SIDE-BY-SIDE COMPARISON OF MAJOR HEALTH CARE REFORM PROPOSALS

This side-by-side compares the leading comprehensive reform proposals across a number of key characteristics and plan components. Included in this side-by-side are proposals for moving toward universal coverage that have been put forward by the President and Members of Congress. In an effort to capture the most important proposals, we have included those that have been formally introduced as legislation as well as those that have been offered as principles or in White Paper form. This side-by-side will be regularly updated to reflect changes in the proposals and to incorporate major new proposals as they are announced.

	Senate Finance Committee Policy Options	Senate HELP Committee Affordable Health Choices Act	House Tri-Committee Health Reform Proposal	President Obama Principles for Health Reform
Date plan announced	April – May 2009	June 9, 2009	June 19, 2009	February 26, 2009
Overall approach to expanding access to coverage	The Senate Finance Committee released a series of papers laying out options for health reform. While not a formal proposal, these papers offer a framework for achieving health reform goals and present the range of options the Committee will consider as it works to draft health reform legislation. Require all individuals to have health insurance. Create a Health Insurance Exchange through which individuals and small businesses can purchase health coverage, with subsidies available to individuals/families with incomes between 100 and 400% of the federal poverty level. Impose new regulations on the non-group and small group insurance markets. Expand Medicaid and CHIP and offer a temporary Medicare buy-in for the pre-Medicare population.	Require all individuals to have health insurance. Create state-based American Health Benefit Gateways through which individuals and small businesses can purchase health coverage, with subsidies available to individuals/families with incomes up to 500% of the federal poverty level. Impose new regulations on the individual and small group insurance markets. Expand Medicaid to all individuals with incomes up to 150% of the poverty level.	Require all individuals to have health insurance. Create a Health Insurance Exchange through which individuals and employers can purchase health coverage, with premium and cost-sharing credits available to individuals/families with incomes up to 400% of the federal poverty level. Require employers to provide coverage to employees or pay into a Health Insurance Exchange Trust Fund, with exceptions for certain small employers, and provide certain small employers a credit to offset the costs of providing coverage. Impose new regulations on plans participating in the Exchange and in the small group insurance market. Expand Medicaid to 133% of the poverty level.	President Obama outlined eight principles for health care reform in his FY 2010 Budget overview. The President has indicated that comprehensive health reform should: • Reduce long-term growth of health care costs for businesses and government. • Protect families from bankruptcy or debt because of health care costs. • Guarantee choice of doctors and health plans. • Invest in prevention and wellness. • Improve patient safety and quality care. • Assure affordable, quality health coverage for all Americans. • Maintain coverage when you change or lose your job. • End barriers to coverage for people with pre-existing medical conditions.

	Senate Finance Committee Policy Options	Senate HELP Committee Affordable Health Choices Act	House Tri-Committee Health Reform Proposal	President Obama Principles for Health Reform
Individual mandate	• Require all individuals to have insurance that meets minimum coverage standards. Enforced through an excise tax equal to a percentage of the premium for the lowest cost option available through the Health Insurance Exchange in the area where the individual resides. Exemptions will be granted for financial hardship; if the lowest cost plan option exceeds 10% of an individual's income; and if the individual has income below 100% of the poverty level.	• Require all individuals to have qualifying health coverage. Enforced through a tax penalty, the amount of which is to be determined by the Secretary of the Treasury. Exemptions to the individual mandate will be granted to residents of states that do not establish an American Health Benefit Gateway, members of Indian tribes, those for whom affordable coverage is not available, and those who can demonstrate financial hardship.	• Require all individuals to have "acceptable health coverage". Enforced through a 2% tax on adjusted gross income up to the cost of the average national premium for the basic plan in the Health Insurance Exchange. Exceptions granted for dependents, religious objections, and financial hardship.	• The plan must put the country on a clear path to cover all Americans.
Employer requirements	• **Proposed Option A:** Require employers with more than $500,000 in total payroll per year to offer coverage to their employees and contribute at least 50% of the premium or pay an assessment. The employer assessment could be structured in several ways: 1) a set fee per enrollee per month based on total annual payroll; 2) a tiered penalty calculated as a percentage of payroll; or 3) a larger penalty only on firms with annual payroll of more than $1,500,000. • **Proposed Option B:** No employer "pay or play" requirement.	Policy under development.	• Require employers to offer coverage to their employees and contribute at least 72.5% of the premium cost for single coverage and 65% of the premium cost for family coverage of the lowest cost plan that meets the essential benefits package requirements or pay 8% of payroll into the Health Insurance Exchange Trust Fund. • Exempt certain small businesses (to be determined) from the employer "pay or play" requirement.	Not specified.

	Senate Finance Committee Policy Options	Senate HELP Committee Affordable Health Choices Act	House Tri-Committee Health Reform Proposal	President Obama Principles for Health Reform
Expansion of public programs	**Medicaid** • Expand Medicaid to all individuals with incomes up to 115% FPL, with a possible increase in eligibility for parents, pregnant women, and children to a higher level. Coverage could be provided through the current program structure or by enrolling children, pregnant women, parents, and childless adults in the Health Insurance Exchange. Another alternative is to enroll all populations except childless adults in Medicaid. Under this approach, childless adults would not be eligible for Medicaid but would be given tax credits to purchase coverage through the Exchange or to buy-in to Medicaid. **Children's Health Insurance Program** • After September 30, 2013, expand CHIP eligibility to 275% FPL. Once the Health Insurance Exchange is fully operational, CHIP enrollees would obtain coverage through the Exchange and states would be required to continue to provide services not covered by plans in the Exchange, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. **Medicare** • Until the Health Insurance Exchange is underway, allow individuals aged 55-64 without coverage to buy-in to Medicare at full-cost. • Phase-out or reduce the two-year waiting period for Medicare eligibility for people with disabilities.	• Expand Medicaid to all individuals with incomes up to 150% FPL. Individuals eligible for Medicaid will be covered through state Medicaid programs and will not be eligible for credits to purchase coverage through American Health Benefit Gateways. • Grant individuals eligible for the Children's Health Insurance Program (CHIP) the option of enrolling in CHIP or enrolling in a qualified health plan through a Gateway. • Create a public plan to be offered through state Gateways. The details of the public plan are under development.	• Expand Medicaid to all individuals with incomes up to 133% FPL. Newly eligible, non-traditional (childless adults) 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. After five years, states may request that some or all categories of Medicaid beneficiaries obtain coverage through the Exchange provided the state can demonstrate the ability to provide wrap-around coverage and the plans in the Exchange are deemed capable of supporting this population. • Provide optional Medicaid coverage to low-income HIV-infected individuals; provide optional Medicaid coverage for family planning services to certain low-income women. • Require CHIP enrollees to obtain coverage through the Health Insurance Exchange.	• As a foundation for health reform, the President signed the Children's Health Insurance Program Reauthorization Act (CHIPRA), which provides coverage to 11 million children.

