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

Comprehensive health reform legislation is currently being debated in Congress. On November 7, 2009, the U.S. House of Representatives passed the Affordable Health Care for America Act and the U.S. Senate introduced the Patient Protection and Affordable Care Act on November 18, 2009. The following summaries of these bills focus on provisions to expand health care coverage, control health care costs, and improve the health care delivery system. These summaries will be updated to reflect changes made during the legislative process.

	Senate Bill **Patient Protection and Affordable Care Act (H.R. 3590)**	**House Bill** **Affordable Health Care for America Act (H.R. 3962)**
Date plan announced	November 18, 2009 (passed by the Senate on December 24, 2009)	October 29, 2009 (passed by the House on November 7, 2009)
Overall approach to expanding access to coverage	Require most U.S. citizens and legal residents to have health insurance. Create state-based American Health Benefit Exchanges through which individuals can purchase coverage, with premium and cost-sharing credits available to individuals/families with income between 100-400% of the federal poverty level (the poverty level is $18,310 for a family of three in 2009) and create separate Exchanges through which small businesses can purchase coverage. Require employers to pay penalties for employees who receive tax credits for health insurance through an Exchange, with exceptions for small employers. Impose new regulations on health plans in the Exchanges and in the individual and small group markets. Expand Medicaid to 133% of the federal poverty level.	Require most individuals to have health insurance. Create a Health Insurance Exchange through which individuals and smaller employers can purchase health coverage, with premium and cost-sharing credits available to individuals/families with incomes up to 400% of the federal poverty level (the poverty level is $18,310 for a family of three in 2009). Require employers to provide coverage to employees or pay into a Health Insurance Exchange Trust Fund, with exceptions for certain small employers, and provide certain small employers a credit to offset the costs of providing coverage. Impose new regulations on plans participating in the Exchange and in the small group insurance market. Expand Medicaid to 150% of the poverty level.
INDIVIDUAL MANDATE		
Requirement to have coverage	• Require U.S. citizens and legal residents to have qualifying health coverage. Those without coverage pay a tax penalty of the greater of $750 per year up to a maximum of three times that amount ($2,250) per family or 2% of household income. The penalty will be phased-in according to the following schedule: $95 in 2014, $495 in 2015, and $750 in 2016 for the flat fee or .5% of taxable income in 2014, 1.0% of taxable income in 2015, and 2% of taxable income in 2016. Beginning after 2016, the penalty will be increased annually by the cost-of-living adjustment. Exemptions will be granted for financial hardship, religious objections, American Indians, those without coverage for less than three months, undocumented immigrants, incarcerated individuals, if the lowest cost plan option exceeds 8% of an individual's income, and if the individual has income below 100% of the poverty level.	• Require individuals to have "acceptable health coverage". Those without coverage pay a penalty of 2.5% of their adjusted income above the filing threshold up to the cost of the average national premium for self-only or family coverage under a basic plan in the Health Insurance Exchange. Exceptions granted for those with incomes below the filing threshold (in 2009 the threshold for taxpayers under age 65 is $9,350 for singles and $18,700 for couples), religious objections and financial hardship. (Effective January 1, 2013)

	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
EMPLOYER REQUIREMENTS		
Requirement to offer coverage	• Assess employers with more than 50 employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit a fee of $750 per full-time employee. Employers with more than 50 employees that offer coverage but have at least one full-time employee receiving a premium tax credit, will pay the lesser of $3,000 for each employee receiving a premium credit or $750 for each full-time employee. For employers that impose a waiting period before employees can enroll in coverage, require payment of $400 for any full-time employee in a 30-60 day waiting period and $600 for any employee in a 60-90 day waiting period. (Effective January 1, 2014) • Exempt employers with 50 or fewer employees from any of the above penalties. • Require employers that offer coverage to their employees to provide a free choice voucher to employees with incomes less than 400% FPL whose share of the premium exceeds 8% but is less than 9.8% of their income and who choose to enroll in a plan in the Exchange. The voucher amount is equal to what the employer would have paid to provide coverage to the employee under the employer's plan and will be used to offset the premium costs for the plan in which the employee is enrolled. Employers