma, she received her doctoral degree in economics from Rice University, which recognized her achievements with a Distinguished Alumna Award in 1991. Ms. Davis has published a number of significant books, monographs, and articles on health and social policy issues, including the landmark books *Health Care Cost Containment; Medicare Policy; National Health Insurance: Benefits, Costs, and Consequences;* and *Health and the War on Poverty.* She can be e-mailed at kd@cmwf.org.

Rachel Nuzum, M.P.H., is the senior policy director for The Commonwealth Fund and the Commission on a High Performance Health System. In this role, she is responsible for implementing the Fund's national policy strategy for improving health system performance, including building and fostering relationships with congressional members and staff and members of the executive branch to ensure that the work of the Fund and its Commission on a High Performance Health System informs their deliberations. Her work also includes fostering public–private collaboration on health system performance improvement, especially with national associations of key stakeholders. Previously, she headed the Fund's program on State Innovations. Ms. Nuzum has over 10 years of experience working in health policy at the federal, state, and local levels of government

as well as in the private sector. Immediately prior to joining the Fund, she was a legislative assistant for Senator Maria Cantwell (D–Wash.), serving as a policy adviser on health, retirement, and tax issues. She holds a B.A. in political science from the University of Colorado and an M.P.H. in Health Policy and Management from the University of South Florida. She can be e-mailed at rn@cmwf.org.

Sheila D. Rustgi is a program associate for the Affordable Health Insurance program at The Commonwealth Fund. She is a graduate of Yale University with a B.A. in economics. While in school, she volunteered in several local and international health care organizations, including Yale-New Haven Hospital and a Unite for Sight eye clinic. Prior to joining the Fund, she worked as an analyst at a management consulting firm.

Stephanie Mika is a program associate for The Commonwealth Fund. Ms. Mika graduated from Stanford University in June 2006 with a B.A. in human biology. At Stanford, she was head course associate for the human biology program and taught weekly sections with lecture topics including social theory, cultural anthropology, population growth, economics, health care, and health policy. She also served as research assistant at the Center for Infant Studies, where she earned the Firestone Medal for Excellence in Undergraduate Research.

Jennifer L. Nicholson, M.P.H., is associate program officer for the Affordable Health Insurance program at The Commonwealth Fund, where she is responsible for project development and grants management, and is also involved in researching emerging policy issues regarding the extent and quality of health insurance coverage and access to care in the United States, researching and writing reports and articles, and survey development and analysis. She holds a B.S. in public health from the University of North Carolina at Chapel Hill and an M.P.H. in epidemiology from Columbia University's Mailman School of Public Health.

ACKNOWLEDGMENTS

The authors gratefully acknowledge the contributions of Katie Horton, William Scanlon, Steven Stranne, and Emily Strunk at HealthPolicy R&D for their analyses of the bills, and Stuart Guterman of The Commonwealth Fund for helpful comments.

Editorial support was provided by Chris Hollander.

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 major 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 Senate, the Health, Education, Labor, and Pensions (HELP) Committee passed its bill in July and the Finance Committee passed its bill on October 13. 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 October 29, 2009, Speaker Pelosi introduced the blended House bill, H.R. 3962, for floor consideration.

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 more detailed descriptions of these provisions in Appendix A, Appendix B, and Appendix C (separately available on the Fund's Web site). It also discusses estimates prepared by the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) of the number of people potentially covered under the bills and the projected effect on the federal budget. Forthcoming Commonwealth Fund reports will analyze the coverage, system reform, and financing implications of these proposals in more detail.

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; and 3) slowing the rise in health care costs for employers, families, and government.[1] 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,[2] 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] 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 between 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 also 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, among them 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.[4] 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 their income that they could be considered underinsured; this represents an increase of 9 million adults since 2003.[5] 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 the cost.[6] The relentless growth in health care costs, combined with the severe downturn in the economy, has almost certainly deepened the health insurance crisis facing families across the country, with little relief in the future. If current cost trends continue, the average family premium for employer plans is expected to nearly double by 2020.[7]

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. For example, the U.S. is failing to keep pace with the gains in health outcomes being achieved by other countries: the U.S. is now in last place, behind 18 other nations, on "mortality amenable to health care" before age 75, or deaths that are potentially preventable with timely, effective health care or with early efforts to screen and prevent the onset of disease.[8] The gap between the U.S. and those 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.[9]

OVERALL APPROACH OF THE CONGRESSIONAL HEALTH REFORM BILLS

Health Insurance Reforms

The bills passed by the Senate Finance and HELP committees and the three House committees all 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 October 2009

	Senate Finance Committee 10/13/09 (as amended)	Senate HELP Committee 7/15/09 (as amended)	House of Representatives 10/29/09
Insurance market regulations	GI, adjusted CR 4:1; 5-yr phase-in for small group; report medical loss ratio; uninsured eligible for high-risk pools until 2013	GI, adjusted CR 2:1; meet medical loss standards	GI, adjusted CR 2:1; meet 85% medical loss ratio; uninsured immediately eligible for high-risk pools
Individual mandate	Penalty: $750/year per adult in household phased in at $200 in 2014, $400 in 2015, $600 in 2016, $750 in 2017; exempts premiums >8% of income	Penalty: $750/year per person (exemptions if unaffordable)	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	State or regional	State or regional	National or state
Plans offered	Private and co-op	Private and public	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 < 50	Individuals and small businesses <25 in 2013; <50 by 2014; <100 by 2015: 100+ after 2015
Minimum benefit standard, tiers	Essential health benefits 65%-90% actuarial value, Four tiers plus young adults policy	Essential health benefits 76%–93% actuarial value, three tiers	Essential health benefits 70%–95% actuarial value, four tiers
Premium/cost-sharing assistance	Sliding scale 2%–12% of income up to 300% FPL/ flat cap at 12% for 300%–400% FPL; cost-sharing credits for 100%–200%FPL	Sliding scale 1%–12.5% of income up to 400% 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	Up to 150% FPL
Shared responsibility/ Employer pay-or-play	Firms >50 FTEs pay uncovered worker fee Small-employer tax credit including nonprofit firms	Play or pay; firms >25 workers 60%+ premium contribution; penalty $750/yr per uncovered FTE, $375/yr per uncovered PTE Small-employer subsidy; 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

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

Insurance Market Regulation

Each bill 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 Senate HELP bills and 4:1 in the Senate Finance Committee bill) and family structure. The House and Senate HELP bills would require qualified health benefits plans to meet a medical loss ratio standard; the Senate Finance Committee bill would make information about medical loss ratios public but would not set a standard.

Insurance Market Exchange

Each bill 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 that meet the requirements of participation set by the exchange.[10] 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 Finance bills and plans with less cost-sharing in the Senate HELP bill 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 bills call for states or regions to create and operate exchanges within federal guidelines.

Choice of plan. The most important difference in the exchanges to be established by the bills is the provision of a choice of private and public plans. The House bill and Senate HELP bill would include a public plan ("public option") in the exchange, in addition to private plans, while the Senate Finance bill would not. 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, as would the Senate HELP bill, which would set a ceiling at prices paid by the average commercial insurer. In the House bill, 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. Private plans under the Senate HELP bill would be required to implement a payment structure that provides increased reimbursement or other market-based incentives to reward quality and to pursue activities, with guidelines established by the secretary, that would improve health outcomes, prevent hospital readmissions, improve patient safety, and reduce medical errors.

