Side-By-Side of Major Health Reform Proposals

Issue	House TriCommittee Legislation	Senate HELP Committee Legislation
Public Option	**Plan.** Creates a new public health insurance option to be offered only through Health Insurance Exchanges. The Secretary will contract with health carriers to provide administrative functions in the same manner as Medicare contractors. This means providing government defined benefits at rates negotiated by HHS. Contractors may not accept insurance risk under the program. **Coverage.** The public option must offer basic, enhanced and premium plans, and may offer premium-plus plans. **Benefits.** The public option is required to provide the same benefit levels, provider networks, consumer protections, and cost-sharing as private plans. **Premiums.** Premiums would be set by the Secretary to reflect the cost of benefits and administrative costs, and to provide for a contingency margin, which is undefined. Data collection on health status of individuals to determine premiums is required. **Start Up Costs.** $2 billion is appropriated to the Secretary for start up costs and initial payment of claims. Repayment of the $2 billion is required over a 10 year period, although it is unclear who would repay the amount. **Payment Rates.** Payments for services would be based on Medicare rates under Parts A and B for the first three years.	**Plan.** Creates a new community health insurance option to be offered through the Health Insurance Exchange. The Secretary may contract with health carriers to provide administrative functions in the same manner as Medicare contractors. Contractors may not accept insurance risk under the program and must be not-for-profit. Contracts are for at least five years, but no more than 10 years. Fees would be paid to contractors on a performance basis. **Coverage.** The Community health insurance option must offer essential benefits only. States may require an option to cover additional benefits. **Benefits.** The public option is required to provide the same benefit levels, provider networks, consumer protections, and cost-sharing as private plans. **Premiums.** Premiums would be set by the Secretary to reflect the cost of benefits and administrative costs, and to provide for a contingency margin, which is undefined. Data collection on health status of individuals to determine premiums is required. Establishes risk corridor payments to plans for the first 2 years of operation, which may be extended by the Secretary. **Start Up Costs.** Provides loans for start up costs and initial payment of claims. Repayment of the loans is required over a 10 year period. **Payment Rates.** Payments for services are negotiated by the Secretary and may be no more than rates paid by private insurers in the exchange. There is no floor on payments.

	▪ Physician services would be updated by at least 1 percent per year. Services performed by physicians that participate in both the public option and Medicare would be eligible for a 5 percent bonus for the first three years. ▪ Payments for drugs not covered under Parts A or B would be at rates negotiated by the Secretary. ▪ Payments for services not covered by Medicare would be set by the Secretary. ▪ Payments in years four and thereafter would be set to promote payment accuracy and to promote affordability, but cannot be set at levels expected to increase overall medical costs beyond Medicare payment rates.	
	Alternate Payments. The Secretary is authorized to use alternative payment mechanisms, such as a medical home, accountable care organizations, value based purchasing, differential payments to reflect quality, bundling of services and partial capitation. Payments can vary geographically.	**Alternate Payments.** States and designated state public or not-for-profit advisory councils may develop or encourage innovative payment policies. The Secretary may apply the payment recommendations of one state to any other state or to all states.
	Recourse. There is no due process (Administrative or Judicial review) of the payment rates or payment methodologies employed by the Secretary.	**Recourse.** Presumably normal rule making process, although not specified.
	Participation. Medicare providers are automatically public option providers unless they opt out.	**Participation.** Rule of construction that no provider is required to participate in the community option or would face a penalty for not participating in the community option.
	• *E&C Amendment (Ross):* Requires the public health insurance option to negotiate rates with providers so that rates are not lower that Medicare and not higher than the average rates paid by other qualified plans. This attempts to create a floor and a ceiling, although the floor is arguably lower than in the base bill (Medicare plus 5 percent). • *E&C Amendment (Ross):* Public option must meet same requirements as other plans relating to guarantee issue and renewability, insurance rating rules, network adequacy, and transparency. • *E&C Amendment (Baldwin):* Public option must include a prescription drug formulary.	No floor on provider payments.