providing free choice vouchers will not be subject to penalties for employees that receive premium credits in the Exchange. (Effective January 1, 2014)	• Require employers to offer coverage to their employees and contribute at least 72.5% of the premium cost for single coverage and 65% of the premium cost for family coverage of the lowest cost plan that meets the essential benefits package requirements or pay 8% of payroll into the Health Insurance Exchange Trust Fund. (Effective January 1, 2013) • Eliminate or reduce the pay or play assessment for small employers with annual payroll of less than $750,000: – Annual payroll less than $500,000: exempt – Annual payroll between $500,000 and $585,000: 2% of payroll; – Annual payroll between $585,000 and $670,000: 4% of payroll; – Annual payroll between $670,000 and $750,000: 6% of payroll. (Effective January 1, 2013)
Other requirements	• Require employers with more than 200 employees to automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of coverage.	• Require employers that offer coverage to automatically enroll into the employer's lowest cost premium plan any individual who does not elect coverage under the employer plan or does not opt out of such coverage. (Effective January 1, 2013) • Require a government study of the impact of employer responsibility requirements and recommend to Congress whether an employer hardship exemption is appropriate. (Report due January 1, 2012)
EXPANSION OF PUBLIC PROGRAMS		
Treatment of Medicaid	• Expand Medicaid to all individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL based on modified adjusted gross income (MAGI). All newly eligible adults will be guaranteed a benchmark benefit package that at least provides the essential health benefits. To finance the coverage for the newly eligible (those who were not previously eligible for a full benchmark benefit package or who were eligible for a capped program but were not enrolled), states will receive 100% federal funding for 2014 through 2016. Beginning in 2017, financing for the newly eligible will be shared between the states and the federal	• Expand Medicaid to all individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 150% FPL. Provide Medicaid coverage for all newborns who lack acceptable coverage and provide optional Medicaid coverage to low-income HIV-infected individuals (with enhanced matching funds) until 2013 and for family planning services to certain low-income women. In addition, increase Medicaid payment rates for primary care providers to 100% of Medicare rates by 2012. Require states to submit a state plan amendment specifying the payment rates to be paid under the state's Medicaid program. The coverage expansions (except the optional

	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
EXPANSION OF PUBLIC PROGRAMS (continued)		
Treatment of Medicaid (continued)	government through an increase in the federal medical assistance percentage (FMAP). For states that already cover adults with incomes at or above 100% FPL, the percentage point increase in the FMAP will be 30.3 in 2017 and 31.3 in 2018. For all other states, the percentage point increase in the FMAP will be 34.3 in 2017 and 33.3 in 2018, except Nebraska, which will continue receiving 100% federal funding for newly eligibles after 2017. Beginning in 2019, all states will receive an FMAP increase of 32.3 percentage points for the newly eligible. The increased FMAP for all states, except Nebraska, will be capped at 95%. Certain states not eligible for the enhanced federal funding because they had already expanded Medicaid to adults with incomes above 133% FPL will receive a 2.2 percentage point increase in their FMAP for parents and childless adults who are not newly eligible for 2014 through 2019 or a .5 percentage point increase in the FMAP for 2014 through 2016. (Effective January 1, 2014)	expansions) and the enhanced provider payments will be financed with 100% federal financing through 2014 and 91% federal financing beginning in year 2015. (Effective January 1, 2013)
Treatment of CHIP	• Require states to maintain current income eligibility levels for children in Medicaid and the Children's Health Insurance Program (CHIP) until 2019 and extend funding for CHIP through 2015. CHIP benefit package and cost-sharing rules will continue as under current law. Beginning in 2015, states will receive a 23 percentage point increase in the CHIP match rate up to a cap of 100%. CHIP-eligible children who are unable to enroll in the program due to enrollment caps will be eligible for tax credits in the state Exchanges.	• Repeal the Children's Health Insurance Program (CHIP) and require enrollees in separate state CHIP programs with incomes above 150% FPL to obtain coverage through the Health Insurance Exchange beginning in 2014. Children with incomes above 150% of poverty enrolled in Medicaid-expansion CHIP programs will keep Medicaid coverage and states will receive the enhanced CHIP match rate for these children starting in 2014. CHIP enrollees with incomes between 100% and 150% FPL will be transitioned to Medicaid and states will receive the CHIP enhanced match rate for children above current levels and up to 150% FPL. Require a report to Congress with recommendations to ensure that coverage in the Health Insurance Exchange is comparable to coverage under an average CHIP plan and that there are procedures to transfer CHIP enrollees into the exchange without interrupting coverage or with a written plan of treatment. (Report due by December 31, 2011)