The Senate Finance Committee bill does not include a public plan. Instead, it offers new state-level, nonprofit, private insurance cooperatives. The House bill creates a Consumer Operated and Oriented Plan (CO-OP) program in addition to the public plan.

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 three to 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. In the Senate HELP bill, actuarial values are .76 to .93, and in the Senate Finance plan they are .65 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 Finance bill requires families above the poverty level to contribute no more than 2 percent of income, a share that increases to no more than 12 percent of income for those at three to four times the poverty level. The Senate HELP bill provides premium credits on a sliding scale up to 400 percent of poverty, such that premiums are no more than 1 percent of income for people at 150 percent of poverty or less and no more than 12.5 percent of income for those at 400 percent of poverty.

In addition to premium subsidies, the House and Senate Finance 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 Finance 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. The Senate HELP bill would tie its sliding-scale premium subsidies to plans with less cost-sharing, such that people with lower incomes would be enrolled in plans with higher actuarial values.

Medicaid Expansion

Coverage under Medicaid would be expanded up to 150 percent of the federal poverty level (about $30,000 for a family of four) under the House bill and the Senate HELP Committee bill. The Senate Finance bill would raise eligibility to 133 percent of poverty.

In the House bill, individuals who are eligible for Medicaid are not also eligible to obtain subsidized coverage through the insurance exchange. The Senate Finance bill would eventually allow people earning between 100 percent and 133 percent of poverty the option to enroll in Medicaid or subsidized coverage through the exchange.

The House bill provides 100 percent federal financing of Medicaid expansions through 2014, then 91 percent financing beginning in 2015. The Senate Finance bill provides more limited federal financing for adults over the poverty level who are already covered by states than it does for adults newly eligible for Medicaid; the bill also requires all states to share in the cost of expanded coverage.

Individual Responsibility

Americans would be required to have health insurance coverage. The House bill has a higher penalty for failure to meet this shared responsibility than the Senate bills have: it requires adults who do not obtain insurance to 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 their the tax-filing threshold, up to the cost of the average national premium for the "basic" benefit plan. The Senate HELP bill would have uninsured individuals pay up to $750 per year, while the Senate Finance bill begins with a $200-per-year contribution in 2014, phasing up to $750 in 2017. Hardship exemptions are provided in the Senate Finance bill for those individuals for whom the premium would exceed 8 percent of their income; in the Senate HELP bill, the threshold is set at 12.5 percent of income. There are unspecified exceptions for financial hardship in the House bill.

Employer Shared Responsibility

Under the House and Senate HELP bills, 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 Finance bill does not set standards on employer coverage but does require 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 bill requires employers (and all other health plans) to include dependents up to age 27.

The Senate HELP bill requires employers to offer health coverage that meets the federal standard of "minimum qualifying coverage" and to contribute at least 60 percent of the premium cost. Employers that do not meet this requirement would pay $750 annually for each full-time employee who is not offered health benefits, and $375 for each uncovered part-time worker. The bill also requires employers to include dependents up to age 26. The Senate Finance bill does not set standards on employer qualifying coverage but does require firms with 50 or more full-time employees to pay if employees obtain subsidized coverage through the exchange (the lower of the average national premium subsidy times the number of employees receiving the subsidy, or $400 per employee for all employees).

Small businesses. Very 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. The Senate HELP bill exempts small businesses with fewer than 25 employees from the mandate. As noted above, the Senate Finance Committee exempts firms with fewer than 50 employees from any obligations to provide or contribute to coverage.

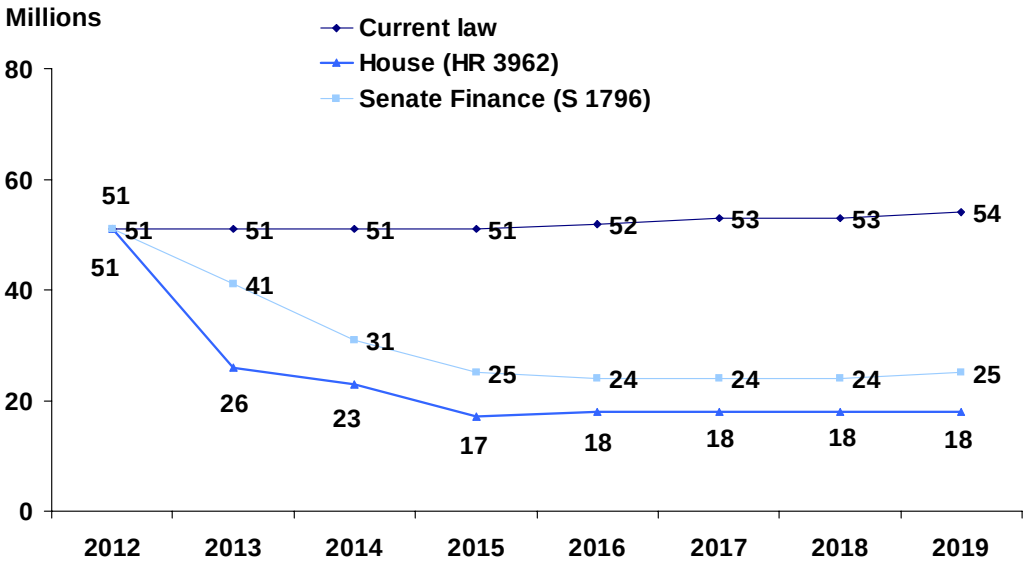
In addition, the House bill provides a tax credit equal to 50 percent of the premium contribution paid by small low-wage firms that are in compliance with the requirement to offer health insurance for up to two years. The Senate HELP bill provides "program credits" to small low-wage firms for up to three years: $1,000 for single coverage and $2,000 for family coverage, with bonus payments available for firms that make higher premium contributions. The Senate Finance Committee bill provides limited subsidies in the start-up years of 2011 to 2012, 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 35 percent.

Impact on Coverage

In the absence of health reform, CBO 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 Finance Committee bill, the number of people

uninsured is projected to decline by 29 million people, or about 94 percent of legal residents.[11]

Figure 2. Trend in the Number of Uninsured, 2012–2019 Under Current Law and Senate Finance 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 Finance and House proposal, respectively.
Data: Estimates by The Congressional Budget Office.

THE COMMONWEALTH FUND

Health System Reforms

Each of the three bills proposes reforms aimed at improving health outcomes and the 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. Because the systems reforms focus largely on the Medicare program, the following subsections deal primarily with the bills from the House and the Senate Finance Committee, which have jurisdiction over Medicare.

