Congressional Health Reform Proposals

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	America's Affordable Health Choices Act of 2009 (HR 3200)	Senate HELP Committee Affordable Health Choices Act	Senate Finance Committee Bipartisan Group Framework
Individual Mandate	Included	Included	Included
Changes in Tax policy	Mandate enforced through 2.5% tax penalty on adjusted gross income up to cost of average national premium, with exemptions based on religion or hardship	Mandate enforced through tax penalty of no more than $750, with exemptions for states without American Health Benefit Gateway, Indian tribes, and those for whom coverage is not affordable	Mandate enforced through penalty of $750/$1,500 for individual/family under 300% FPL and $950/$3,800 for individual/family above 300% FPL, exemptions for financial hardship
Individual premium subsidies	Sliding scale credits up to 400% FPL ($80,000+ for a family of four) with contribution caps on premiums and cost-sharing	Sliding scale credits up to 400% FPL with contribution caps on premiums and cost-sharing	Sliding scale tax credits for individuals and families up to 300% FPL ($60,000+ for a family of four) who are not offered affordable employer-provided coverage, based on percentage of income the premium represents; additional assistance for cost-sharing. Flat percent of income tax credit for individuals 300-400% FPL
Employer Requirements	Pay or play: 72.5% of premium cost for single and 65% for family OR pay percentage of payroll into Health Insurance Exchange Trust fund (small business exemption)	$750/employee fee for employers who do not offer coverage (small business exemption)	Mandated coverage for employers with 200+ employees. Pay or play with fee requirement (capped at $400 per employee) for employers with 50+ employees whose employees receive tax credits through the Exchange (small business exemption)
Employer premium subsidies	Sliding scale tax credits to employers with fewer than 25 employees and average wages less than $40,000. Temporary reinsurance program for employers providing coverage to retirees 55 to 64	$1,000/$2000 credits per employee/family to employers with fewer than 50 full-time employees and average wages less than $50,000. Temporary reinsurance program for employers providing coverage to retirees 55 to 64	Temporary tax credit up to 35% of employer cost of premiums for firms with less than 25 employees and average wages less than $40,000. Permanent tax credit of up to 50% of premium cost to low wage small businesses beginning in 2013

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Purchasing Pools for Individuals, Small Employers and the Uninsured	National Health Insurance Exchange with risk adjustment and four benefits categories: basic, enhanced, premium, premium plus	State American Health Benefit Gateways with optional regional Gateways within states, adjustments based on Secretary's recommendations	Separate individual and small group State Health Insurance Exchanges with state-based ombudsman office to act as consumer advocate, immediate funding for state high risk pools
New Public Plan Option	Yes, but only through the Exchange, requires that costs of plan be financed fully through premium revenues. Payment rates to providers are negotiated, Medicare providers are considered participating in plan unless they opt out	Yes, to be offered through state Gateways and be fully financed through premiums with negotiated payment rates with providers	No, federal funding instead for Consumer Operated and Oriented Plans (CO-OP) to compete in reformed individual and small group market, with minimum one co-op per state
Medicaid Expansion and Reform	To 133% FPL for all individuals ($13,000+ for an individual) with full federal funding of expansion, CHIP (Child Health Insurance Program) children required to obtain coverage through Exchange	To 150% FPL for all individuals, with CHIP children able to choose between CHIP program or a qualified plan in Gateway	To all individuals up to 133% FPL, drug benefits are mandated for state with higher drug company rebates, CHIP eligibility extends to 250% FPL and transition to supplementary wrap around program in 2013 for children enrolled in Exchange, Minimum FMAP (federal matching) increased 50% to 55%, State option to cover medical home
Medicare Reform	Modify payment rates to include efficiency incentives, reduce payments to hospitals with excessive readmissions, bundle payments for post acute care, phase Medicare Advantage payments down to Medicare rates, eliminate doughnut hole for seniors, negotiate for lower drug prices in Medicare Part D	Not specified	Immediate 50% manufacturer discount on negotiated prices in Part D to close doughnut hole, coverage for biannual personal prevention and wellness plan, removal of preventive service cost sharing, pilot programs for healthy living incentives, replace scheduled 21% payment reduction in physician payments with 0.5% increase, establish new Medicare Advantage benchmarks incentivizing care coordination