PREMIUM AND COST-SHARING SUBSIDIES TO INDIVIDUALS		
Eligibility	• Limit availability of premium credits and cost-sharing subsidies through the Exchanges to U.S. citizens and legal immigrants who meet income limits. Employees who are offered coverage by an employer are not eligible for premium credits unless the employer plan does not have an actuarial value of at least 60% or if the employee share of the premium exceeds 9.8% of income. Legal immigrants who are barred from enrolling in Medicaid during their first five years in the U.S. will be eligible for premium credits.	• Limit availability of premium and cost-sharing credits to US citizens and lawfully residing immigrants who meet the income limits and are not enrolled in qualified or grandfathered employer or individual coverage, Medicare, Medicaid (except those eligible to enroll in the Exchange), TRICARE, or VA coverage (with some exceptions). Individuals with access to employer-based coverage are eligible for the premium and cost-sharing credits if the cost of the employee premium exceeds 12% of the individuals' income.

	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
PREMIUM AND COST-SHARING SUBSIDIES TO INDIVIDUALS (continued)		
Premium credits	• Provide refundable and advanceable premium credits to individuals and families with incomes between 100-400% FPL to purchase insurance through the Exchanges. The premium credits will be tied to the second lowest-cost silver plan in the area and will be set on a sliding scale such that the premium contributions are limited to 2.8% of income for those at 100% FPL to 9.8% of income for those between 300-400% FPL, except that for those with incomes between 100 and 133% FPL, the premium contribution is limited to 2% of income. (These are the provisions as drafted; however, individuals with incomes less than 133% FPL are intended to get their coverage through Medicaid.) • Increase the premium contributions for those receiving subsidies annually by the rate of premium growth from the preceding year. • Provisions related to the premium and cost-sharing subsidies are effective January 1, 2014.	• Provide affordability premium credits to eligible individuals and families with incomes up to 400% FPL to purchase insurance through the Health Insurance Exchange. The premium credits will be based on the average cost of the three lowest cost basic health plans in the area and will be set on a sliding scale such that the premium contributions are limited to the following percentages of income for specified income tiers: 133-150% FPL: 1.5 - 3% of income 150-200% FPL: 3 – 5.5% of income 200-250% FPL: 5.5 - 8% of income 250-300% FPL: 8 - 10% of income 300-350% FPL: 10 - 11% of income 350-400% FPL: 11 - 12% of income (Effective January 1, 2013) • Index the affordability premium credits after 2013 to maintain the ratio of government to enrollee shares of the premiums over time.
Cost-sharing subsidies	• Provide cost-sharing subsidies to eligible individuals and families with incomes between 100-200% FPL. For those with incomes between 100-150% FPL, the cost-sharing subsidies will result in coverage for 90% of the benefit costs of the plan. For those with incomes between 150-200%, the cost-sharing subsidies will result in coverage for 80% of the benefit costs of the plan. American Indians with income less than 300% FPL will not be subject to any cost-sharing requirements.	• Provide affordability cost-sharing credits to eligible individuals and families with incomes up to 400% FPL. The cost-sharing credits reduce the cost-sharing amounts and annual cost-sharing limits and have the effect of increasing the actuarial value of the basic benefit plan to the following percentages of the full value of the plan for the specified income tier: 133-150% FPL: 97% 150-200% FPL: 93% 200-250% FPL: 85% 250-300% FPL: 78% 300-350% FPL: 72% 350-400% FPL: 70% (Effective January 1, 2013) • Lower the out-of-pocket spending limits established in the essential benefits package ($5,000/individual and $10,000/family) for eligible individuals and families with incomes up to 400% FPL to the following amounts: 133-150% FPL: $500/individual; $1,000/family 150-200% FPL: $1,000/individual; $2,000/family 200-250% FPL: $2,000/individual; $4,000/family 250-300% FPL: $4,000/individual; $8,000/family 300-350% FPL: $4,500/individual; $9,000/family 350-400% FPL: $5,000/individual; $10,000/family (Effective January 1, 2013)

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PREMIUM AND COST-SHARING SUBSIDIES TO INDIVIDUALS (continued)		
Verification	• Require verification of both income and citizenship status in determining eligibility for the federal premium credits.	• Require verification of both income and citizenship status in determining eligibility for the federal premium and cost-sharing credits.