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

	Senate Finance Committee 10/13/09 (as amended)	Senate HELP Committee 7/15/09 (as amended)	House of Representatives 10/29/09
Exchange standards and plans	State or regional exchanges; private and co-op plans offered; essential health benefits 65%–90% actuarial value, four tiers plus young adults policy; insurers must report percent of premium spent on items other than medical care	State exchanges (can band together to form regional); private and public plans offered; essential health benefits 76%–93% actuarial value, three tiers; insurers must meet specified medical loss ratio	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% bonus payments for 5 years; cut all other payments by 0.5%		Increase Medicare payments for PCPs by 5%; bring Medicaid PCPs up to Medicare level
Prevention and wellness	Provide annual wellness visit and/or health risk assessment for Medicare beneficiaries; strengthen state and employer wellness programs; remove cost-sharing for proven preventive services	Develop a national prevention and wellness strategy; remove cost-sharing for proven preventive services; invest in preventive programs; grants to wellness incentive programs; grants to support community prevention 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; Innovations Center	Grants to support medical home model	Adopt medical homes, ACOs, and bundled payments on large scale if pilot programs prove successful; Center for Payment 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	Create Center for Health Outcomes Research and Evaluation with AHRQ	Establish Center for Comparative Effectiveness Research within AHRQ
Quality improvement	Direct HHS to develop national quality strategy	Direct HHS to develop national quality strategy; provide grants for improving health system efficiency	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.

Physician Payment Updates Under Medicare

The Senate Finance bill provides for a one-year "fix" to the current formula for determining physician fee updates under Medicare, averting the need to decrease fees by 21 percent in the coming year. Both the Senate and House are considering separate legislation to enact a permanent fix to the SGR under separate legislation are under way in the House.[12]

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 Finance bill calls for a 10 percent increase in primary care fees. In addition, both bills promote reform in graduate medical education to expand and improve training opportunities in primary care.

Prevention and Wellness

The House bill provides 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 provides grants to support small and mid-size employer wellness programs. In addition, the House bill establishes a Prevention and

Wellness Trust Fund to provide funding for community-based prevention programs, childhood obesity programs, and other similar programs. Finally, the House bill creates a task force on clinical preventive services and community preventive services to develop, update, and disseminate evidence-based recommendations for prevention services. The Senate HELP bill removes cost-sharing from preventive services, and calls for the development of a national prevention and wellness strategy, along with grant funding for wellness incentive programs and community prevention programs. The Senate Finance bill creates a new annual wellness visit and/or health risk assessment for Medicare beneficiaries, removes cost-sharing from proven preventive services for Medicare beneficiaries as well as people under age 65, and funds state and employer wellness programs.

Innovative Payment Pilots

Both the House and Senate Finance bills call for the creation of a center on payment innovation 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 Finance bills slow the update in payment rates for all providers, other than physicians, by one percentage point a year 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 plans in the exchange whose premiums increase faster than 150 percent of medical inflation. Both the House and Senate Finance 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 Finance bill creates an independent commission to identify areas of savings 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.

Quality Improvement

The House bill establishes a Center for Quality Improvement and the Senate HELP and Senate Finance bills direct the secretary of health and human services to develop a

national quality strategy. All three bills include processes for developing standard quality measures to facilitate performance improvement and enhance data collection.

Impact on Federal Budget

The cost-containment and budget-savings provisions are estimated to generate $426 billion in savings over the period 2010–2019 in the House bill, and $404 billion in the Senate Finance 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. However, in the Finance bill, these savings will be used to finance the cost of a one-year change to the Medicare physician fee update formula, at $11 billion.

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

Dollars in billions

	CBO estimate of Senate Finance Committee Bill	CBO estimate of H.R. 3962
Total Savings from Payment and System Reforms	**–$404**	**–$426**
• Productivity improvement/provider payment updates	–151	–176
• Medicare Advantage reform	–130	–170
• Primary care, geographic adjustment	4	–6
• Payment innovations	–10	–2
• Hospital readmissions	–2	–9
• Disproportionate share hospital adjustment	–45	–20
• Prescription drugs	1	–75
• Home health	–33	–58
• Independent Commission	–22	—
• Other improvements and interactions	–16	90

Source: The Congressional Budget Office Preliminary Analysis of the Senate Finance Chairman's Mark of the America's Healthy Future Act, as Amended, Oct. 7, 2009, http://www.cbo.gov/doc.cfm?index=10642. The Congressional Budget Office Analysis of H.R. 3962, The Affordable Health Care for America Act, Oct. 29, 2009, http://www.cbo.gov/ftpdocs/106xx/doc10688/hr3962Rangel.pdf.

THE COMMONWEALTH FUND

Paying for Reform: Revenue Sources and Financing

The Congressional Budget Office has estimated that coverage expansion in the House bill would cost $894 billion, while coverage expansion in the Senate Finance Committee bill would cost $719 billion over 2010–2019 (Figure 5).[13] While there are differences between the House and Senate Finance 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 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. In the Senate, the largest new revenue source is an excise tax of 40 percent on insurers that write policies costing more than $8,000 for an individual or $21,000 for a family (Figure 7). Because the Senate HELP committee does not have jurisdiction over raising revenue, only the provisions of the Senate Finance Committee and the House bill are discussed in this section.

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

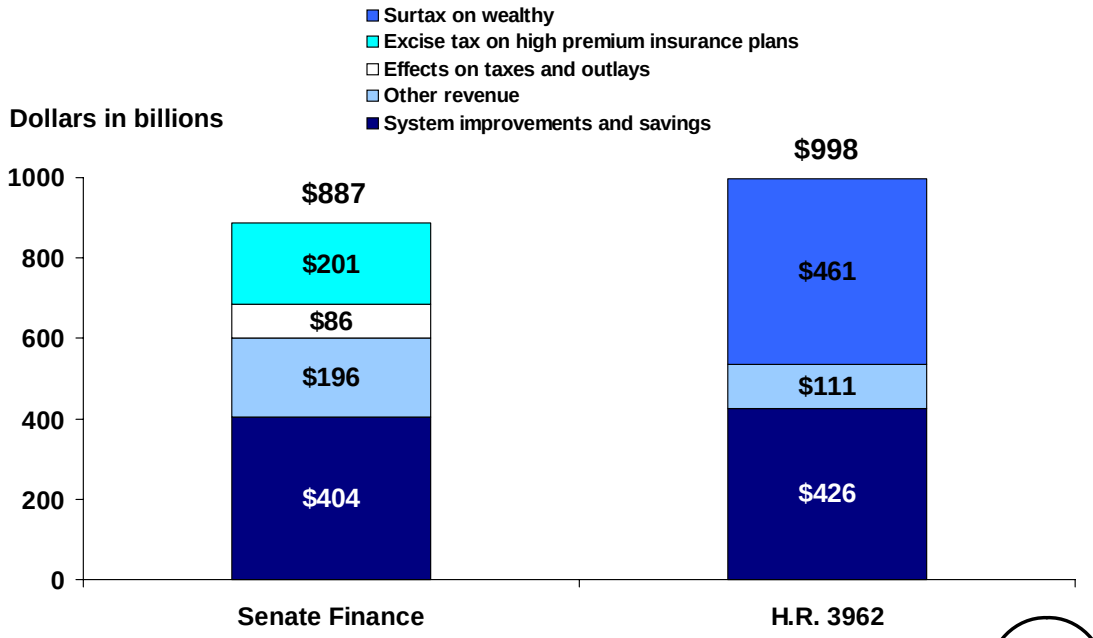
Dollars in billions

	CBO estimate of Senate Finance Committee Bill	CBO estimate of H.R. 3962
Total Net Impact on Federal Deficit, 2010-2019	**–$81**	**–$104**
Total Federal Cost of Coverage Expansion and Improvement	***$719***	***$894***
• Medicaid/CHIP outlays	345	425
• Exchange subsidies	461	605
• Small employer subsidies	23	25
• Payments by uninsured individuals	–4	–33
• Play-or-pay payments by employers	–23	–135
• Associated effects on taxes and outlays	–83	6
Total Savings from Payment and System Reforms	***–$404***	***–$426***
• Productivity updates/provider payment changes	–151	–176
• Other improvements and savings	–253	–250
Total Revenues	***–$397***	***–$572***
• Excise tax on high premium insurance plans	–201	—
• Surtax on wealthy individuals and families	—	–461
• Other revenues	–196	–111