	• *E&L Amendment (Kucinich):* Allows states to seek a waiver of ERISA to create a state single-payer option instead of the public option. • *E&L Amendment:* Sense of Congress that Members who vote for a public option and senior members of the Administration are urged to forgo their right to enroll in FEHB and enroll in the public option.	
Co-ops	*E&C Amendment (Ross):* Provides grants or loans to facilitate the establishment of not-for-profit, member-run health insurance cooperatives to provide insurance through the exchange. Loans are made for start up costs and grants are made for meeting State solvency requirements. Grants and loans are not available for co-ops existing prior to July 16, 2009. The co-op may not be structured to allow insurance industry "involvement or interference" with the governance of the cooperative, but the cooperative must be licensed to offer insurance in each State in which it offers insurance. The cooperative may not be established by a State government. Any profits must be used to reduce premiums or enhance benefits for members. This appears to conflict with the benefit requirements for all exchange plans.	No provision.
Gateways/ Exchanges	**Eligibility.** Beginning in 2013, individuals, their dependents and employers (phasing-in employer eligibility starting with the smallest employers) can purchase insurance through the Exchange from private health plans and the public health insurance option. States may set up state-based exchanges subject to approval. • *E&L Amendment (Titus):* Employers with 15 or fewer employees would be permitted to join the exchange in the first year, with employers of 25 or	**Eligibility.** Each State would receive grants to establish a Health Benefit Gateway, administered by the State or non-profit organization, through which individuals, employers and the self-employed can purchase qualified coverage including the Community Insurance Option. States may operate regional gateways. If a State fails to establish an exchange after four years, the Secretary will establish an exchange in that state.

	fewer employees permitted to join in its second year. Access to the Exchange would be restricted to individuals not enrolled in qualified or grandfathered employer or individual coverage, Medicare, Medicaid, TRICARE, VA coverage, or other coverage like a State health benefits risk pool as determined by the Secretary. • Individuals eligible for Medicaid will be enrolled in Medicaid rather than the Exchange, with exceptions made for childless adults with incomes under 133% of FPL ($14,400/year) who had other qualifying coverage within the previous 6 months. These individuals would be allowed to choose between Medicaid or the Exchange. • An annual enrollment period will occur between September and November. • *E&C Amendment (Buyer):* Members of the armed forces and those with coverage through TRICARE or VA are permitted to enroll in a health benefits plan offered through the exchange. **Plan Requirements.** Plans must submit competitive bids to participate in the exchange. Plans participating in the Exchange must be state licensed, report data, meet adequacy standards, provide culturally and linguistically appropriate services, and participate in risk pooling. Requires guarantee issue and renewability. Requires risk adjustment of participating plans to minimize adverse selection. Premiums may only vary based on age and geography (by no more than a 2:1 ratio). In order to qualify as an exchange eligible qualified plan, entities must at least offer a basic plan. A plan that offers a basic plan, may offer an enhanced plan. A plan that offers an enhanced plan may offer a premium plan. A plan that offers a premium plan may offer a premium plus plan. **Plan Categories.** Four categories of benefits to be offered. Benefits that must be	Access to gateways would be restricted to individuals who are not incarcerated and who are not eligible for employer-sponsored coverage meeting minimum qualifying criteria and are not enrolled in Medicare, Medicaid, TRICARE or FEHB. States would assist enrollment of individuals in gateway plans, Medicaid, CHIP and other Federal Support programs, through the use of information technology. CHIP eligibles may elect to enroll in a gateway plan. **Plan Requirements.** Plans must at least offer the essential benefits package, be NCQA accredited, have quality improvement and grievance and appeals programs in place. Requires states to collect payments from plans with participants with below average health risks and pay plans with above average health risks. State benefit mandates would continue to apply, but States must reimburse the Commissioner for the cost of continuing the mandate.