	Senate Finance Committee Policy Options	Senate HELP Committee Affordable Health Choices Act	House Tri-Committee Health Reform Proposal	President Obama Principles for Health Reform
Expansion of public programs (continued)	**Public Health Insurance Option** • **Proposed Option A:** Create a new public plan to be offered through the Exchange that will be subject to the same rating and risk adjustment rules as the private plans. The public plan could be administered by the federal government, by multiple third-party administrators, or by the states. • **Proposed Option B:** Do not create a public plan option.		• Create a new public health insurance option to be offered through the Health Insurance Exchange that must meet the same requirements as private plans regarding benefit levels, provider networks, consumer protections, and cost-sharing. Require that costs of the public plan be financed through revenues from premiums. Set provider payment rates in the public plan at Medicare rates and allow bonus payments of 5% for providers that participate in both Medicare and the public plan and for pediatricians and other providers that don't typically participate in Medicare. Permit the public plan to develop innovative payment mechanisms, including medical home and other care management payments, value-based purchasing, bundling of services, performance based payments, or partial capitation.	

	Senate Finance Committee Policy Options	Senate HELP Committee Affordable Health Choices Act	House Tri-Committee Health Reform Proposal	President Obama Principles for Health Reform
Premium subsidies to individuals	• Provide refundable tax credits to individuals and families with incomes between 100 and 400% FPL to purchase insurance through the Health Insurance Exchange. The level of the premium tax credit could be set as a percentage of income or as a percentage of the premium, with additional limits on cost-sharing.	• Provide premium credits on a sliding scale basis to individuals and families with incomes up to 500% to purchase coverage through the Gateway. The premium credits will be determined by the Secretary, but will be such that individuals with incomes less than 500% FPL pay no more than 10% of income and individuals with incomes less than 150% FPL pay 1% of income, with additional limits on cost sharing. • Individuals are not eligible for premium credits through the Gateway if they have access to employer-based coverage that meets minimum qualifying criteria and affordability standards, or are eligible for Medicare, Medicaid, TRICARE, or FEHBP.	• Provide affordability premium credits to individuals and families with incomes up to 400% FPL to purchase insurance through the Health Insurance Exchange. The premium credits will be based on the average cost of the three lowest cost basic health plans in the area and will be set on a sliding scale such that the premium contribution is no more than 1% of income for individuals with income at or below 133% FPL and no more than 10% of income for individuals with income at 400% FPL. • Provide affordability cost-sharing credits to individuals and families with incomes up to 400% FPL. The cost-sharing credits are offered on a sliding scale basis such that the cost-sharing limit for those with income at or below 133% FPL is $250 per individual and $500 per family and for those with income at 400% FPL is $5,000 per individual and $10,000 per family.	• The plan must protect families' from bankruptcy or debt because of health care costs. • The American Recovery and Reinvestment Act makes coverage more affordable for Americans who lose their jobs and their access to employer-based health coverage by offering a subsidy of 65 percent of the premium costs for COBRA coverage.

	Senate Finance Committee Policy Options	Senate HELP Committee Affordable Health Choices Act	House Tri-Committee Health Reform Proposal	President Obama Principles for Health Reform
Premium subsidies to employers	• Provide certain small employers that purchase insurance for their employees with a tax credit. The full credit of 50% of the average total premium cost paid by the employer would be available to employers with 10 or fewer employees and whose employees have average annual wages of less than $20,000. The tax credit would be phased out as firm size and earnings increase. The tax credit would not be payable in advance or refundable.	• Provide qualifying small employers with a health options program credit. To qualify for the credit, employers must have fewer than 50 full-time employees, pay an average wage of less than $50,000, and must pay at least 60% of employee health expenses. The credit is equal to $1,000 for each employee with single coverage and $2,000 for each employee with family coverage, adjusted for firm size (phasing out as firm size increases) and number of months of coverage provided. Bonus payments are given for each additional 10% of employee health expenses above 60% paid by the employer. • Create a temporary reinsurance program for employers providing health insurance coverage to retirees ages 55 to 64. Program will reimburse employers for 80% of retiree claims between $15,000 and $90,000. Program will end when the state Gateway is established.	• Provide small employers with fewer than 25 employees and average wages of less than $40,000 with a health coverage tax credit. The full credit of 50% of premium costs paid by employers is available to employers with 10 or fewer employees and average annual wages of $20,000 or less. The credit phases-out as firm size and average wage increases.	Not specified.
Tax changes related to health insurance	• Considers several health insurance-related tax changes affecting the tax preference for employer-sponsored insurance, health savings accounts, flexible spending accounts, and deductions for medical expenses.	Not specified.	Not specified.	Not specified.

	Senate Finance Committee Policy Options	Senate HELP Committee Affordable Health Choices Act	House Tri-Committee Health Reform Proposal	President Obama Principles for Health Reform
Creation of insurance pooling mechanisms	• Create one national or multiple regional Health Insurance Exchanges through which individuals and small employers can purchase qualified insurance. • Require all state-licensed insurers in the non-group and small group markets to participate in the Health Insurance Exchange(s). • Require guarantee issue and renewability and allow rating variation based only on age, tobacco use, family composition, and geography (not health status) in the Exchange(s). • Require the Exchange(s) to develop a standardized format for presenting insurance options, create a web portal to help consumers find insurance, maintain a call center for customer service, and establish procedures for enrolling individuals and businesses and for determining eligibility for tax credits.	• Create state-based American Health Benefit Gateways through which individuals and small employers can purchase qualified coverage. States may form regional Gateways or allow more than one Gateway to operate in a state as long as each Gateway serves a distinct geographic area. • Require the Gateway to certify participating health plans, provide consumers with information allowing them to choose among plans, contract with navigators to conduct outreach and enrollment assistance, and create a single point of entry for enrolling in coverage through the Gateway or through Medicaid, CHIP or other federal programs. • Require states to adjust payments to health plans based on the actuarial risk of plan enrollees using methods established by the Secretary. • Require plans participating in the Gateway to provide incentives to providers to better coordinate care, reduce hospital readmissions and implement wellness and health promotion activities; prohibit plans from contracting with hospitals with greater than 50 beds unless those hospitals adopt patient safety and discharge planning programs.	• Create a National Health Insurance Exchange through which individuals and employers (phasing-in eligibility for employers starting with smallest employers) can purchase qualified insurance. • Restrict access to coverage through the Exchange to individuals who are not enrolled in qualified or grandfathered coverage, Medicare, Medicaid (with some exceptions), TRICARE, or VA coverage. • Create four benefit categories (basic, enhanced, premium, and premium plus) of plans to be offered through the Exchange. Require participating plans to offer one basic plan for each service area and permit them to offer additional plans. • Require guarantee issue and renewability; allow rating variation based only on age (limited to 2 to 1 ratio), premium rating area, and family enrollment; and limit the medical loss ratio to 85%. • Require plans participating in the Exchange to be state licensed, report data as required, implement affordability credits, meet network adequacy standards, provide wrap-around coverage for Medicaid eligible individuals, provide culturally and linguistically appropriate services, and contract with essential community providers. • Require risk adjustment of participating Exchange plans. • Provide information to consumers to enable them to choose among plans in the Exchange, including establishing a telephone hotline and maintaining a website.	• The plan should provide portability of coverage and should offer Americans a choice of health plans.