Source: The Congressional Budget Office Preliminary Analysis of the Senate Finance Chairman's Mark of the America's Healthy Future Act, as Amended, Oct. 7, 2009, http://www.cbo.gov/doc.cfm?index=10642. The Congressional Budget Office Analysis of H.R. 3962, The Affordable Health Care for America Act, Oct. 29, 2009, http://www.cbo.gov/ftpdocs/106xx/doc10688/hr3962Rangel.pdf.

THE COMMONWEALTH FUND

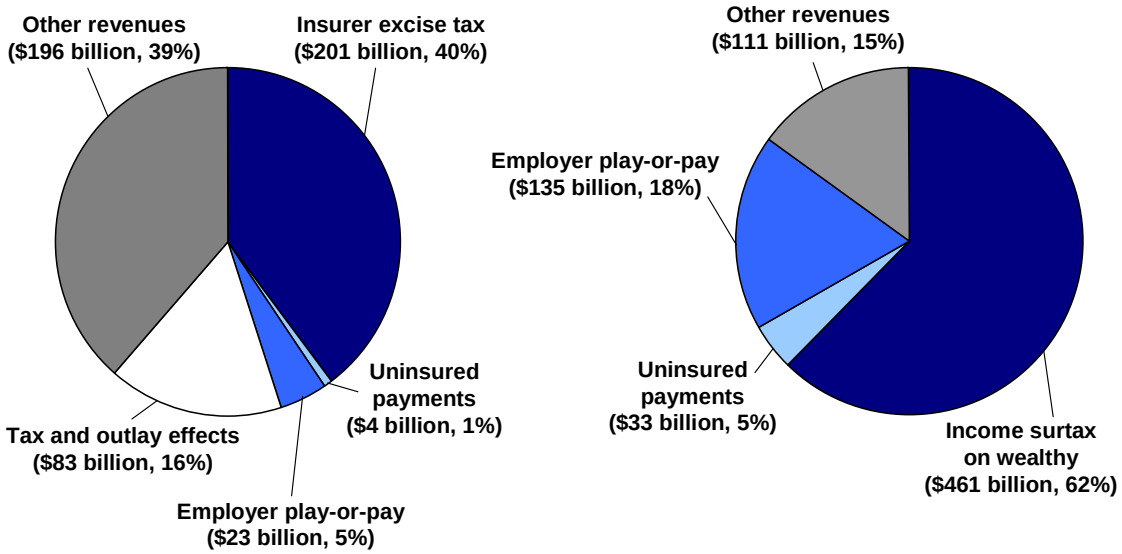
Figure 6. Proportions of System Savings and New Revenue in H.R. 3962 and Senate Finance Committee Bill as Reported



Source: The Congressional Budget Office Preliminary Analysis of Specifications for the Senate Finance Chairman's Mark of the America's Healthy Future Act, Oct. 7, 2009, http://www.cbo.gov/doc.cfm?index=10642, and The Joint Committee on Taxation Estimated Revenue Effects of the Revenue Provisions in the Chairman's Mark, as Modified, Sept. 22, 2009, http://jct.gov/publications.html?func=startdown&id=3581. The Congressional Budget Office Analysis of H.R. 3962, The Affordable Health Care for America Act, Oct. 29, 2009, http://www.cbo.gov/ftpdocs/106xx/doc10688/hr3962Rangel.pdf.

THE COMMONWEALTH FUND

Figure 7. Sources of New Revenue in H.R. 3962 and Senate Finance Committee Bill as Reported



Note: Percentages may not sum to 100% due to rounding.
Source: The Congressional Budget Office Preliminary Analysis of Specifications for the Senate Finance Chairman's Mark of the America's Healthy Future Act, Oct. 7, 2009, http://www.cbo.gov/doc.cfm?index=10642, and The Joint Committee on Taxation Estimated Revenue Effects of the Revenue Provisions in the Chairman's Mark, as Modified, Sept. 22, 2009, http://jct.gov/publications.html?func=startdown&id=3581. The Congressional Budget Office Analysis of H.R. 3962, The Affordable Health Care for America Act, Oct. 29, 2009, http://www.cbo.gov/ftpdocs/106xx/doc10688/hr3962Rangel.pdf.

THE COMMONWEALTH FUND

In the House, the total net impact on the federal budget deficit in the 10-year period 2010–2019 is a reduction of $104 billion (Figure 8). This figure reflects the federal costs of expanding coverage ($894 billion), offset by reductions in health system spending ($426 billion) as well as new revenues ($572 billion) (Figure 4 and Appendix C).

Under the amended Senate Finance Committee bill, the total net impact on the federal budget deficit in the 10- year period 2010–1019 is a reduction of $81 billion (Figure 8). This figure reflects the federal costs of expanding coverage of $719 billion, offset by reductions in health system spending of $404 billion and by increased total revenue of $397 billion.

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

	Senate Finance Committee 10/13/09	House of Representatives 10/29/09
Formerly uninsured now covered, 2019	29 million	36 million
Additionally covered by Medicaid/CHIP, 2019	11 million	15 million
Covered in exchange, 2019	25 million	30 million
Net cost of coverage expansion, 2010–2019	$719 billion	$894 billion
Net impact on federal deficit, 2010–2019	–$81 billion	-$104 billion

Source: The Congressional Budget Office Preliminary Analysis of Specifications for the Senate Finance Chairman's Mark of the America's Healthy Future Act, Oct. 7, 2009, http://www.cbo.gov/doc.cfm?index=10642. The Congressional Budget Office Preliminary Analysis of H.R. 3962, The Affordable Health Care for America Act, Oct. 29, 2009, http://www.cbo.gov/ftpdocs/106xx/doc10688/hr3962Rangel.pdf.

THE COMMONWEALTH FUND

COMPARING THE BILLS: SIMILARITIES AND DIFFERENCES

Conceptually, the bills introduced by the different committees are similar in many ways (Figure 9). All the bills 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 the House and Senate

Finance bills would create a center for payment innovation for rapid-cycle testing of innovative payment methods. The House and Finance 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.