Subsidies and abortion coverage	• Ensure that federal premium or cost-sharing subsidies are not used to purchase coverage for abortion if coverage extends beyond saving the life of the woman or in cases of rape or incest. If an individual who receives federal assistance purchases coverage in a plan that chooses to cover abortion services beyond those for which federal funds are permitted, those federal subsidy funds (for premiums or cost-sharing) must not be used for the purchase of the abortion coverage and must be segregated from private premium payments or state funds.	• Prohibit federal premium subsidies from being used to purchase a health plan in the Exchange that includes coverage for abortions except to save the life of the woman or in cases of rape or incest. Individuals receiving federal subsidies may purchase supplemental coverage for abortions but that coverage must be paid for entirely with private funds.
PREMIUM SUBSIDIES TO EMPLOYERS		
Small business tax credits	• Provide small employers with no more than 25 employees and average annual wages of less than $50,000 that purchase health insurance for employees with a tax credit. – *Phase I:* For tax years 2010 through 2013, provide a tax credit of up to 35% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost or 50% of a benchmark premium. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than $25,000. The credit phases-out as firm size and average wage increases. Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 25% of the employer's contribution toward the employee's health insurance premium. – *Phase II:* For tax years 2014 and later, for eligible small businesses that purchase coverage through the state Exchange, provide a tax credit of up to 50% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost. The credit will be available for two years. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than $25,000. The credit phases-out as firm size and average wage increases. Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 35% of the employer's contribution toward the employee's health insurance premium.	• Provide small employers with fewer than 25 employees and average wages of less than $40,000 with a health coverage tax credit for up to two years. The full credit of 50% of premium costs paid by employers is available to employers with 10 or fewer employees and average annual wages of $20,000 or less. The credit phases-out as firm size and average wage increases and is not permitted for employees earning more than $80,000 per year. (Effective January 1, 2013)
Reinsurance program	• Create a temporary reinsurance program for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare. Program will reimburse employers or insurers for 80% of retiree claims between $15,000 and $90,000. Payments from the reinsurance program will be used to lower the costs for enrollees in the employer plan. Appropriate $5 billion to finance the program. (Effective 90 days following enactment through January 1, 2014)	• Create a temporary reinsurance program for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare. Program will reimburse employers for 80% of retiree claims between $15,000 and $90,000. Payments from the reinsurance program will be used to lower the costs for enrollees in the employer plan. Appropriate $10 billion over ten years for the reinsurance program. (Effective 90 days after enactment)

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TAX CHANGES RELATED TO HEALTH INSURANCE OR FINANCING HEALTH REFORM		
Tax changes related to health insurance	• Impose a tax on individuals without qualifying coverage of the greater of $750 per year up to a maximum of three times that amount or 2% of household income to be phased-in beginning in 2014. • Exclude the costs for over-the-counter drugs not prescribed by a doctor from being reimbursed through an HRA or health FSA and from being reimbursed on a tax-free basis through an HSA or Archer Medical Savings Account. (Effective January 1, 2011) • Increase the tax on distributions from a health savings account or an Archer MSA that are not used for qualified medical expenses to 20% (from 10% for HSAs and from 15% for Archer MSAs) of the disbursed amount. (Effective January 1, 2011) • Limit the amount of contributions to a flexible spending account for medical expenses to $2,500 per year increased annually by the cost of living adjustment. (Effective January 1, 2011) • Increase the threshold for the itemized deduction for unreimbursed medical expenses from 7.5% of adjusted gross income to 10% of adjusted gross income for regular tax purposes; waive the increase for individuals age 65 and older for tax years 2013 through 2016. (Effective January 1, 2013) • Increase the Medicare Part A (hospital insurance) tax