	Senate Finance Committee Policy Options	Senate HELP Committee Affordable Health Choices Act	House Tri-Committee Health Reform Proposal	President Obama Principles for Health Reform
Benefit design	• Create four benefit categories (lowest, low, medium, and high). Require all plans to provide a comprehensive set of services and prohibit inclusion of lifetime limits on coverage or annual limits on benefits. • All policies (except certain grandfathered employer-sponsored plans) must comply with one of the four benefit categories, including those offered through the Exchange and those offered outside of the Exchange.	• Create three benefit tiers based on the percentage of allowed benefit costs covered by the plan, ranging from 76% of benefit costs for the lowest tier to 93% of benefit costs for the highest tier. Require plans to provide at least the essential benefits specified by the Medical Advisory Council and prohibit inclusion of lifetime or annual limits on benefits. • Establish a Medical Advisory Council to make recommendations on essential health care benefits, criteria for minimum qualifying coverage, and affordability standards.	• Create an essential benefits package that provides a comprehensive set of services as recommended by the Health Benefits Advisory Council. The essential benefits package covers 70% of the actuarial value of the covered benefits; limits annual cost-sharing to $5,000/individual and $10,000/family; and does not impose annual or lifetime limits on coverage. • All policies, including those offered through the Exchange and those offered outside of the Exchange (except certain grandfathered individual and employer-sponsored plans) must provide at least the essential benefits package.	Not specified.

	Senate Finance Committee Policy Options	Senate HELP Committee Affordable Health Choices Act	House Tri-Committee Health Reform Proposal	President Obama Principles for Health Reform
Changes to private insurance	• Require guarantee issue and renewability and allow rating variation based only on age, tobacco use, family composition, and geography (not health status) in the non-group, micro-group (2-10 employees), and small group markets. Require risk adjustment in all markets. • Require all state-licensed insurers in the non-group and small group markets to participate in the Health Insurance Exchange. • Require all insurers to issue policies in each of the four new benefit categories. • Allow states the option of merging the non-group and small group markets.	• Require guarantee issue and renewability of health insurance policies in the individual and small group markets; prohibit pre-existing condition exclusions; and allow rating variation based only on family structure, geography, the actuarial value of the health plan benefit, and age (with only 2 to 1 variation). • Require health insurers to: report cost information; to meet medical loss ratios established by the Secretary or provide rebates to enrollees; to provide incentives to providers to better coordinate care, reduce hospital readmissions and reduce medical errors. • Require insurers to provide coverage for preventive care services without cost sharing. • Provide dependent coverage for children up to age 26.	• Prohibit coverage purchased through the individual market from qualifying as acceptable coverage for purposes of the individual mandate unless it is grandfathered coverage. Individuals can purchase a qualifying health benefit plan through the Health Insurance Exchange. • Require guarantee issue and renewability and allow rating variation based only on age (limited to a 2 to 1 ratio), premium rating area, and family enrollment in the small group market and the Exchange. Prohibit imposition of any pre-existing condition exclusions. • Limit health plans' medical loss ratio to 85% enforced through a rebate back to consumers. • Require all insurers to offer coverage that meets the essential benefits package requirements. • Standardize health care claims forms, operating rules for using and processing health care transactions, and quality reporting requirements and increase electronic exchange of administrative and clinical data.	• The plan must end barriers to coverage for people with pre-existing medical conditions.
State role	• Allow states the option of merging the non-group and small group insurance markets. • Require state insurance commissioners to provide oversight of health plans with regard to consumer protections, rate reviews, solvency, reserve fund requirements, and premium taxes and to define rating areas.	• Establish American Health Benefit Gateways meeting federal standards and adopt individual and small group market regulation changes. • Create temporary "RightChoices" programs to provide uninsured individuals with immediate access to preventive care and treatment for identified chronic conditions. States will receive federal grants to finance these programs.	• Require states to enter into a Memorandum of Understanding with the Health Insurance Exchange to coordinate enrollment of individuals in Exchange-participating health plans and under the state's Medicaid program. • May require states to determine eligibility for affordability credits through the Health Insurance Exchange.	Not specified.

	Senate Finance Committee Policy Options	Senate HELP Committee Affordable Health Choices Act	House Tri-Committee Health Reform Proposal	President Obama Principles for Health Reform
Cost containment	• Encourage adoption and use of health information technology by expanding eligibility for the Medicare HIT incentives in the American Recovery and Reinvestment Act to include additional providers. • Eliminate fraud, waste, and abuse in public programs through more intensive screening of providers, the development of the "One PI database" to capture and share data across federal and state programs, increased penalties for submitting false claims and violating EMTALA, and increase funding for anti-fraud activities. • Restructure payments to Medicare Advantage plans to promote efficiency and quality. • Require drug or device manufacturers to disclose payments and incentives given to providers and any investment interest held by a physician. • Improve transparency of information about skilled nursing facilities. • Allow providers organized as accountable care organizations that voluntarily meet quality thresholds to share in the cost-savings they achieve for the Medicare program. • Improve prevention by covering only proven preventive services in Medicare and Medicaid and providing incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs.	• 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. • 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. • 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; to design and implement regional emergency care and trauma systems.	• Simplify health insurance administration by standardizing health care claims forms, operating rules for using and processing health care transactions, and quality reporting requirements and increasing electronic exchange of administrative and clinical data. • Modify provider payments under Medicare to: – Reform the sustainable growth rate for physicians and include incentive payments to physicians practicing in efficient areas; – Reduce payments to hospitals with excess readmissions and apply the readmissions policy to post acute care providers and physicians; and – Reform payment for post acute care services to include a bundled payment for post acute care services. • Restructure payments to Medicare Advantage plans to link to fee-for-services payments and incorporate incentives for quality; require Medicare Advantage plans to have medical loss ratios of at least 85%. • Increase the Medicaid drug rebate percentage and extend the prescription drug rebate to Medicaid managed care plans.	• The plan should reduce high administrative costs, unnecessary tests and services, waste, and other inefficiencies that consume money with no added benefit. • The plan must invest in public health measures proven to reduce cost drivers in our system—such as obesity, sedentary lifestyles, and smoking—as well as guarantee access to proven preventive treatments. The American Recovery and Reinvestment Act provides $1 billion for prevention and wellness.