Figure 9. Major Areas of Similarities and Differences Between Bills

Similarities between bills	Differences between bills
❖ Individual mandate	❖ Choice of public plan in exchange
❖ Insurance exchange	❖ Employer shared responsibility
❖ Premium and cost-sharing subsidies	❖ Medicare Commission to extend Medicare solvency, slow Medicare cost growth and increase quality of care
❖ Insurance market regulations	❖ Sources of revenue: surcharges on higher income vs. excise tax on high cost health plans
❖ Essential standard benefit package standard	
❖ Medicaid / CHIP expansion	
❖ 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	

THE COMMONWEALTH FUND

Source: Commonwealth Fund analysis of health reform proposals.

While the general framework of the bills are very similar, they differ in a few key areas, namely: a public plan option in an insurance exchange; a requirement for employers to share financial responsibility for coverage; a new independent Medicare commission that will make recommendations to contain Medicare spending; and sources of revenue to finance the proposal. The Senate Finance Committee bill does not include a public plan option or a requirement for standards of employer coverage or shared employer responsibility for paying premiums—whereas the House bill does all of the above. The Senate Finance bill does give great authority to a new Medicare commission, whose proposals would go into effect unless defeated by a two-thirds majority in Congress. 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 Finance bill includes a new tax on

high-cost insurance plans. Despite earlier attempts, neither the House nor the Senate bills have included a permanent fix to the sustainable growth rate (SGR), the mechanism that sets the reimbursement rate for physicians under the Medicare program.

NOTES

[1] 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.

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

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

[4] 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).

[5] 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.

[6] 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).

[7] 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).

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

[9] 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.

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

[11] Because the Senate HELP Committee does not have jurisdiction over Medicaid, CBO did not include a Medicaid expansion in its estimates of the bill. Estimates for the bill are therefore not included.

[12] *Medicare Physician Fairness Act of 2009*, S. 1776, 111th Congress, 1st sess. (Oct. 13, 2009), http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:s1776pcs.txt.pdf; *Medicare Physician Payment Reform Act of 2009*, H.R. 3961, 111th Congress, 1st sess. (Oct. 29, 2009), http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3961ih.txt.pdf.

[13] 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.

Table 1. Congressional Health Reform Bills: Coverage, as of 10/29/2009

Features	Senate Finance Committee 10/13/09[14] (as amended)	Senate HELP Committee 7/15/09[15] (as amended)	House of Representatives 10/29/09[16]
Insurance Market Regulations	National regulations apply inside and outside the exchange Guaranteed issue; Rating based on age (max 4:1), tobacco use (1.5:1), family composition (max 3:1), and geography; no health rating; premiums within a family category could not vary by more than 6:1; 5-year phase-in for small group; no annual or lifetime limits on benefits Prohibits rescissions by insurance companies Health plans required to report the proportion of premiums spent on items other than medical care beginning in 2010 Uninsured who have been denied coverage because of a preexisting condition eligible for high-risk pools until 2013	National regulations apply inside and outside the exchange Guaranteed issue; no health rating; rating based on age (2:1), family composition, tobacco use, plan value, and geography; no annual or lifetime limits on benefits Prohibits rescissions by insurance companies except in cases of fraud Insurers must meet a specified medical loss ratio Insurers that offer dependent coverage must cover dependents through age 26	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 Prohibits rescissions by insurance companies except in cases of fraud Insurers must meet a medical loss ratio of 85% Repeals exemption of insurance companies from anti-trust laws Establishes annual review process for premium increases by HHS secretary and states
Insurance Exchange	State or regional; each state would be required to establish an exchange for the individual market and a separate Small Business Health Options Program (SHOP) exchange for the small-group market; no competing sub-state exchanges; all insurance carriers licensed in any state would be required to offer a plan through the exchanges; does not replace individual market States would be able to opt out of federal requirements through a waiver in 2015 if they could demonstrate that they could offer all residents coverage at least as comprehensive as that required by the bill	State (can band together to form regional); no competing sub-state exchanges; does not replace individual market	National or state; no competing sub-state exchanges; replaces individual market
Eligibility to purchase through exchange	Individuals and small businesses with up to 50 employees (states have option to allow firms with 51–100 employees to purchase through exchange); beginning in 2015, states must allow small businesses with up to 100 employees to purchase coverage through the SHOP exchange; states may allow employers with more than 100 employees into the state exchange beginning in 2017; uninsured eligible for high-risk pools until 2013	Individuals without access to employer coverage that is in compliance with the employer mandate and who are not eligible for Medicaid; small businesses with <50 employees. Under an amendment, states or the secretary of HHS could increase to >50 employees	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

Table 1. Congressional Health Reform Bills: Coverage, as of 10/29/2009

Features	Senate Finance Committee 10/13/09[14] (as amended)	Senate HELP Committee 7/15/09[15] (as amended)	House of Representatives 10/29/09[16]
	Businesses that grow beyond the upper employee limit for the SHOP exchange may continue to purchase insurance through it An amendment would require members of Congress and Congressional employees beginning July 1, 2013, to use their employer contribution (adjusted for age rating) to purchase coverage through a state-based exchange, rather than FEHBP		
Minimum benefit standard; tiered standards; content	Essential health benefits would range from 65% to 90% actuarial value; Four tiers: bronze actuarial value 65%; 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 $11,200 for family policies; no cost-sharing for preventive services Young adult catastrophic policy would be available for those 25 or younger, would cover preventive services; 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	Health plans offering coverage through exchange must be certified as qualified health plans. All plans must provide essential services as specified by HHS. Three benefit tiers: Tier 1 essential health benefits covers 76% of costs with out-of-pocket spending limits to HSA level of $5,950 for individual policies and $11,200 for family policies; Tier 2 covers 84% with out-of-pocket spending limits at half the HSA level; Tier 3 covers 93% with out-of-pocket spending limits at 20% of the HSA level; no cost-sharing for preventive services Amendments establish a temporary National Independent Commission on Essential Health Care Benefits to advise the secretary of HHS	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
Premium subsidies to individuals	Sliding-scale credits would be available for purchasing in exchange beginning in 2013 for individuals and families between 134%–400% FPL, and beginning in 2014 for those between 100%–133% FPL; 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 12% of income for 300%–400% FPL; no subsides for those with employer-based coverage with plans that have an actuarial value of 65% or higher and premiums that are <10% of income	Premium credits on sliding scale up to 400% FPL for purchasing in exchange; subsidies based on three lowest-cost private plans so that people with incomes at 400% of poverty pay no more than 12.5% of income and people with incomes of 150% of poverty or less pay no more than 1% of income on premiums; no subsidies for those with employer-based coverage that meets minimum qualifying criteria and affordability standards (premiums must be <12.5% of income)	Premium credits on a sliding scale 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)