	made available each year would be determined by the Health Choices Commissioner. • Basic plan, which includes the essential benefits package and covers 70% of benefit costs. • Enhanced plan, which includes the essential benefits package and covers 85% percent of benefit costs. • Premium plan, which includes the essential benefits package and covers 95% of the benefit costs. • Premium plus plan, which provides additional benefits such as oral health and vision care and a separate premium for the additional benefits. Cost sharing may vary within each benefit category (mental health, hospital care) by plus or minus 10 percent. State benefit mandates would continue to apply, but States must reimburse the Commissioner for the cost of continuing the mandate. **Financing.** Creates a Health Insurance Exchange Trust Fund that includes new individual and employer taxes, penalties and appropriations, to finance the operation of the exchanges and for affordability credits. • *E&C Amendment:* Prohibits plans participating in the exchange from discriminating against any provider due to their willingness or unwillingness to provide abortions. • *E&C Amendment (Schakowsky):* The annual increase in premiums charged under any Exchange-participating health benefits plan may not exceed 150% of the annual percentage increase in medical inflation unless the plan receives approval for a higher rate increase. This would not apply to plans able to demonstrate that complying with this ceiling would threaten its financial viability.	**Financing.** Gateways can charge a tax on participating plans of up to 4% of premiums to cover implementation and administrative costs. **Outreach and Education.** Establishes Navigators to assist employers and individuals with enrollment and selection of health plans within the gateways. Navigators cannot be health insurers.
Group and Individual	The legislation includes mandates on plans offered in the individual and group markets. The bill requires group plans and individual policies to meet new	Establishes comprehensive insurance market regulations in the group (both inside and outside Gateway) and individual market, including:

Market Reforms	requirements that include: • Bans coverage exclusions on pre-existing conditions. • Guarantees issue and renewal of policies. • Modified community rating in the group and individual market, with age bands not to exceed 2:1. • Prohibits annual or lifetime limits. • Requires dependent coverage to age 26. • Requires adequate provider networks to ensure adequate access to services and requires transparency in cost sharing differences between in-and out-of-network coverage. • Prohibits discrimination in offering of benefits. • *E&C Amendment (Burgess):* Requires plans to establish an internal and external review process. Establishes penalties for plans that fail to comply with benefit determinations related to coverage decisions.	• Bans coverage exclusions on pre-existing conditions. • Guarantees issue and renewal of policies. • Modified community rating in the group and individual market, with age bands not to exceed 2:1. • Prohibits annual or lifetime limits. • Requires dependent coverage to age 26. • Requires adequate provider networks to ensure adequate access to services. • Prohibits discrimination against individuals based on health-status, including establishing eligibility rules based on: (1) health status; (2) medical condition; (3) claims experience; (4) receipt of health care; (5) medical history; (6) genetic information; (7) evidence of insurability; and (8) disability.
	Grandfather Clauses. Existing plans would be grandfathered only if closed to new enrollees and if they do not vary premiums for individuals by factors other than geography. Group health plans would have a 5-year grace period to meet new benefit standards and requirements, although the election portion of the bill (where an employer certifies it offers compliant coverage) treats any plan as a new plan, thereby nullifying the grace period. • *E&L Amendment (Petri):* Creates an exception for consumer for consumer directed health plans and arrangements, including HSAs, and treats these plans as qualified coverage. • *E&L/E&C Amendment:* Reduces the look back period from 6 months to 30 days and reduces the pre-existing condition exclusion period (i.e., the waiting period) from 12 months to 3 months for a timely enrollee and 18	**Grandfather Clauses.** Current individual policies are grandfathered. Group plans are grandfathered and may enroll new members and family members if the plan operated prior to enactment of the bill. Collective bargaining agreements (CBA) ratified before enactment of the legislation would not be affected, until the collective bargaining agreements terminate.