	Senate Finance Committee Policy Options	Senate HELP Committee Affordable Health Choices Act	House Tri-Committee Health Reform Proposal	President Obama Principles for Health Reform
Cost containment (continued)			• Reduce waste, fraud, and abuse in public programs by – Refusing Medicaid payments for health care-acquired conditions; – Allowing provider screening, enhanced oversight periods, and enrollment moratoria in areas identified as being at elevated risk of fraud in all public programs; – Requiring Medicare and Medicaid program providers and suppliers to establish compliance programs; and – Requiring evaluations and reports under Medicare and Medicaid integrity programs. • Improve transparency of information about skilled nursing facilities. • Improve prevention by covering only proven preventive services in Medicare and Medicaid and eliminate any cost-sharing for preventive services. • Develop a national strategy to improve the nation's health through evidenced-based clinical and community-based prevention and wellness activities. Create task forces on Clinical Preventive Services and Community Preventive Services to develop, update, and disseminate evidenced-based recommendations on the use of clinical and community prevention services.	

	Senate Finance Committee Policy Options	Senate HELP Committee Affordable Health Choices Act	House Tri-Committee Health Reform Proposal	President Obama Principles for Health Reform
Improving quality/health system performance	• Strengthen primary care and chronic care management by providing bonus payments to certain primary care providers and providing reimbursement for certain care management activities for patients with hospital stays related to a major chronic condition. • Establish a framework to set national priorities for comparative clinical effectiveness research. • Create a Chronic Care Management Innovation Center within CMS to disseminate innovations that foster patient-centered care coordination innovations for high-cost, chronically ill Medicare beneficiaries. • Bundle payments for acute, inpatient hospital services and post-acute care services occurring within 30 days of discharge from a hospital. • Establish a hospital value-based purchasing program to pay hospitals based on performance on quality measures. • Develop a strategy for the development, selection, and implementation of quality measures that involves input from multiple stakeholders. Improve public reporting of quality and performance information that includes making information available on the web. • 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.	• 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, through a multi-stakeholder process, quality measures that allow 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 Patient Safety Research Center charged with identifying, evaluating, and disseminating information on best practices for improving health care quality. • Develop interoperable standards for using HIT to enroll individuals in public programs and provide grants to states and other governmental entities to adopt and implement enrollment technology.	• Support comparative effectiveness research by establishing a Center for Comparative Effectiveness Research within the Agency for Healthcare Research and Quality to conduct, support, and synthesize research on outcomes, effectiveness, and appropriateness of health care services and procedures. An independent CER Commission will oversee the activities of the Center. • Strengthen primary care and care coordination by increasing Medicaid payments for primary care providers, providing Medicare bonus payments to primary care practitioners serving in health professional shortage area, conducting a Medicare pilot program to test payment incentive models for accountable care organizations, and conducting pilot programs in Medicare and Medicaid to assess the feasibility of reimbursing qualified patient-centered medical homes. • Improve coordination of care for dual eligibles by creating a new office within the Centers for Medicare and Medicaid Services and allow certain Medicare Advantage plans to serve as fully integrated dual eligible special needs plans. • Develop national priorities for performance improvement and quality measures for the delivery of health care services.	• The plan must ensure the implementation of patient safety measures and provide incentives for changes in the delivery system to reduce unnecessary variability in patient care. It must support the widespread use of health information technology and the development of data on the effectiveness of medical interventions to improve the quality of care delivered. • To lay the foundation for improving the health care delivery system and quality of care, the American Recovery and Reinvestment Act invests $19 billion in health information technology, including $17 billion in incentives to providers to encourage their use of electronic medical records, and provides $1.1 billion for comparative effectiveness research.

	Senate Finance Committee Policy Options	Senate HELP Committee Affordable Health Choices Act	House Tri-Committee Health Reform Proposal	President Obama Principles for Health Reform
Improving quality/health system performance (continued)			• Reduce racial and ethnic disparities by conducting a study on the feasibility of developing Medicare payment systems for language services and provide Medicare demonstration grants to reimburse culturally and linguistically appropriate services. • Develop standards for the collection of data on race, ethnicity, and primary language.	
Other investments	• Promote prevention and wellness by providing grants to states to implement innovative approaches to promoting integration of health care services to improve health and wellness outcomes and providing tax credits to small businesses that implement proven wellness programs. • Change the Medicaid 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. • Reform Graduate Medical Education to increase training of primary care providers and promote training in outpatient settings, and ensure the availability of residency programs in rural and underserved areas. • 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.	• Establish a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program). The program will provide individuals with functional limitations a cash benefit to purchase non-medical services and supports necessary to maintain community residence. The program is financed through voluntary payroll deductions: all working adults will be automatically enrolled in the program, unless they choose to opt-out. • 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.	• Require a report on the continued role for Medicare and Medicaid Disproportionate Share Hospital payments including the appropriate targeting of Medicare and Medicaid DSH payments to hospitals and the distribution of Medicaid DSH among the states. • Reform Graduate Medical Education to increase training of primary care providers by redistributing residency positions and promote training in outpatient settings. • 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. • Provide grants to each state health department to address core public health infrastructure needs. • Provide full federal funding for Medicaid expansions and enhanced federal funding for Medicaid improvements.	• As an initial investment in strengthening the health care workforce, the American Recovery and Reinvestment Act provides $500 million to train the next generation of doctors and nurses.