Table 1. Congressional Health Reform Bills: Coverage, as of 10/29/2009

Features	Senate Finance Committee 10/13/09[14] (as amended)	Senate HELP Committee 7/15/09[15] (as amended)	House of Representatives 10/29/09[16]
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 $1,964 for individuals and $3,937 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 $3,927 for individuals and $7,392 for families	Premium subsidies are tied to benefit tiers, lowering cost-sharing by income: ≤200% FPL—3rd tier (93% AV) 201%–300% FPL—2nd tier (84% AV) 301%–400% FPL—Basic plan (76% AV)	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 $5000/$10,000 at 350-400% FPL
Plans offered	Private and co-op; All state-licensed insurers in the nongroup and small-group markets must participate Cantwell amendment would provide states option of pooling federal subsidies for low-income people (133%–200% FPL) to offer "Basic Health Plan" policies through state-negotiated private insurance programs	Private and public; Participating plans provide incentives to providers to reward quality and to deliver care more efficiently; providers not required to participate in public plan; secretary of HHS would negotiate rates with providers up to commercial rate States could assess a surcharge on all health insurance carriers that offer qualified health plans through the exchange, not to exceed 4% of premiums collected by a plan	Private, public and co-op; public option pay providers at rates negotiated between providers and HHS
Insurance administrative simplification	Accelerate development, adoption and implementation of standard, consensus-based operating rules for eligibility verification, claims status, claims payment, and the electronic transfer of funds	Simplify health insurance administration by adopting standards for financial and administrative transactions	Simplify health insurance administration by adopting standards for financial and administrative transactions
Risk adjustment for plans	All health insurance issuers would be required to contribute to a reinsurance program for individual policies; nonprofit entity would use funds from insurers to support a reinsurance mechanism directed at individuals enrolled in plans offered through state exchanges; health plans would receive payments from reinsurance pool for benefit costs (minus administrative expenses) above 103% of the target amount, and would make a payment if benefit costs were below 97% of the target amount	Health plans that provide coverage through a gateway to an individual or employer group whose size is less than a threshold set by the state/HHS required to submit risk-adjustment payments: health plans would be required to make a payment if yearly actuarial risk is less than the average actuarial risk of all enrollees in all plans in the state, would receive a payment if yearly actuarial risk is more than the average actuarial risk of all enrollees in all plans in the state	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 10/29/2009

Features	Senate Finance Committee 10/13/09[14] (as amended)	Senate HELP Committee 7/15/09[15] (as amended)	House of Representatives 10/29/09[16]
Medicaid/CHIP Expansion	In 2013, expansion up to 133% FPL for all nonelderly individuals; newly eligible beneficiaries would receive "benchmark" plan; in 2014 people with incomes between 100-133% of poverty could choose Medicaid or subsidized coverage through exchange. States would be required to maintain existing income eligibility levels for all Medicaid populations until state exchange becomes fully operational; states will receive an initial increase in the federal medical assistance percentage (FMAP) of 27.3 percentage points for states that already cover adults with incomes above 100% of poverty, and 37.3 percentage points for other states; increases will be adjusted over time so that by 2019 all states will receive an FMAP increase of 32.3 percentage points An amendment by Senator Rockefeller requires states to continue CHIP through 2019 and maintain existing Medicaid coverage for children. An amendment by Senator Bingaman establishes a coordinated and unified enrollment and renewal system for Medicaid, CHIP, and the subsidy program available through the exchanges	Expansion up to 150% FPL; people enrolled in Medicaid are not allowed to purchase coverage through the exchange	Expansion up to 150% FPL; people enrolled in Medicaid are not allowed to purchase coverage through the exchange; 100% federal financing of expansions through 2014, 91% financing from 2015 on
Individual Mandate	Yes; amendment charges excise tax of $750 per adult in household phased in at $200 in 2014, $400 in 2015, $600 in 2016, $750 in 2017; exemption if premium of lowest cost option is >8% of income and allows these individuals to purchase a young adults policy regardless of age; exemptions for those below 100% FPL (133% FPL in 2013) and certain other groups	Yes; penalty to be no more than $750 per year for an individual, and not more than $3,000 for all dependents for which an individual is responsible; exemptions if premium is not affordable (>12.5% of income), for those with incomes below 150% FPL, for those living an a state that has not yet established an exchange, and certain other groups	Yes; penalty is 2.5% of the difference between modified adjusted gross income and the tax filing threshold, up to the cost of the average national 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	Not required; firms with >50 FTEs must pay a flat fee equal to the national average tax credit for each employee who receives tax credit through an exchange; penalty is capped at $400 multiplied by total number of FTEs, regardless of how many utilize tax credits	Required to provide at least 60% premium contribution or pay $750/year per uncovered full-time worker, $375/year per uncovered part-time worker; small business exclusions (firms <25 workers); penalty indexed to CPI in 2013; employers required to cover dependents up to age 26	Required to provide at least 72.5% premium contribution for individuals, 65% for families or pay 8% payroll; small firms with <$500,000 payroll exempted and tax phased in starting at 0% at $500,000 up to $750,000

Table 1. Congressional Health Reform Bills: Coverage, as of 10/29/2009

Features	Senate Finance Committee 10/13/09[14] (as amended)	Senate HELP Committee 7/15/09[15] (as amended)	House of Representatives 10/29/09[16]
Small Business Tax Credits	Temporary program (2011–12): Tax credit up to 35% 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 $40,000; full amount of credit is available to employers with 10 employees or average wages of $20,000 and phases out Permanent program (beginning 2013): 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 $40,000 who buy plans through the exchange. The full amount of the credit is available for employers with <10 FTEs and average wages below $20,000; credit phases out for firms with 10–25 employees (at rate of 6% of base credit percentage for each employee above 10) and average wages $20,000–$40,000 (at rate of 5% for each $1,000 increase of average wages above $20,000) Amended to allow nonprofits to be eligible for the small business premium subsidies, though they are somewhat lower: 25% of employer contribution to premium in the first phase (2011–12) (compared with 35% for other companies) and 35% in the second phase beginning in 2013 (compared with 50% for other companies)	Firms with 50 employees or less and average wage <$50,000 eligible for program credits for three years if they offer and pay 60% of premiums. Credit is equal to $1,000/single and $2,000/family, with bonus payments for greater premium contributions	50% of amount paid by a small employer in compliance with mandate (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 10/15/09; Commonwealth Fund analysis of proposals; HealthPolicy R&D analysis of proposals.

[14] S. 1796, America's Healthy Future Act of 2009, October 19, 2009, 111th Congress, 1st session; Chairman's Mark, America's Healthy Future Act of 2009, October 2, 2009, available at http://www.finance.senate.gov/sitepages/leg/LEG%202009/100209_Americas_Healthy_Future_Act_AMENDED.pdf; Chairman's Mark, America's Healthy Future Act of 2009, Sept. 16, 2009, available at http://finance.senate.gov/sitepages/leg/LEG%202009/092209%20Modifications%20to%20the%20Chairman%27s%20Mark%20Final.pdf; Baucus Introduces Landmark Plan to Lower Health Care Costs, Provide Quality, Affordable Coverage, Senate Finance Committee Press Release, Sept. 16, 2009, available at http://finance.senate.gov/press/Bpress/2009press/prb091609h.pdf; Modifications to the Chairman's Mark "America's Healthy Futures Act", September 22, 2009, available at http://finance.senate.gov/sitepages/leg/LEG%202009/092209%20Modifications%20to%20the%20Chairman%27s%20Mark%20Final.pdf.