	months to 9 months for a late enrollee to the plan. • *E&C Amendment:* Collective bargaining agreements ratified before enactment of the legislation would not be affected, until the collective bargaining agreements terminate or three years after enactment of the legislation.	
Health Benefit Requirements	All qualified health benefits plans: • Requires minimum set of benefits, determined by the health board • No lifetime or annual coverage limits • Hospitalization, emergency & outpatient services • Physician services • Prescription drugs • Rehabilitative services • Mental health and substance abuse services • Preventive care with no cost sharing (defined as services with A or B rating from USPSTF) • Vaccines consistent with CDC recommendations • Maternity benefits • Well-baby and well-child care including: oral, vision, hearing and related equipment until age 21 • Total cost-sharing, including deductible, may not exceed $5,000 for an individual or $10,000 per family per year. This limit would be increased yearly by the increase in CPI-U. Prohibits limits besides cost sharing on coverage unrelated to clinical appropriateness. Requires copayments and not coinsurance to be used to the maximum extent possible. • *E&C Amendment:* Requires plans to provide information related to end-	Establishes minimum federal requirements for health insurance coverage (for insurers and group plans, including ERISA) through "essential health benefits" that plans must cover for premiums to be eligible for credits/subsidies, including coverage in the following categories: • Ambulatory patient services • Emergency services • Hospitalization • Maternity and newborn care • Mental health and substance abuse services • Prescription drugs • Rehabilitative and laboratory services • Preventive and wellness services (defined as services with A or B rating from USPSTF) • Pediatric services, including oral and vision care. • All qualified health plans would include annual out-of-pocket limits equal to out-of-pocket maximums for high-deductible/HSA plans ($5,800 for self-only coverage and $11,600 for family coverage in 2009). Requires all insurers and self-insured group health plans to develop and implement reimbursement structures that provide incentives for: • The provision of high quality care, case management, • Care coordination and chronic care management, • Reduction in preventable hospital readmissions through discharge

	of-life planning to individuals and provide option to establish advance directives and physician's order for life sustaining treatment. Prohibits counseling for assisted suicide or euthanasia. • *E&C Amendment (Doyle/Deal):* Requires mental health and substance abuse, including behavioral health services to be covered under minimum benefits package. • *E&C Amendment:* Prohibits the Center for Quality Improvement from developing quality-adjusted life year measures or any other measures that can be used to deny benefits against a beneficiary's wishes.	planning, • Improvements in patient safety and reduction in medical errors through the appropriate use of best clinical practices, evidenced based medicine and health information technology, • Wellness and health promotion activities, • Child health measures, as defined under the Social Security Act, • Culturally and linguistically appropriate care, as defined by the Secretary of HHS.
Medical Loss Ratio	**QHBPs:** Beginning in 2011, qualified plans are required to achieve a medical loss ratio of a percentage to be determined by the Health Choices Commissioner. Plans exceeding that limit are required to issue rebates to enrollees. **Medicaid:** Requires qualified plans to have a minimum medical loss ratio of not less than 85%, with the methodology to be determined by the Health Choices Commissioner. Provision would take effect on or after July 1, 2010. **Medicare Advantage:** Beginning in 2014, if the Secretary determines that an MA plan has failed to have a medical loss ratio of at least 85%: • A rebate must be provided to enrollees; • New enrollees will be prohibited if plan does not achieve such a ratio for three consecutive years; and • Plan will be terminated if it does not achieve such a ratio for five consecutive years.	**Qualified Plans:** Insurers are required to provide an "annual rebate" for administrative costs that exceed certain thresholds. Requires health insurance issuers offering group or individual coverage to disclose total premium revenue spending on: (1) reimbursement for clinical services; (2) activities to improve quality; and (3) all other non-claims costs.
Employer Mandate	**Play or Pay.** Requires employers to offer coverage to employees or pay an 8% payroll tax to the Health Insurance Exchange Trust Fund. An employer meets the mandate requirement if it offers qualified benefits. Employers must meet a minimum contribution requirement for full-time employees equal to at least 72.5%	**Play or Pay.** Requires employers with 25 or more employees to offer health coverage to their employees and contribute at least 60% of premium cost or pay $750 for each employee not offered coverage ($375 for part-time workers).