	Senate Finance Committee Policy Options	Senate HELP Committee Affordable Health Choices Act	House Tri-Committee Health Reform Proposal	President Obama Principles for Health Reform
Financing	Not specified. Considering a range of options for achieving savings and for generating new revenues.	Not specified.	Not specified.	President Obama dedicated $630 billion over ten years toward a Health Reform Reserve Fund in his budget outline released in February 2009 to partially offset the cost of health reform.
Sources of information	Go to following link: http://finance.senate.gov/sitepages/baucus.htm then select these items 5-11-09 Baucus, Grassley Policy Options for Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans 4-28-09 Baucus, Grassley Policy Options for Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs	http://help.senate.gov/	http://edworkforce.house.gov/	http://www.whitehouse.gov/omb/budget/ http://www.HealthReform.gov

	Sens. Tom Coburn and Richard Burr Reps. Paul Ryan and Devin Nunes Patients' Choice Act of 2009 (S. 1099 and H.R. 2520)	Rep. John Conyers U.S. National Health Care Act (H.R. 676)	Rep. John Dingell National Health Insurance Act (H.R. 15)
Date plan announced	May 20, 2009	January 26, 2009	January 6, 2009 (Has introduced similar legislation in each Congressional session since 1957)
Overall approach to expanding access to coverage	Create state-based health insurance exchanges through which private plans offer coverage meeting certain benefit and other standards. Allow employers to continue providing coverage to their employees, but replace the current tax preference for employer-sponsored insurance with a tax credit for individuals and families to provide incentives for insurance coverage. Integrate low-income families into private insurance by providing additional financial support and maintain Medicaid coverage for low-income people with disabilities.	Create a public health insurance program for all U.S. residents. Replace employer coverage and eliminate the Medicare, Medicaid and CHIP programs. Individuals are not required to pay premiums or cost-sharing. Require conversion to a non-profit health care system. Provide for global budgets for hospitals and negotiate annual reimbursement rates with physicians and other non-institutional providers. Finance program by redirecting current federal and state health care spending, impose an employer/employee payroll tax, and leverage additional taxes.	Create a national health insurance program for individuals meeting eligibility requirements. Require states to administer the program and provide for equivalent care for "needy" individuals who do not meet eligibility requirements. A National Health Insurance Board determines allotments for the classes of covered services. Financed by a value-added tax imposed on certain transactions.
Individual mandate	• No requirement for individuals to have coverage.	• All individuals residing in the US are covered under the United States National Health Care Act (USNHC).	• Individuals meeting certain requirements are entitled to benefits under the National Health Insurance Program.
Employer requirements	Not specified.	No provision.	No provision.
Expansion of public programs	• Restructure the Medicaid program to provide care only to low-income people with disabilities. Integrate low-income families into private insurance by providing them with a tax credit plus other financial support. • Allow private facilities to compete with Veteran's Administration facilities to provide care to veterans. • Allow eligible American Indians to access medical care outside of Indian Health Service facilities.	• Create a new public plan, the USNHC program, that provides coverage for a comprehensive set of benefits, including long-term care services, to all US residents. • Eliminate the Medicare, Medicaid, and CHIP programs as beneficiaries of these programs are eligible for the USNHC program. • VA health programs will remain independent for 10 years after which they will either remain independent or be integrated into the USNHC program. The Indian Health Service will remain independent for 5 years after which it will be integrated into the USNHC program.	• Create a new public plan, covering medical, dental, podiatric, home-nursing, hospital, and auxiliary services. A National Health Insurance Board, in consultation with a National Advisory Medical Council determines the scope of benefits consistent with the statute. • Continue Medicare, but enrollees may be transferred into the new program in the future. Medicare beneficiaries are covered under the new program for services that are not covered by Medicare. • Require states to provide equivalent services to those not eligible under the new plan. Current federal Medicaid funds and other federal funds provided to states under the Social Security Act are available for this purpose.

	Sens. Tom Coburn and Richard Burr Reps. Paul Ryan and Devin Nunes Patients' Choice Act of 2009 (S. 1099 and H.R. 2520)	Rep. John Conyers U.S. National Health Care Act (H.R. 676)	Rep. John Dingell National Health Insurance Act (H.R. 15)
Premium subsidies to individuals	• Provide a tax credit of $2,300 for individuals and $5,700 for families to be used to purchase insurance. • Provide additional financial support to low-income families to enable them to afford private insurance.	• Individuals are not required to pay premiums to obtain coverage nor are they charged copayments or coinsurance for covered benefits.	• Individuals are not required to pay premiums to obtain coverage.
Premium subsidies to employers	Not specified.	No provision.	No provision.
Tax changes related to health insurance	• Reform the tax code to eliminate the exclusion of the value of health insurance plans offered by employers from workers' taxable income. • Allow individuals and families purchasing high-deductible health plans that are less than the value of the tax credit to deposit the excess amount into a health savings account. • Change health savings account (HSA) requirements by allowing health insurance premiums to be paid tax-free from an HSA, increasing the allowable contribution amounts for people with chronic conditions, and permitting high-deductible health plans to cover preventive services, maintenance costs of chronic diseases, and concierge-style primary care services.	No provision.	No provision.
Creation of insurance pooling mechanisms	• Partner with states to create State Health Insurance Exchanges through which individuals can purchase qualified private insurance. • Require plans participating in the Exchanges to provide coverage on a guarantee issue basis and to provide coverage similar to that provided to Members of Congress. • Require risk-adjustment among insurance plans participating in the Exchange. A non-profit, independent board will develop the risk-adjustment methodology.	No provision other than pooling achieved through USNHC.	No provision other than pooling achieved through new public program.

	Sens. Tom Coburn and Richard Burr Reps. Paul Ryan and Devin Nunes Patients' Choice Act of 2009 (S. 1099 and H.R. 2520)	Rep. John Conyers U.S. National Health Care Act (H.R. 676)	Rep. John Dingell National Health Insurance Act (H.R. 15)
Benefit design	• Provide coverage that meets the same statutory requirements used for the health benefits for Members of Congress.	• Provide coverage for all medically necessary services, including primary care and prevention; inpatient care; outpatient care; emergency care; prescription drugs; durable medical equipment; long-term care; palliative care; mental health services; dental services; chiropractic services; basic vision correction; hearing services; and podiatric care.	• Provide the following classes of personal health services: – Medical services including primary and specialty care; – Dental services; – Podiatric services; – Home-nursing services; – Hospital services, for a maximum of 60 days in a benefit year; – Auxiliary services including diagnostic laboratory services, X-ray and related therapy, physiotherapy, optometry services, prescription drugs, and eyeglasses.
Changes to private insurance	Not specified.	• Prohibit insurers from duplicating USNHC benefits but they may offer coverage for benefits not covered by the USNHC program.	No provision.
State role	• Create state Health Insurance Exchanges that meet federal standards. • Form voluntary compacts (at state option) with other state Exchanges to diversify pooling, ease administrative burdens, and increase the availability of innovative insurance products.	No provision.	• Assume responsibility for administration of the program. States must submit a state plan of operations that designates a state agency for administering the program benefits; creates, among other things, an advisory committee; establishes local health service areas to further decentralize program administration; and provides a plan for ensuring that benefits will be provided efficiently and to all areas of the state.