[15] S. 1679, Affordable Health Choices Act, September 17, 2009, 111th Congress, 1st session; S. 1679, Affordable Health Choices Act, September 17, 2009, 111th Congress; Senate Committee on Health, Education, Labor and Pensions draft, June 9, 2009, 111th Congress, first session. Affordable Health Choices Act: Shared Responsibility of Employers, Senate Committee on Health, Education, Labor and Pensions Fact Sheet, July 2, 2009; Affordable Health Choices Act, Senate Committee on Health, Education, Labor and Pensions, additional Chairman's mark on coverage, July 2, 2009, http://help.senate.gov/BAI09F54_xml.pdf.

[16] H.R. 3962 Affordable Health Care for America Act, October 29, 2009, 111th Congress, 1st session; 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 10/29/2009

	Senate Finance Committee 10/13/09[17] (as amended)	Senate HELP Committee 7/15/09[18] (as amended)	House of Representatives 10/29/09[19]
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. Half of the increased payments would be funded by cutting payments for all other services, except for providers in HPSAs 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 GME funding to promote training in outpatient settings, and ensure the availability of residency programs in rural and underserved areas Establish a Workforce Advisory Committee to develop and implement a national workforce strategy 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 Workforce Commission to make recommendations and disseminate information on health workforce priorities, goals, and policies, including education and training, workforce supply and demand, and retention practices Reform graduate medical education to increase the supply, education, and training of doctors, nurses, and other health care workers, especially in pediatric, geriatric, and primary care. Improve access to care by providing additional funding to increase the number of community health centers and school-based health centers	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	Provide Medicare beneficiaries access to a comprehensive health risk assessment and creation of a personalized prevention plan Make Medicare beneficiaries eligible for annual wellness visit, with no copays or deductibles During the first year of coverage under Medicare, beneficiaries could receive either the annual wellness visit or the Initial Preventive Physical Examination, but not both services	Develop a national prevention and health promotion strategy that sets specific goals for improving health Create a prevention and public health investment fund to expand and sustain funding for prevention and public health programs Award competitive grants to state and local governments and community-based organizations to implement and evaluate proven community preventive health activities	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 Create task forces on clinical preventive services and community preventive services to develop, update, and disseminate

Table 2. Congressional Health Reform Bills: System Reform, as of 10/29/2009

	Senate Finance Committee 10/13/09[17] (as amended)	Senate HELP Committee 7/15/09[18] (as amended)	House of Representatives 10/29/09[19]
	Eliminate cost-sharing for evidence-based preventive services under Medicare and eligible private plans 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 Require HHS secretary to establish five-year initiative to provide incentives to Medicare beneficiaries to improve health status Provide financial incentives to states to cover recommended preventive services under Medicaid Promote prevention and wellness by: 1) providing states with grants to facilitate integration of health care services to improve health and wellness outcomes, and 2) providing tax credits to small businesses that implement proven wellness programs Require coverage of tobacco cessation programs for pregnant women under Medicaid Strengthen employer-sponsored wellness programs by codifying HIPAA provisions	to reduce chronic disease rates and address health disparities Create a medication management program through the new Patient Safety Research Center to support provision of services by local providers Permit insurers to create incentives for health promotion and disease prevention practices Encourage employers to provide wellness programs by conducting targeted educational campaigns to raise awareness of the value of these programs and by increasing from 20 percent to 30 percent the allowable premium discount for employees who participate in these programs Create a temporary Right Choices Program to provide uninsured adults with access to preventive services	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
Medical Home/ Coordinated Care	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 Strengthen chronic care management by providing reimbursement for certain care management activities for patients with hospital stays related to a major chronic condition	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	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

Table 2. Congressional Health Reform Bills: System Reform, as of 10/29/2009

	Senate Finance Committee 10/13/09[17] (as amended)	Senate HELP Committee 7/15/09[18] (as amended)	House of Representatives 10/29/09[19]
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 and establish an Interagency Working Group on health care quality 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 Implement quality measure reporting programs for long-term care hospitals, inpatient rehabilitation facilities, IPPS-exempt cancer hospitals, hospice providers by 2011 Improve transparency of information about skilled nursing facilities Improve public reporting of quality and performance information that includes making information available on the internet 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 Screen providers and suppliers before granting Medicare billing privileges	Develop a national strategy to improve the delivery of health care services, patient health outcomes, and population health that includes publishing an annual national health care quality report card Agency for Healthcare Research and Quality (AHRQ) will provide grants to eligible organizations to develop quality measures that assess health outcomes; health care coordination; patient, caregiver and involved person experience; safety, effectiveness and timeliness of care; health disparities, by population and geography; appropriate use of health care; and use of innovative strategies Create a Patient Safety Research Center charged with identifying, evaluating, and disseminating information on best practices for improving health care quality Require public reporting on quality measures through a user-friendly website Require hospitals to report preventable readmission rates; hospitals with high readmission rates will be required to work with local patient safety organizations to improve their rates Create an Interagency Working Group to coordinate and streamline federal quality activities, as directed by the President Quality measures would be reviewed at least once every 3 years to ensure relevance Provide Technical Assistance and Process Implementation grants to local providers to promote teaching and implementation of quality improvement best practices	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 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

Table 2. Congressional Health Reform Bills: System Reform, as of 10/29/2009

	Senate Finance Committee 10/13/09[17] (as amended)	Senate HELP Committee 7/15/09[18] (as amended)	House of Representatives 10/29/09[19]
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 Direct HHS to develop a national workforce strategy	Develop a national strategy to improve the delivery of health care services, patient health outcomes, and population health that includes publishing an annual national health care quality report card	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 CMS Innovation Center to test new provider payment models; if successful, implement models in Medicare, Medicaid, and CHIP programs Develop voluntary pilot program to encourage hospitals, doctors, and post-acute providers to achieve savings for Medicare through better collaboration and coordination; allow providers to share in savings Reduce payments for hospitals with high readmission rates if patient is rehospitalized with preventable readmission condition within 15 days Prohibit federal payments for Medicaid services related to hospital-acquired conditions Create Community 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 Establish a physician value-based purchasing program. Reward providers who participate in 2011, penalize eligible providers who do not participate by 2012, establish payment incentives to appropriately order high-cost imaging services, expand Medicare physician feedback program, and penalize physicians who use significantly more resources than do their peers		Establish a Center for Medicare and Medicaid Payment 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

Table 2. Congressional Health Reform Bills: System Reform, as of 10/29/2009

	Senate Finance Committee 10/13/09[17] (as amended)	Senate HELP Committee 7/15/09[18] (as amended)	House of Representatives 10/29/09[19]
	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		Improve payment accuracy for imaging services in Medicare
Accountable Care Organizations (ACOs)	Allow providers organized as ACOs to share in savings they generate for Medicare 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 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
Physician Payment Update Formula—Sustainable Growth Rate (SGR)	Replace scheduled 21% reduction in physician payment rates with 0.5% increase in 2010; continue in 2011 as if change in 2010 had not occurred		