	of the premium cost of single coverage and 65% of the premium cost for family coverage of the lowest cost plan that meets the essential benefits package requirements. **Exemption.** Employers with less than $750,000 in payroll would be exempt. • *E&L Amendment (Hunter):* Provides hardship exemption for employers that would be negatively affected by job losses resulting from requirement. • *E&C Amendment (Ross):* Extends the reduction in pay-or-play requirement for small employers with annual payroll of less than $750,000: • Annual payroll less than $500,000: exempt; • Annual payroll between $500,000-$585,000: 2% of payroll; • Annual payroll between $585,000 and $670,000: 4% of payroll; • Annual payroll between $670,000 and $750,000: 6% of payroll. **Auto Enrollment.** Requires employers offering coverage to automatically enroll into the employer's lowest cost premium plan any individual not electing coverage under the employer plan or does not opt out of coverage.	**Exemption.** Employers with fewer than 25 employees would be exempt from the requirement. Seasonal workers and independent contractors exempted from being counted in total number of employees. Individuals with gross incomes not exceeding 150% of FPL would not be considered "qualified individuals". Individuals eligible for employer-sponsored coverage are considered "qualified individuals" only if that coverage does not meet criteria for minimum qualifying coverage or is not affordable. • Unaffordable coverage is defined as when the portion of worker-paid premiums exceeds 12.5% of the worker's adjusted gross income in 2013. No provision.

Lawsuits	State laws relating to private rights of action with remedies shall apply to ERISA plans within the exchange, expressly overturning ERISA's federal, uniform remedy scheme. • *E&C Amendment (Gordon/Deal/Matheson):* States would receive incentive payments if they enact and implement a medical liability reform law that prevents and promptly resolves disputes, encourages the disclosure of medical errors, and maintains access to affordable liability insurance. Such laws may contain certificates of merit or early offers as an alternative to litigation. Grants will be used by states to "improve health care".	No provision.
Premium Subsidies to Employers	**Small Employer Credit.** The legislation provides a 50 percent credit towards qualified expenses for employee health coverage. The credit phases out for: • Employers whose average and annual employee compensation exceeds $20,000 (indexed to inflation); • The number of employees exceeds 10 ; and • Is not available for coverage of any employee whose aggregate compensation exceeds $125,000. Small business is defined as an employer with 25 or fewer employees. For employers with more than 10 employees, the tax credit is reduced by an amount which bears the same ratio to the amount of the credit as the excess of the number of employees over 10:15. The credit is not permitted for employees earning more than $80,000/year. • *E&L Amendment (Fudge/Titus):* The Commissioner and SBA would	**Small Employer Credit.** Provides employers with fewer than 50 full-time employees paid an average wage of less than $50,000 with a health options program credit. Employers must pay 60% of employee health expenses to obtain the credit, which is equal to $1,000 for each employee with single coverage and $2,000 for each employee with family coverage, adjusted for firm size. Bonus payments are given for each additional 10% of health expenses above 60% paid by the employer. Employers may not receive the credit for more than three consecutive years. Self-employed individuals not receiving premium credits for purchasing coverage through the Gateway are eligible for the credit.

	establish a program to provide counseling and technical assistance to small employers. **Retiree Health.** Creates a temporary reinsurance program for businesses providing retiree health coverage. • $10 billion Reserve Trust Fund at Department of Treasury to help offset costs of a health claim that is between $15,000 and $90,000 for employers providing retirees age 55-64 with retiree health care. • Reimbursement is on a claim-by-claim basis and not for aggregate costs. • Amounts paid are used to reduce premiums and cost sharing for plan participants and cannot be used to reduce the costs of an employer.	**Retiree Health.** Creates a temporary reinsurance program for employers providing health insurance coverage to retirees ages 55 to 64. • The program will reimburse employers for 80% of a retiree claim that is between $15,000 and $90,000. • Reimbursement is on a claim by claim basis, and not for aggregate costs. • Amounts paid are used to reduce premiums and cost sharing for plan participants and cannot be used to reduce the costs of an employer.
COBRA	*E&L Amendment (Davis):* Allows workers to keep COBRA coverage until they become eligible for other coverage or the Exchange is in place (2013).	No provision.
Individual Mandate	**Mandate.** Requires individuals to have 'acceptable health coverage." Those without coverage pay a penalty of 2.5% of modified adjusted gross income up to the cost of the average national premium for self-only or family coverage under a basic plan in the Health Insurance Exchange. **Exceptions.** Exceptions would be granted for dependents, religious objections and financial hardship.	**Mandate.** Requires all individuals and their dependents to have health insurance, which would be enforced through a penalty determined by the Secretary, but which cannot be less than 50 percent of the average annual premium for basic coverage. **Exceptions.** Exceptions would be granted for residents of states without Gateways, those for whom affordable coverage is not available, those with religious objections, those with financial hardship, an Indian, and those without coverage for fewer than 90 days.
Subsidies to Individuals	**Affordability Credits.** The bill provides affordability premium credits to eligible individuals and families with incomes up to 400% FPL to purchase insurance through the Exchange. Premium credits would be based on average cost of the three lowest cost basic health plans in the area and will be set on a sliding scale such that the premium	**Affordability Credits.** Provides premium credits on a sliding scale to individuals and families with incomes up to 400% FPL to purchase coverage through the Gateway. Premium costs will be based on the average cost of the three lowest cost qualified health plans in the area. Individuals with incomes less than 400%