	Sens. Tom Coburn and Richard Burr Reps. Paul Ryan and Devin Nunes Patients' Choice Act of 2009 (S. 1099 and H.R. 2520)	Rep. John Conyers U.S. National Health Care Act (H.R. 676)	Rep. John Dingell National Health Insurance Act (H.R. 15)
Cost containment	• Encourage adoption and use of health information technology by providing incentives to hospitals and individual providers. Create personal health records maintained by an independent health record bank and available to the individual through a card, much like an ATM card. • Emphasize prevention by developing a national strategic prevention plan, creating a web-based prevention tool capable of producing personalized prevention plans, and implementing national science-based media campaigns on health promotion and disease prevention. • Reward seniors who adopt healthier behaviors with lower Medicare premiums. • Allow providers to form accountable care organizations and receive bonuses in Medicare if they improve quality and satisfaction while also lowering costs. • Adopt competitive bidding for private plans in Medicare. • Require higher income Medicare beneficiaries to pay more for Medicare Part B and Part D premiums. • Adopt medical malpractice reforms that create independent expert panels or state "health courts" or both to review cases and render decisions. Parties will still have access to state courts if not satisfied with decisions.	• Establish annual budgets for health care professional staffing, capital expenditures, reimbursement for providers, and health professional education. • Pay institutional providers, including hospitals, nursing homes, community or migrant health centers, home care agencies, and other institutional and prepaid group practices, a monthly lump sum to cover operating expenses. • Pay physicians and other non-institutional providers based on a simplified fee scheduled or as a salaried employee in an institution receiving a global budget or in a group practice or HMO receiving capitation payments. • Establish a uniform electronic billing system and create an electronic patient record system. • Allow only public or not-for-profit institutions to participate in USNHC. Private physicians, clinics, and other participating providers may not be investor owned. • Require USNHC program to negotiate annually prices for drugs, medical supplies, and assistive equipment. • Establish a prescription drug formulary that encourages best practices in prescribing and promotes use of generics and other lower cost alternatives.	• Require the National Health Insurance Board to establish allotments for each of five classes of services to be provided under the program (medical services, dental services, home-nursing services, hospital services, and auxiliary services). Allotments are made to the states based on population, medical professionals and facilities, and cost of services. • Require a study of cost control mechanisms, including an analysis of the impact on medical malpractice claims and liability insurance on health care costs.

	Sens. Tom Coburn and Richard Burr Reps. Paul Ryan and Devin Nunes Patients' Choice Act of 2009 (S. 1099 and H.R. 2520)	Rep. John Conyers U.S. National Health Care Act (H.R. 676)	Rep. John Dingell National Health Insurance Act (H.R. 15)
Improving quality/health system performance	• Create a new Health Care Services Commission to establish uniform measures for reporting price and quality information. The HSC, managed by five commissioners from the private sector appointed by the President, will issue a report containing guidelines regulating the publication and dissemination of health care information and will be authorized to enforce these standards.	• Require participating providers to meet state quality and licensing guidelines. • Create a National Board of Universal Quality and Access to address issues, such as access to care, quality improvement, administrative efficiency, budget adequacy, reimbursement levels, capital needs, long term care, and staffing levels. • Establish a universal standard of care relating to appropriate staffing levels; appropriate medical technology; scope of work in the workplace; best practices; salary levels for medical professional and support staff.	• Require state and local administration to: – Promote coordination among providers, between providers and public health centers and educational and research institutions. – Emphasize prevention of disease, disability, and premature death. – Insure the provision of efficient, high quality services.
Other investments	• Make changes to Medicaid long-term care services to provide states with a defined allotment for Medicaid long-term care services in exchange for having the Medicare program assume responsibility for the premiums, cost-sharing, and deductibles for low-income Medicare beneficiaries and ensure choice between institutionalized and home-based long-term care services.	• Establish regional budgets to cover the full array of long-term care services covered by the USNHC program. • Establish a USNHC Employment Transition Fund to assist people who lose their jobs as a result of the transition to the new national system. • Create a mechanism to facilitate the conversion of for-profit providers of care to not-for-profit status and provide compensation for the financial losses associated with the conversion.	• Provide grants for training and education of professional and technical personnel needed to provide or administer benefits. Makes available $5 million in 2010 and 2011; and up to one half of one percent of benefit payments annually thereafter.
Financing	Not specified, but claims proposal is revenue and budget neutral.	The USNHC program will be funded through the USNHC Trust Fund. Funding for the Trust Fund will come from redirecting existing federal payments for health care; increasing the income tax for the top 5% of earners, instituting a modest and progressive payroll tax, and imposing a tax on stock and bond transactions.	Program will be financed through a National Health Care Trust Fund. The trust fund will be funded with a value-added tax of 5 percent imposed on certain transactions.
Sources of information	http://coburn.senate.gov/public/index.cfm?FuseAction=HealthCareReform.Home&ContentRecord_id=5e3b30a4-802a-23ad-4b44-14f0219114c6	http://conyers.house.gov/index.cfm?FuseAction=Issues.Home&Issue_id=063b74a4-19b9-b4b1-126b-f67f60e05f8c	http://www.house.gov/dingell/issue_healthcare.shtml

	Sen. Bernie Sanders American Health Security Act of 2009 (S. 703)	Rep. Pete Stark AmeriCare Health Care Act of 2009 (H.R. 193)	Sens. Ron Wyden and Bob Bennett Healthy Americans Act (S. 391)
Date plan announced	March 25, 2009	January 6, 2009	February 5, 2009
Overall approach to expanding access to coverage	Create a state-based public health insurance program for all U.S. residents. Replace employer coverage and eliminate the Medicare, Medicaid and CHIP programs. Individuals are not required to pay premiums or cost-sharing. Provide for global budgets for hospitals and negotiate annual reimbursement rates with physicians and other non-institutional providers. Finance program by redirecting current federal and state health care spending, impose an employer/ employee payroll tax, and leverage a new health care income tax.	Create a new public plan, modeled on Medicare, as default coverage for all Americans. Individuals in a qualified group plan or Medicare may opt out of AmeriCare. Require employers and individuals to contribute toward the cost of the plan, with federal premium subsidies available for individuals below 300% FPL. Use Medicare's administrative structure to govern the plan. Financed by premium contributions from employers and individuals, state maintenance of effort payments, and from general revenue.	Require most Americans to purchase private coverage (called Healthy Americans Private Insurance or HAPI) meeting certain standards, with federal subsidies available for individuals/ families up to 400% of the federal poverty level. State-based Health Help Agencies administer the offering of HAPI plans, which have to meet federal benefit and other standards. Employers can continue to sponsor health plans but many are unlikely to do so because the favorable tax treatment for individuals of employer-paid and insurance is eliminated.
Individual mandate	• All individuals residing in the US are entitled to coverage under the American Health Security Act.	• All U.S. residents are entitled to coverage under AmeriCare. Individuals may choose not to enroll in the AmeriCare plan if they have coverage under a group health plan.	• Require all citizens over age 19 to have insurance along with dependent children. Those without coverage are subject to a financial penalty based on the number of uncovered months and the weighted average of HAPI premiums.
Employer requirements	• Prohibit employers from offering health benefits that duplicate those provided by State health security programs.	• Require employers to contribute at least 80% of the AmeriCare premiums for employees or at least 80% of the cost of the group plan if the employer provides qualifying employee coverage. Employers with fewer than 100 employees will be given an additional three years to come into compliance with this provision. A surcharge may be imposed on employers to prevent adverse selection.	• Require employers to contribute an amount equal to a percentage of the average premium of their workforce times the number of workers. Percentage of the average premium varies for large and small employers from 2% to 25%. • For the first two years, permit employers previously providing health insurance to increase their workers' wages by the amount of the health insurance premium in lieu of the employer shared responsibility payment described above. • Employers who continue to sponsor health plans must provide information on HAPI plans to employees. • Require employers to deduct individual and family premiums from workers' payroll.