Table 2. Congressional Health Reform Bills: System Reform, as of 10/29/2009

	Senate Finance Committee 10/13/09[17] (as amended)	Senate HELP Committee 7/15/09[18] (as amended)	House of Representatives 10/29/09[19]
Other Payment Reforms	Require HHS to apply physician payment modifier to Medicare fee-for-service payment to pay physicians differentially based on quality of care and costs. Publish measures in 2012; subject all physicians to modifier by 2017 Establish panel of stakeholders to identify physicians' services that are overvalued in Medicare fee schedule 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 payments to hospitals in top 25th percentile of rates of hospital-acquired conditions by 1% Improve payment accuracy of home health payments in 2013 Improve payment accuracy of Medicare hospice payment system Reform Medicare wage index system Update oxygen rental equipment and contents payments, power wheelchair payments, durable medical equipment outlier payment rule, and outpatient payments for PPS-exempt cancer hospitals		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
Geographic Disparities	Extend the 1.00 floor for the Geographic Practice Cost Index (GPCI) for physician work for an additional two years through December 2012 Adjust the GPCI for practice expense by blending local and national averages for below-average cost areas		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 necessary

Table 2. Congressional Health Reform Bills: System Reform, as of 10/29/2009

	Senate Finance Committee 10/13/09[17] (as amended)	Senate HELP Committee 7/15/09[18] (as amended)	House of Representatives 10/29/09[19]
Medicare Advantage (MA)	Restructure payments to MA plans using new benchmarks computed from weighted average of plan bids beginning in 2012, 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 Simplify extra benefits plans can offer and make them more consistent across plans 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 Exclude Medicare Advantage rebates and bonus payments from the premium amount when calculating the regional low-income subsidy benchmark rates, so that more plans are available to low-income beneficiaries at fully subsidized premiums Reduce the Medicare Part D premium subsidy for high-income beneficiaries Require drug and device manufacturers to disclose payments and incentives to providers 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 Require pharmaceutical benefit managers to disclose discounts negotiated with drug makers and pass savings on to consumers		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

Table 2. Congressional Health Reform Bills: System Reform, as of 10/29/2009

	Senate Finance Committee 10/13/09[17] (as amended)	Senate HELP Committee 7/15/09[18] (as amended)	House of Representatives 10/29/09[19]
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 Change the Medicaid federal match (FMAP) formula to include data on a state's poverty level and increase Medicaid FMAP rates during economic downturns to assist states in financing increased Medicaid enrollment	Establish a Health Care Program Integrity Coordinating Council and two new federal department positions to oversee policy, program development, and oversight of health care fraud, waste, and abuse in public and private coverage	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
Medicare Commission	Establish an independent Medicare Commission in HHS to submit proposals to Congress to extend Medicare solvency and improve quality. Recommendations provided by proposed Medicare Commission will be enacted unless defeated by two-thirds vote in Congress		

Table 2. Congressional Health Reform Bills: System Reform, as of 10/29/2009

	Senate Finance Committee 10/13/09[17] (as amended)	Senate HELP Committee 7/15/09[18] (as amended)	House of Representatives 10/29/09[19]
Comparative Effectiveness	Create a private, nonprofit Patient-Centered Outcomes Research Institute to set national research agenda and conduct comparative clinical effectiveness research	Create a Center for Health Outcomes Research and Evaluation within AHRQ to promote health outcomes research and evaluation, which would enable patients and providers to identify the most effective therapies for preventing and treating health conditions	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 HIT incentives under Medicare	Develop and update interoperable standards for using HIT to enroll individuals in public programs Provide grants to community-based organizations for infrastructure and training to establish electronic assistance programs Provide grants to states to adopt electronic enrollment technology	Develop and update standards for electronic administrative transactions

Table 2. Congressional Health Reform Bills: System Reform, as of 10/29/2009

	Senate Finance Committee 10/13/09[17] (as amended)	Senate HELP Committee 7/15/09[18] (as amended)	House of Representatives 10/29/09[19]
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 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	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) 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
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		Establish a new voluntary grant program to encourage states to implement alternatives to traditional medical malpractice litigation

Table 2. Congressional Health Reform Bills: System Reform, as of 10/29/2009

	Senate Finance Committee 10/13/09[17] (as amended)	Senate HELP Committee 7/15/09[18] (as amended)	House of Representatives 10/29/09[19]
Long-Term Care	Improve the availability of long-term care services by increasing access to home- and community-based services through changes in Medicaid program requirements and through grants to states Allow cafeteria plans to offer long-term care insurance contracts as a qualified benefit so that employee contributions for the long-term care insurance premiums can be made on a pretax basis. Permit reimbursement for employee premiums for long-term care insurance through flexible spending accounts on a pretax basis 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 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	Establish a national, voluntary, long-term care 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 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

Table 2. Congressional Health Reform Bills: System Reform, as of 10/29/2009

	Senate Finance Committee 10/13/09[17] (as amended)	Senate HELP Committee 7/15/09[18] (as amended)	House of Representatives 10/29/09[19]
New Leadership Councils and Commissions	Patient-Centered Outcomes Research Institute Medicare Commission CMS Innovation Center Workforce Advisory Committee CMS Coordinated Healthcare Office	Health Care Program Integrity Coordinating Council Patient Safety Research Center Interagency Working Group to coordinate and streamline federal quality activities Center for Health Outcomes Research and Evaluation 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 Payment Innovation Center Task Forces on Clinical Preventive Services and Community Preventive Services

Sources: Kaiser Family Foundation Side-by-Side Comparison of Major Health Care Reform Proposals, updated 10/15/09; Commonwealth Fund analysis of proposals; HealthPolicy R&D analysis proposals.

[17] S. 1796, America's Healthy Future Act of 2009, October 19, 2009, 111th Congress, 1st session; Chairman's Mark, America's Healthy Future Act of 2009, October 2, 2009, available at http://www.finance.senate.gov/sitepages/leg/LEG%202009/100209_Americas_Healthy_Future_Act_AMENDED.pdf; Chairman's Mark, America's Healthy Future Act of 2009, Sept. 16, 2009, available at http://finance.senate.gov/sitepages/leg/LEG%202009/092209%20Modifications%20to%20the%20Chairman%27s%20Mark%20Final.pdf; Baucus Introduces Landmark Plan To Lower Health Care Costs, Provide Quality, Affordable Coverage, Senate Finance Committee Press Release, September 16, 2009, available at http://finance.senate.gov/press/Bpress/2009press/prb091609h.pdf; Modifications to the Chairman's Mark "America's Healthy Futures Act", September 22, 2009, available at http://finance.senate.gov/sitepages/leg/LEG%202009/092209%20Modifications%20to%20the%20Chairman%27s%20Mark%20Final.pdf.

[18] S. 1679, Affordable Health Choices Act, September 17, 2009, 111th Congress, 1st session; Affordable Health Choices Act, Senate Committee on Health, Education, Labor and Pensions draft, June 9, 2009, 111th Congress, first session; Affordable Health Choices Act: Shared Responsibility of Employers, Senate Committee on Health, Education, Labor and Pensions Fact Sheet, July 2, 2009; Affordable Health Choices Act, Senate Committee on Health, Education, Labor and Pensions, additional Chairman's mark on coverage, July 2, 2009, http://help.senate.gov/BAI09F54_xml.pdf.

[19] H.R. 32962 Affordable Health Care for America Act, October 29, 2009, 111th Congress, 1st session; 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.