	contributions are limited to the following percentages of income for specified income tiers:
	
	• 133-150% FPL: 1.5-3% of income;
	• 150-200% FPL: 3-5% of income;
	• 200-250% FPL: 5-7% of income;
	• 250-300% FPL: 7-9% of income; and
	• 300-350% FPL: 10-11% of income.
	
	• *E&C Amendment (Ross):* replaces the above subsidy schedule with the following:
	  ◦ 133-150% FPL: 1.5-3% of income;
	  ◦ 150-200% FPL: 3-5.5% of income;
	  ◦ 200-250% FPL: 5.5-8% of income;
	  ◦ 250-300% FPL: 8-10% of income;
	  ◦ 300-350% FPL: 10-11% of income; and
	  ◦ 350-400% FPL: 11-12% of income.
	
	• *E&C Amendment:* Increase the affordability credits annually by the estimated savings achieved through adopting a formulary in the public health insurance option, pharmacy benefit manager transparency requirements, developing accountable care organization pilot programs in Medicaid, and administrative simplification.
	
	• *E&C Amendment (Schakowsky):* Increase the affordability credits annually by the estimated savings achieved through limiting increases in premiums for plans in the Exchange to no more than 150% of the annual increase in medical inflation and by requiring the Secretary to negotiate prices directly with prescription drug manufacturers on behalf of Medicare Part D Plans.
		FPL would pay no more than 12.5% of income, and individuals with incomes less than 150% FPL would pay no more than 1% of income, with additional limits on cost sharing.
		
		The bill limits the availability of premium credits through the Gateway to those not eligible for employer-based coverage that meets minimum qualifying criteria and affordability standards, Medicare, Medicaid, TRICARE, or FEB program.
		
		Individuals with access to employer-based coverage are eligible for the premium credits if the cost of the employee premium exceeds 14.5% of the individuals' income.
		
		• Subsidies would be paid to the state/regional Gateway on behalf of an eligible individual/family

Health Board	Establishes a public-private Health Benefits Advisory Committee to recommend to the Secretary minimum covered benefits and the essential benefits package. The	Creates a temporary, independent commission to advise the Secretary in the development of the essential health benefits package.

	Secretary will determine whether to adopt the recommendations, which would be required to be covered by qualified benefits plans. • *E&C Amendment (Walden):* At least 25 percent of the Board must be practicing rural health care providers and have practiced in a rural area for at least five years. Creates the Health Choices Administration as an independent, executive Branch agency, headed by a health Choices Commissioner appointed by the President and confirmed by the Senate. The Commissioner is required to establish standards for plans and administer the health insurance exchange and the affordability credits.	
Expansion of Public Programs	Expands Medicaid to all individuals with incomes up to 133% FPL. Newly eligible, non-traditional Medicaid beneficiaries may enroll in coverage through the Exchange if they were enrolled in qualified health coverage during the six months before becoming Medicaid eligible. Provides Medicaid for all newborns lacking coverage and provides optional Medicaid coverage to low-income HIV infected individuals and for family planning services for low-income women. Increases Medicaid payment rates for primary providers to 100% of Medicare rates. • *E&C Amendment (Murphy):* Requires states to submit a state plan amendment specifying the payment rates to be paid under the state's Medicaid program. The coverage expansions and enhanced provider payments would be fully financed with federal funds. • *E&C Amendment (Ross):* Replace full federal financing for Medicaid coverage expansions with 100% federal financing through 2014 and 90% federal financing beginning in 2015.	Expands Medicaid to all individuals with incomes up to 150% of FPL. Individuals eligible for Medicaid will be covered through state Medicaid programs and are not eligible for credits to purchase coverage through Gateways. Individuals eligible for CHIP would be given the option of enrolling in CHIP or enrolling in a qualified plan through a Gateway.