rate on wages by 0.9% (from 1.45% to 2.35%) on earnings over $200,000 for individual taxpayers and $250,000 for married couples filing jointly; funds deposited into the Medicare Part A Trust Fund. (Effective January 1, 2013) • Impose an excise tax on insurers of employer-sponsored health plans with aggregate values that exceed $8,500 for individual coverage and $23,000 for family coverage (these threshold values will be indexed to the consumer price index for urban consumers (CPI-U) plus one percentage point). The threshold amounts will be increased for retired individuals age 55 and older who are not eligible for Medicare and for employees engaged in high-risk professions by $1,350 for individual coverage and $3,000 for family coverage. In the 17 states with the highest health care costs, the threshold amount is increased by 20% initially; this increase is subsequently reduced by half each year until it is phased out in 2015. The tax is equal to 40% of the value of the plan that exceeds the threshold amounts and is imposed on the issuer of the health insurance policy, which in the case of a self-insured plan is the plan administrator or, in some cases, the employer. The aggregate value of the health insurance plan includes reimbursements under a flexible spending account for medical expenses (health FSA) or health reimbursement arrangement (HRA), employer contributions to a health savings account (HSA), and coverage for dental, vision, and other supplementary health insurance coverage. (Effective January 1, 2013)	• Impose a tax on individuals without acceptable health care coverage of 2.5% of adjusted income above the filing threshold up to the cost of the average national premium for self-only or family coverage under a basic plan in the Health Insurance Exchange. (Effective January 1, 2013) • Permit only prescribed drugs to be reimbursable through a health savings account, Archer medical savings account, health reimbursement arrangement, or flexible spending arrangement for medical expenses. (Effective January 1, 2011) • Increase the tax on distributions from a health savings account that are not used for qualified medical expenses to 20% (from 10%) of the disbursed amount. (Effective January 1, 2011) • Limit the amount of contributions to a flexible spending arrangement for medical expenses to $2,500 per year. (Effective January 1, 2013)

	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
TAX CHANGES RELATED TO HEALTH INSURANCE OR FINANCING HEALTH REFORM (continued)		
Tax changes related to financing health reform	• Impose new fees on segments of the health care sector: – $2.3 billion annual fee on the pharmaceutical manufacturing sector (effective for sales after December 31, 2008); – $2 billion annual fee on the medical device manufacturing sector increasing to $3 billion after 2017 (effective for sales after December 31, 2009); and – Annual fees on the health insurance sector of $2 billion in 2011, $4 billion in 2012, $7 billion in 2013, $9 billion in 2014-2016, and $10 billion in 2017 and thereafter (effective for net premiums written after December 31, 2009). • Limit the deductibility of executive and employee compensation to $500,000 per applicable individual for health insurance providers. (Effective January 1, 2009) • Impose a tax of 10% on the amount paid for indoor tanning services. (Effective January 1, 2010)	• Impose a tax of 5.4% on individuals with modified adjusted gross income exceeding $500,000 and families with modified adjusted gross income exceeding $1,000,000. (Effective January 1, 2011) • Impose a tax of 2.5% of the price on the first taxable sale of any medical device. (Effective January 1, 2013)
HEALTH INSURANCE EXCHANGES		
Creation and structure of health insurance exchanges	• Create state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges, administered by a governmental agency or non-profit organization, through which individuals and small businesses with up to 100 employees can purchase qualified coverage. Permit states to allow businesses with more than 100 employees to purchase coverage in the SHOP Exchange beginning in 2017. States may form regional Exchanges or allow more than one Exchange to operate in a state as long as each Exchange serves a distinct geographic area. (Funding available to states to establish Exchanges within one year of enactment and until January 1, 2015)	• Create a National Health Insurance Exchange, through which individuals and employers (phasing-in eligibility for employers starting with smallest employers) can purchase qualified insurance, including from private health plans and the public health insurance option. • Allow states to operate state-based exchanges if they demonstrate the capacity to meet the requirements for administering the exchange.