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Waste and fraud in Medicare/ Medicaid	Refuse payment for health-care acquired conditions, provider screening in high risk areas, requiring evaluations and reports under integrity programs	Establish Health Care Program Integrity Coordinating Council to better address waste, fraud, and abuse	New office to coordinate care for dual-eligibles, Provider screening, one PI database to capture/share data, increase penalties for false claims, increase anti-fraud activities
Innovative public payment mechanisms	Medical home, value-based purchasing, bundling, pay-for-performance, partial capitation	Incentives for better coordinated care, reduced readmissions, payment innovation in public plan	Provide bonus payments for care management activities, bundle payments for acute+post-acute care, incentives for accountable care organizations
Insurance Market Reform	Guaranteed issue and renewability, minimum benefits package, rating variation only on age (2:1), family size and geography, 85% medical loss ratio	Guaranteed issue and renewability, rating variation on family structure, geography, actuarial value, and age	Guaranteed issue and renewability, rating variation on age (5:1), tobacco use (1.5:1), family structure (3:1) and geography all totaling no more than 7.5:1, prohibits annual/lifetime limits and cost sharing for preventive services
Benefits	Creation of essential benefits package by Health Benefits Advisory Council with 4 benefits categories	3 benefit tiers with essential benefits package specified by Medical Advisory Council	4 benefits categories (bronze, silver, gold, platinum) with set actuarial values, plus 'young invincible' policy of catastrophic and preventive coverage
Other Market Reform	Individual market coverage acceptable under mandate is purchased through the Exchange	Require cost reporting, medical loss ratio established by Secretary, preventive service coverage, dependent coverage up to age 26	Require reporting and disclosure on medical loss ratios and service charges, risk sharing mechanisms including risk adjustment, reinsurance, and risk corridors, allow states to form 'health care choice compacts' for interstate sale of insurance
Individuals Without Legal Residency Documents	Excluded from public subsidies through the Exchange	Excluded	Excluded
Cost Sharing Limits	Annual cost sharing limits of $5,000/individual and $10,000/family	Sliding scale limits on costs of premium and cost sharing beginning at 1% of income for individuals under 150% FPL increasing to 12.5% of income for individuals under 400% FPL	Sliding scale limits on premiums and cost sharing to 3% of income for those at 100% FPL rising to 13% of income for those over 300% FPL

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Cost Containment	Standardized claim forms, quality reporting requirements, operating rules for processing and increasing electronic data exchange, limiting annual increases in premiums to 150% of medical inflation, allow generic versions of biologics after 12 years	Provide grants to improve system efficiency (medical home model, community health teams, medication management services)	Require payment and provider incentive disclosures from drug and device manufacturers, improve transparency of information in hospital and skilled nursing facilities, 10% Medicare payment bonus for primary care practitioners and providers in shortage areas, increase imaging utilization rate from 50% to 90% to calculate payment
Prevention	Eliminate cost-sharing, cover only proven services, create task forces on Clinical Preventive Services and Community Preventive services for evidence-based recommendations	Develop national strategy with specific goals, create a health investment fund and council to expand and sustain prevention and public health efforts	Eliminate cost sharing with some exceptions, cover only proven preventive services, provide incentives through program to complete behavior modification programs, provide grants to states to promote integration of health care services and other services
Quality and System Performance	Establish Center for Comparative Effectiveness within AHRQ, increase Medicaid payments to primary care, develop national priorities for performance and quality, create accountable care organization pilots	Create Patient Safety Research Center, develop interoperable standards for HIT, require public reporting on quality measures	Establish bundling programs and value-based purchasing program to pay hospitals based on performance and quality in public programs, improve public reporting, establish institute for comparative effectiveness research, create Innovation Center within CMS
State Roles	Coordinate enrollment of individuals, determine eligibility for affordability credits, grant waivers to states seeking to establish single payer system	Establish Gateways with federal standards, create temporary RightChoices programs for immediate access to preventive/chronic disease services for uninsured	Allow states the option to create or merge into regional Exchange, create coops, enter into compacts to create interstate health coverage, incentives to promote access to preventive services

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Cost and Financing	$1.04 trillion over 10 years paid for through savings in Medicare and Medicaid and surcharge on incomes over $280,000/$350,000 for individuals/families	$615 billion over 10 years, financing not in Committee's jurisdiction	$880 billion over 10 years, funded by 35% excise tax on "Cadillac" group health plans costing over $8,000/21,000 for individual/family, limits on HSA contributions and expenses, eliminating exclusion for employer Part D subsidy, fees on multiple health care industries
Other reform	Require report on future role, appropriate targeting, and distribution of DSH payments, reform GME to increase primary care training	Establish voluntary insurance program to purchase community living assistance services, reform GME (with focus on pediatric, primary, and geriatric care), establish Health Care Workforce Commission, provide funding to increase community health centers and school-based health centers	Reform GME to promote primary care and residency programs in rural and underserved area through slot-redistribution programs, allow Certified Diabetes Educators to provide outpatient self-management training services, allow physician assistants to order post-acute care services and serve hospice patients as an attending physician, exempt small pharmacies from Medicare accreditation requirement

Finance Committee: http://finance.senate.gov/press/Bpress/2009press/prb090909.pdf
HELP Committee: http://help.senate.gov/BAI09A84_xml.pdf
HR 3200: http://www.energycommerce.house.gov/Press_111/20090714/aahca.pdf