Side-By-Side of Major Health Reform Proposals

Tax Changes	Imposes a tax on individuals without acceptable health coverage of 2.5% of modified adjusted gross income. New payroll taxes on non-electing employers up to 8 percent of payroll. Credit for small businesses. • *W&M Amendment (Rangel):* Disallows use of HSA, FSA, or HRA funds as a qualified medical expense for over the counter drugs ($8.2 billion) • *W&M Amendment (Rangel):* Income surtax ($544 billion) • *W&M Amendment (Rangel)* Premium tax to fund CER ($2 billion) • *W&M Amendment (Rangel):* Worldwide interest allocation ($26 billion) • *W&M Amendment (Rangel):* Residency of Foreign Parent ($7.5 billion) • *W&M Amendment (Rangel):* Economic Substance Doctrine ($3.6 billion) • *W&M Amendment (Rangel):* Deduction for spouses and dependents of self employed (-$4 billion)	No provisions.
Quality/ Performance	Support comparative effectiveness research by establishing a Center or Comparative Effectiveness Research within AHRQ to conduct, support, and synthesize research on outcomes, effectiveness, and appropriateness of health care services and procedures. An independent CER Commission will oversee the activities of the Center. • *E&C Amendment (Gingrey):* CMS may not use federally funded comparative effectiveness data to make coverage determinations on the basis of cost. • *E&C Amendment (Rogers):* CER may not be used to deny or ration care. Increases Medicaid payments for primary care providers and providing Medicare bonus payments to primary care providers. • *E&C Amendment:* Establish the CMS Payment Innovation Center to test payment models addressing populations experiencing poor clinical outcomes or avoidable expenditures.	Develop quality measures allowing assessments of health outcomes; continuity and coordination of care; safety, effectiveness and timeliness of care; health disparities; and appropriate use of health care resources. Require public reporting on quality measures through a user-friendly website. Create a Center for Health Outcomes Research and Evaluation within AHRQ to conduct and synthesize research on the effectiveness of care and procedures to provide providers and patients with information on the most effective therapies for preventing and treating health conditions. Provide grants for improving health system efficiency, including grants to establish community health teams to support a medical home model. Develop interoperable standards for using HIT to enroll individuals in public programs and provide grants to states and other governmental entities to adopt and implement enrollment technology.

	• *W&M Amendment:* Require IOM to conduct a study on geographic variation in health care spending and recommend strategies for addressing this variation by promoting high-value care. Establish the Center for Quality Improvement to identify, develop, evaluate, disseminate, and implement best practices in the delivery of health care services. 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. • *E&C Amendment:* Conduct a national public education campaign to raise awareness about planning for end of life care.	
Prevention/ Wellness	Develop a national strategy to improve health through evidence-based clinical and community-based prevention and wellness activities. Creates task forces on Clinical Preventive Services and to develop, update and disseminate evidence-based recommendations on the use of clinical and community prevention services. Improve prevention by covering only proven preventive services in Medicare and Medicaid. Eliminates any cost-sharing for preventive services in Medicare and increase Medicare payments for certain preventive services to 100% of actual charges of fee schedule rates. • *E&C Amendment (Butterfield):* Provide grants to provide pharmacy medication management programs.	Develop a national prevention and health promotion strategy to set specific goals for improving health. Creates a prevention and public health investment fund to expand and sustain funding for prevention and public health programs. Award competitive grants to state and local governments and community-based organizations to implement and evaluate proven community preventive health activities to reduce chronic disease rates and address health disparities. Permit insurers to create incentives for health promotion and disease prevention practices. Encourage employers to provide wellness programs and increasing the allowable premium discount for employees who participate in these programs from 20 percent to 30 percent. Creates a temporary Right Choices program to provide uninsured adults with access to preventive services.