Eligibility to purchase in the exchanges	• Restrict access to coverage through the Exchanges to U.S. citizens and legal immigrants who are not incarcerated.	• Restrict access to coverage through the Exchange to individuals who are not enrolled in qualified or grandfathered employer or individual coverage, Medicare, Medicaid, TRICARE, or VA coverage.
Public plan option	• No similar provision to create a public plan option. • Require the Office of Personnel Management to contract with insurers to offer at least two multi-state plans in each Exchange. At least one plan must be offered by a non-profit entity and at least one plan must not provide coverage for abortions beyond those permitted by federal law. Each multi-state plan must be licensed in each state and must meet the qualifications of a qualified health plan. If a state has lower age rating requirements than 3:1, the state may require multi-state plans to meet the more protective age rating rules. These multi-state plans will be offered separately from the Federal Employees Health Benefit Program and will have a separate risk pool.	• Create a new public health insurance option to be offered through the Health Insurance Exchange that must meet the same requirements as private plans regarding benefit levels, provider networks, consumer protections, and cost-sharing. Require the public plan to offer basic, enhanced, and premium plans, and permit it to offer premium plus plans. Prohibit the public plan from providing coverage for abortions beyond those permitted by federal law (to save the life of the woman and in cases of rape and incest). Finance the costs of the public plan through revenues from premiums. Require the public health insurance option to negotiate rates with providers so that the rates are not lower than Medicare rates and not higher than the average rates paid by other

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HEALTH INSURANCE EXCHANGES (continued)		
Public plan option (continued)		qualified health benefit plan offering entities. Health care providers participating in Medicare are considered participating providers in the public plan unless they opt out. Permit the public plan to develop innovative payment mechanisms, including medical home and other care management payments, value-based purchasing, bundling of services, differential payment rates, performance based payments, or partial capitation and modify cost-sharing and payment rates to encourage use of high-value services.
Consumer Operated and Oriented Plan (CO-OP)	• Create the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of non-profit, member-run health insurance companies in all 50 states and District of Columbia to offer qualified health plans. To be eligible to receive funds, an organization must not be an existing health insurer or sponsored by a state or local government, substantially all of its activities must consist of the issuance of qualified health benefit plans in each state in which it is licensed, governance of the organization must be subject to a majority vote of its members, must operate with a strong consumer focus, and any profits must be used to lower premiums, improve benefits, or improve the quality of health care delivered to its members. (Appropriate $6 billion to finance the program and award loans and grants to establish CO-OPs by July 1, 2013)	• Create a Consumer Operated and Oriented Program (CO-OP) to facilitate the establishment of non-profit, member-run health insurance cooperatives to provide insurance through the Exchange. (Effective six months following enactment)
Benefit tiers	• Create four benefit categories of plans plus a separate catastrophic plan to be offered through the Exchange, and in the individual and small group markets: – *Bronze plan* represents minimum creditable coverage and provides the essential health benefits, cover 60% of the benefit costs of the plan, with an out-of-pocket limit equal to the Health Savings Account (HSA) current law limit ($5,950 for individuals and $11,900 for families in 2010); – *Silver plan* provides the essential health benefits, covers 70% of the benefit costs of the plan, with the HSA out-of-pocket limits; – *Gold plan* provides the essential health benefits, covers 80% of the benefit costs of the plan, with the HSA out-of-pocket limits; – *Platinum plan* provides the essential health benefits, covers 90% of the benefit costs of the plan, with the HSA out-of-pocket limits; – *Catastrophic plan* available to those up to age 30 or to those who are exempt from the mandate to purchase coverage and provides catastrophic coverage only with the coverage level set at the HSA current law levels except that prevention benefits and coverage for three primary care visits would be exempt from the deductible. This plan is only available in the individual market.	• Create four benefit categories of plans to be offered through the Exchange: – *Basic plan* includes essential benefits package and covers 70% of the benefit costs of the plan; – *Enhanced plan* includes essential benefits package, reduced cost-sharing compared to the basic plan, and covers 85% of benefit costs of the plan; – *Premium plan* includes essential benefits package with reduced cost-sharing compared to the enhanced plan and covers 95% of the benefit costs of the plan; – *Premium plus plan* is a premium plan that provides additional benefits, such as oral health and vision care.