	Sen. Bernie Sanders American Health Security Act of 2009 (S. 703)	Rep. Pete Stark AmeriCare Health Care Act of 2009 (H.R. 193)	Sens. Ron Wyden and Bob Bennett Healthy Americans Act (S. 391)
Expansion of public programs	• Create a new state-based American Health Security Program that provides coverage for a comprehensive set of benefits to all U.S. residents. • Eliminate the Medicare, Medicaid, and CHIP programs as beneficiaries of these programs are eligible for State Health Security Programs. • Veteran's Affairs and Indian Health Service programs remain independent.	• Create a new public plan, modeled on Medicare, as default coverage for all Americans. • AmeriCare plan enrollees are subject to deductibles ($350 individual/$500 family) and coinsurance of 20% until limits on out-of-pocket (OOP) expenses are met. The OOP limits are $2,500 per individual and $4,000 per family. Deductibles and limits are indexed to inflation. • Prohibit coverage under state Medicaid and CHIP programs for benefits covered by AmeriCare plans.	• Eliminate Medicaid and CHIP as comprehensive coverage programs and instead provide supplemental, wrap-around coverage for low-income beneficiaries. Provides for a modified Medicaid long-term care services program.
Subsidies to individuals	• Individuals are not required to pay premiums to obtain coverage nor are they charged copayments or coinsurance for covered benefits.	• Low-income individuals (family income <200% FPL) are not required to pay premiums and are not subject to deductibles and co-insurance. • Provide premium subsidies and reduced deductibles for individuals with family incomes between 200% and 300% FPL. • Limit OOP costs for deductibles and coinsurance to 5% of income for those between 200 and 300% FPL, and 7.5% of income for those between 300 and 500% FPL. • No deductibles and coinsurance for pregnancy-related services and covered benefits provided to children (up to age 24).	• Provide premium subsidies for individuals and families with incomes between 100 and 400% FPL; those with incomes below 100% FPL would not pay premiums. • Provide a health care standard tax deduction for individuals and families with incomes above 100% FPL; would phase-out at higher income levels.
Subsidies to employers	No provision.	No provision.	No provision.
Tax changes related to health insurance	• Impose a new health care income tax on individuals of 2.2% of taxable income.	• Individual premium payments for AmeriCare coverage are considered a tax and subject to withholding.	• Reform the tax code to eliminate the exclusion of the value of health insurance plans offered by employers from workers' taxable income (with exceptions, such as for employer-paid retiree health coverage and coverage through a collectively bargained plan). • Provide a new health care standard deduction that phases out for higher income taxpayers.

	Sen. Bernie Sanders American Health Security Act of 2009 (S. 703)	Rep. Pete Stark AmeriCare Health Care Act of 2009 (H.R. 193)	Sens. Ron Wyden and Bob Bennett Healthy Americans Act (S. 391)
Creation of insurance pooling mechanisms	No provision other than pooling achieved through state health security programs.	No provision other than pooling achieved through AmeriCare.	• Create new state-based purchasing pools (Health Help Agencies) that would offer a choice of HAPI plans. • Everyone, except people enrolled in Medicare, retiree benefit plans, or military-related coverage, are required to enroll in plans through the Health Help Agencies. (Note: employers can still sponsor health insurance but would have to inform employees of HAPI plans available through Health Help Agency.) • Participating plans provide coverage similar to that available through FEHBP. • Require insurers to offer HAPI coverage on a guaranteed issue basis and use adjusted community rating principles in setting premiums.
Benefit design	• Provide coverage for services including hospital and professional services; community-based primary health care; preventive care; long-term acute and chronic care services, including home and community-based services; prescription drugs; dental services; mental health and substance abuse; diagnostics tests; outpatient therapy; durable medical equipment; and other services as specified by the American Health Security Standards Board.	• Provide the same benefits available through Medicare, with the addition of benefits, such as well-child visits, early and periodic screening, diagnostic, and treatment (EPSDT) services for children, prenatal and obstetric care, and family planning services to reflect the needs of a younger population.	• Provide benefits through HAPI plans that are actuarially equivalent or greater in value than the benefits offered under the Blue Cross/Blue Shield Standard Plan provided under the Federal Employees Health Benefit Program (FEHBP). • Additionally provide benefits for wellness programs and incentives to promote the use of these programs, coverage for catastrophic medical events for an individual or family if lifetime limits are exhausted, and full parity for mental health benefits. • Create the Healthy America Advisory Committee to issue annual reports recommending modifications to the benefits, items, and services covered by HAPI plans.

	Sen. Bernie Sanders American Health Security Act of 2009 (S. 703)	Rep. Pete Stark AmeriCare Health Care Act of 2009 (H.R. 193)	Sens. Ron Wyden and Bob Bennett Healthy Americans Act (S. 391)
Changes to private insurance	• Prohibit insurers from duplicating State health security program but they may offer coverage for benefits not covered by the health security program.	• Allow AmeriCare supplemental policies to be offered that meet minimum federal standards, including standardized benefits, limitations on sales commissions, and the following: – Require insurers that offer AmeriCare supplemental policies to do so on a guarantee issue and renewability basis and prohibit them from charging higher premiums based on health status. – Require insurers offering AmeriCare supplemental policies to meet minimum medical loss ratios (85% for group policies; 75% for individual policies).	• Require insurers to offer coverage on a guaranteed issue basis and use adjusted community rating principles in setting premiums; prohibit discrimination based on health status. • Require insurers to meet established medical loss ratios. • Require insurers to create an electronic medical record for each covered individual.
State role	• Create a state health security program to provide health care services to state residents. May join with one or more neighboring states to form a regional health security program. State programs must designate a single state agency to administer the program; establish state health security budgets; establish provider payment methodologies; license and regulate health providers and facilities; establish a quality review system; create an independent ombudsman program to resolve consumer complaints and disputes; publish an annual report on the operation of the state program; and create a fraud and abuse prevention and control unit.	• Require states to make maintenance of effort payments in the amount of the state share of Medicaid and CHIP spending for benefits replaced by the AmeriCare plan. • Allow states to impose more stringent requirements on entities offering AmeriCare supplemental policies than specified by the Secretary.	• Create Health Help Agencies and ensure that participating insurers meet requirements related to solvency and financial standards, consumer protections, and establishment of wellness programs. • Implement mechanisms, such as automatic enrollment, to ensure maximum enrollment of individuals into private insurance.