Side-By-Side of Major Health Reform Proposals

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<td>Cost Containment</td>
<td>Administrative Simplification. Simplify health insurance administration by adopting standards for financial and administrative transactions, including timely and transparent claims and denial management processes and use of standard electronic transactions, including EFT.

Medicare Changes: Modify provider payments under Medicare including:

• Modify market basket updates to account for productivity improvements for inpatient hospital, home health, skilled nursing facility and other Medicare providers; and
• Reduce payments for potentially preventable hospital readmissions.
• Restructure payments to Medicare Advantage plans, phasing to 100% of fee-for-services payments, with bonus payments for quality.
• Increase the Medicaid drug rebate percentage and extend the prescription drug rebate to Medicaid managed care plans. Require drug manufacturers to provide drug rebates for dual eligibles enrolled in Part D plans.
• E&C Amendment: Require the Secretary to negotiate directly with pharmaceutical manufacturers to lower drug prices for Medicare Part D plans and Medicare Advantage Part D Plans.
• E&C Amendment (Eshoo): Authorize the FDA to approve generic versions of biologic drugs and grant biologics manufacturers 12 years of exclusivity before generics can enter the market.
• Reduce Medicaid DSH payments by $6 billion in 2019, imposing the largest percentage reductions in state DSH allotments in states with the lowest uninsured rates and those that do not target DSH payments.
• Require hospitals and ASCs to report on health care associated infections to the CDC and refuse Medicaid payments for certain health care-associated conditions.
• Reduce waste, fraud and abuse in public programs by allowing provider screening, enhanced oversight periods, and enrollment moratoria in areas identified at elevated risk of fraud in all public programs, and by requiring Medicare and Medicaid program.</td>
<td>Administrative Simplification. Simplify health insurance administration by adopting standards for financial and administrative transactions, including timely and transparent claims and denial management processes and use of standard electronic transactions.

Establishes 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.</td>
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Side-By-Side of Major Health Reform Proposals

Long-Term Care	*E&C Amendment (Pallone):* Establishes a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program). The program will provide individuals with functional limitations a cash benefit to purchase non-medical services and supports necessary to maintain community residence. Program would be financed through voluntary payroll deductions—all working adults would be automatically enrolled in the program, unless they chose to opt out.	Establishes a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program). The program will provide individuals with functional limitations a cash benefit to purchase non-medical services and supports necessary to maintain community residence. Program would be financed through voluntary payroll deductions—all working adults would be automatically enrolled in the program, unless they chose to opt out.
CBO Estimates*	**Cost.** Over 10 years: • Effects on deficit from coverage provisions: $1.042 trillion • Changes to direct spending, net: -$219 billion • Changes in revenues: $583 billion • Net effect on deficit: $239 billion **Deficit.** "In sum, relative to current law, the proposal would probably generate substantial increases in federal budget deficits during the decade beyond the current 10-year budget window." **Effects on Enrollment.** • 97 percent covered after 10 years. • 17 million still without insurance. • 30 million receive coverage in the exchange. • 11 million more in Medicaid, 2 million more in employer plans. • 6 million reduction in non-group market. **Subsidy.** Average subsidy rises from $4,600 in 2014 to $6,000 in 2019. **Impact on the Labor Market.** • Requiring employers to offer health insurance—or pay a fee if they do not—would be likely to reduce employment. • Providing new subsidies for health insurance that decline in value as a	**Cost/Deficit.** Partial estimate over 10 years (does not include Medicare, Medicaid, CHIP, tax changes). • Proposal would result in a net increase in deficit of $597 billion. **Effect on Enrollment.** • 90 percent covered after 10 years. • 34 million remain uninsured. • 27 million receive coverage in the exchange. • 1 million fewer in Medicaid/CHIP. • Negligible impact on employer coverage. • 6 million reduction in non-group market. **Subsidy.** Average subsidy rises from $4,700 in 2014 to $6,100 in 2019.

	person's income rises could discourage some people from working more hours. • Increasing the availability of health insurance not related to employment could lead more people to retire before the age or 65 or choose not to work at younger ages. *Does not include amendments offered during markups.	*Does not include amendments offered during markup.