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HEALTH INSURANCE EXCHANGES (continued)		
Benefit tiers (continued)	• Reduce the out-of-pocket limits for those with incomes up to 400% FPL to the following levels: – 100-200% FPL: one-third of the HSA limits ($1,983/individual and $3,967/family); – 200-300% FPL: one-half of the HSA limits ($2,975/individual and $5,950/family); – 300-400% FPL: two-thirds of the HSA limits ($3,987/individual and $7,973/family). These out-of-pocket reductions are applied within the actuarial limits of the plan and will not increase the actuarial value of the plan.	
Insurance market and rating rules	• Require guarantee issue and renewability and allow rating variation based only on age (limited to 3 to 1 ratio), premium rating area, family composition, and tobacco use (limited to 1.5. to 1 ratio) in the individual and the small group market and the Exchange. • Require risk adjustment in the individual and small group markets and in the Exchange. (Effective January 1, 2014)	• Require guarantee issue and renewability; allow rating variation based only on age (limited to 2 to 1 ratio), premium rating area, and family enrollment. • Require risk adjustment of participating Exchange plans.
Qualifications of participating health plans	• Require qualified health plans participating in the Exchange to meet marketing requirements, have adequate provider networks, contract with essential community providers, contract with navigators to conduct outreach and enrollment assistance, be accredited with respect to performance on quality measures, use a uniform enrollment form and standard format to present plan information. • Require qualified health plans to report information on claims payment policies, enrollment, disenrollment, number of claims denied, cost-sharing requirements, out-of-network policies, and enrollee rights in plain language.	• Require plans participating in the Exchange to be state licensed, report data as required, implement affordability credits, meet network adequacy standards, provide culturally and linguistically appropriate services, contract with essential community providers and Indian health care providers, and participate in risk pooling. Require participating plans to offer one basic plan for each service area and permit them to offer additional plans. Require plans to provide information related to end-of-life planning to individuals and provide the option to establish advance directives and physician's order for life-sustaining treatment.
Requirements of the exchanges	• Require the Exchanges to maintain a call center for customer service, and establish procedures for enrolling individuals and businesses and for determining eligibility for tax credits. Require states to develop a single form for applying for state health subsidy programs that can be filed online, in person, by mail or by phone. Permit Exchanges to contract with state Medicaid agencies to determine eligibility for tax credits in the Exchanges. • Require Exchanges to submit financial reports to the Secretary and comply with oversight investigations including a GAO study on the operation and administration of Exchanges.	• Provide information to consumers and small employers to enable them to choose among plans in the Exchange, including establishing a telephone hotline and maintaining a website, and provide information on open enrollment periods and how to enroll.
Basic Health Plan	• Permit states the option to create a Basic Health Plan for uninsured individuals with incomes between 133-200% FPL who would otherwise be eligible to receive premium subsidies in the Exchange. States opting to provide this coverage will contract with one or more standard plans to provide at least the essential health benefits and must ensure that	No similar provision.

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HEALTH INSURANCE EXCHANGES (continued)		
Basic Health Plan (continued)	eligible individuals do not pay more in premiums than they would have paid in the Exchange and that the cost-sharing requirements do not exceed those of the platinum plan for enrollees with income less than 150% FPL or the gold plan for all other enrollees. States will receive 95% of the funds that would have been paid as federal premium and cost-sharing subsidies for eligible individuals to establish the Basic Health Plan. Individuals with incomes between 133-200% FPL in states creating Basic Health Plans will not be eligible for subsidies in the Exchanges.	