	Sen. Bernie Sanders American Health Security Act of 2009 (S. 703)	Rep. Pete Stark AmeriCare Health Care Act of 2009 (H.R. 193)	Sens. Ron Wyden and Bob Bennett Healthy Americans Act (S. 391)
Cost containment	• Establish annual budgets for operating expenditures, administrative costs, health professional education, and quality assessment activities. • Require states to pay institutional providers, including hospitals and nursing facilities, through an annual prospective global budget and develop payment methodologies for independent health practitioners that include incentives to encourage practitioners to choose primary care medicine. • Limit national health security spending growth to the average annual percentage increase in the gross domestic product. • Establish individual and state capitation amounts and risk adjustment methodologies to be used for developing state and national global budgets. • Limit state administrative costs to 3% of total expenditures. • Create state fraud and abuse prevention and control units to investigate and prosecute violations of state law. • Develop provider payment methodologies that include global fees for related services furnished to individuals over time. • Establish prices for approved prescription drugs, devices, and equipment.	• Generally apply Medicare payment mechanisms, adjusted to reflect the AmeriCare population. • Limit payments to private plans offered through AmeriCare (similar to Medicare Advantage) to average per capita costs under AmeriCare. • Require AmeriCare to develop a fee schedule for outpatient drugs and biologics, to negotiate directly with drug companies for the purchase price of those drugs and biologics, and to encourage greater use of generics and lower cost alternatives. • Require AmeriCare contractors to submit electronic claims. • Apply Medicare provisions relating to fraud and abuse and administrative simplification to AmeriCare plans.	• Promote prevention by providing premium discounts (including for Medicare Part B premiums) for participation in approved wellness and chronic disease management programs. • Adopt payment policies that reward providers for achieving quality and cost efficiency in prevention, early detection of disease, and chronic care management. • Require insurers to create and implement electronic medical records for each covered individual. • Require insurers to adopt uniform billing and claims forms. • Encourage more rigorous study of new drugs and devices by granting additional exclusivity and patent protections to those subjected to comparative effectiveness reviews. Disallow tax deductions for pharmaceutical manufacturers for direct to consumer advertising for most new drugs. • Require insurers and providers to publicly report data on medical outcomes, health care quality and costs. • Provide bonuses to states that enact medical malpractice reforms.

	Sen. Bernie Sanders American Health Security Act of 2009 (S. 703)	Rep. Pete Stark AmeriCare Health Care Act of 2009 (H.R. 193)	Sens. Ron Wyden and Bob Bennett Healthy Americans Act (S. 391)
Improving quality/health system performance	• Create an American Health Security Quality Council to review and evaluate practice guidelines and performance measures; adopt methodologies for profiling practice patterns and identifying outliers; and develop guidelines for medical procedures to be performed at centers of excellence. • Improve access to care through grants to support the development of primary care centers to serve medically underserved populations in urban and rural areas and the expansion of school health service sites. • Create an Office of Primary Care and Prevention Research to identify research related to primary care and prevention for children and adults and to establish a system for collecting, storing, analyzing, and disseminating information related to primary care and prevention research.	• Apply Medicare provisions relating to outcomes research and quality to AmeriCare.	• Encourage chronic care programs • Require hospitals to demonstrate improvements in quality control, including rapid response teams, heart attack treatments, procedures that reduce medication errors, infection prevention, procedures that reduce the incidence of ventilator-related illnesses. • Provide enhanced Medicare payments to primary care providers and require Medicare to develop a chronic disease management program. • Establish a website for sharing evidence-based best practices and develop a program for incorporating these best practices into medical school curricula. • Provide for improvements in end-of-life care.
Other investments	• Redesign health professional education programs to promote primary care so that within five years at least 50% of residents in medical resident education programs are primary care residents and the number of mid-level primary care practitioners and dentists meets certain targets. • Provide funding to the Public Health Service to support the National Health Service Corps, health professions education, and nursing education. • Provide grants to states to support core public health functions, including data collection and analysis, investigation and control of adverse health events, health promotion and disease prevention activities, research on cost-effective public health practices, and integration and coordination of prevention programs and services.	No provision.	• Provide grants to school districts and communities to increase access to school-based clinics. • Permit states to create State Choices for Long-term Care Programs through their Medicaid programs to provide institutional and home and community-based long-term care for eligible individuals. • Create new long-term care insurance plans that meet standards developed by NAIC or by federal regulations.

	Sen. Bernie Sanders American Health Security Act of 2009 (S. 703)	Rep. Pete Stark AmeriCare Health Care Act of 2009 (H.R. 193)	Sens. Ron Wyden and Bob Bennett Healthy Americans Act (S. 391)
Financing	The American Health Security Act will be funded through the American Health Security Act Trust Fund. Funding for the Trust Fund will come from redirecting existing federal payments for health care; imposing a payroll tax of 8.7% on employers and employees; and imposing a health care income tax of 2.2%.	Plan will be financed through an AmeriCare Trust Fund. The trust fund will be financed with employer and individual premium payments, state maintenance of effort payments, and general revenue for premium subsidies.	In 2008, CBO scored an amended version of the bill which is very similar to this year's version. In that CBO estimate, Federal costs would be offset by revenues and savings in first year of full implementation, Thereafter, the bill would be more than self-financing because of indexing growth in the value of the health insurance deduction and the subsidized benefits. Financing will come from combination of individual premiums, employer assessments, state and federal savings in Medicaid, elimination of most Medicare and Medicaid disproportionate share hospital (DSH) payments, and changes in tax treatment of insurance.
Sources of information	http://www.sanders.senate.gov/news/record.cfm?id=313855	http://www.stark.house.gov/index.php?option=com_content&task=view&id=1081&Itemid=103 http://www.stark.house.gov/index.php?option=com_content&task=view&id=1238&Itemid=84	http://wyden.senate.gov/issues/Legislation/Healthy_Americans_Act.cfm http://wyden.senate.gov/issues/Health_Care.cfm http://www.cbo.gov/ftpdocs/91xx/doc9184/05-01-HealthCare-Letter.pdf

Last Modified: June 22, 2009