Abortion coverage	• Permit states to prohibit plans participating in the Exchange from providing coverage for abortions. • Require plans that choose to offer coverage for abortions beyond those for which federal funds are permitted (to save the life of the woman and in cases of rape or incest) in states that allow such coverage to create allocation accounts for segregating premium payments for coverage of abortion services from premium payments for coverage for all other services to ensure that no federal premium or cost-sharing subsidies are used to pay for the abortion coverage. Plans must also estimate the actuarial value of covering abortions by taking into account the cost of the abortion benefit (valued at no less than $1 per enrollee per month) and cannot take into account any savings that might be reaped as a result of the abortions. Prohibit plans participating in the Exchanges from discriminating against any provider because of an unwillingness to provide, pay for, provide coverage of, or refer for abortions.	• Require private insurers that opt to provide a plan in the Exchange that covers abortions beyond those permitted by federal law (to save the life of the woman and in cases of rape and incest) to also offer an identical plan that does not cover abortions for which federal funding is prohibited. Private plans participating in the Exchange may offer supplemental coverage for abortions. Federal premium subsidies may not be used to purchase a plan or supplemental coverage that covers abortions beyond those permitted by federal law. Prohibit plans participating in the Exchange from discriminating against any provider because of an unwillingness to provide abortions.
Effective dates	• Unless otherwise noted, provisions relating to the American Health Benefit Exchanges are effective January 1, 2014.	• Unless otherwise noted, provisions relating to the Health Insurance Exchange are effective January 1, 2013.
BENEFIT DESIGN		
Essential benefits package	• Create an essential health benefits package that provides a comprehensive set of services, covers at least 60% of the actuarial value of the covered benefits, limits annual cost-sharing to the current law HSA limits ($5,950/individual and $11,900/family in 2010), and is not more extensive than the typical employer plan. Require the Secretary to define and annually update the benefit package through a transparent and public process. (Effective January 1, 2014) • Require all qualified health benefits plans, including those offered through the Exchanges and those offered in the individual and small group markets outside the Exchanges, except grandfathered individual and employer-sponsored plans, to offer at least the essential health benefits package. (Effective January 1, 2014)	• Create an essential benefits package that provides a comprehensive set of services, covers 70% of the actuarial value of the covered benefits, limits annual cost-sharing to $5,000/individual and $10,000/family, does not require cost-sharing for preventive services, and does not impose annual or lifetime limits on coverage. The Health Benefits Advisory Council, chaired by the Surgeon General, will make recommendations on specific services to be covered by the essential benefits package as well as cost-sharing levels. (Health Benefits Advisory Council report due one year following enactment; essential benefits package becomes effective January 1, 2013) • All qualified health benefits plans, including those offered through the Exchange and those offered outside of the Exchange (except certain grandfathered individual and employer-sponsored plans) must provide at least the essential benefits package. (Effective January 1, 2013) • Require a report on including oral health benefits in the essential benefits package. (Report due one year following enactment)

	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
BENEFIT DESIGN (continued)		
Abortion coverage	• Prohibit abortion coverage from being required as part of the essential health benefits package. (Effective January 1, 2014)	• Prohibit abortion coverage from being required as part of the essential benefits package. (Effective January 1, 2013)
CHANGES TO PRIVATE INSURANCE		
Temporary high-risk pool	• Establish a temporary national high-risk pool to provide health coverage to individuals with pre-existing medical conditions. U.S. citizens and legal immigrants who have a pre-existing medical condition and who have been uninsured for at least six months will be eligible to enroll in the high-risk pool and receive subsidized premiums. Premiums for the pool will be established for a standard population and may vary by no more than 4 to 1 due to age; maximum cost-sharing will be limited to the current law HSA limit ($5,950/individual and $11,900/family in 2010). Appropriate $5 billion to finance the program. (Effective within 90 days of enactment until January 1, 2014)	• Establish a temporary national high-risk pool to provide health coverage to individuals (and spouses and dependents) with pre-existing medical conditions. Individuals who have been denied coverage, offered unaffordable coverage, have an eligible medical condition or who have been uninsured for at least six months will be eligible to enroll in the national high-risk pool. Premiums for the high-risk pool will be set at not higher than 125% of the prevailing rate for comparable coverage in the state and could vary by no more than 2:1 due to age; annual deductibles will be limited to $1,500 for an individual; and maximum cost-sharing will be limited to $5,000 for individuals. (Effective January 1, 2010 and until the Health Insurance Exchange is established)
Medical loss ratio and premium rate reviews	• Require health plans to report the proportion of premium dollars spent on clinical services, quality, and other costs and provide rebates to consumers for the amount of the premium spent on clinical services and quality that is less than 85% for plans in the large group market and 80% for plans in the individual and small group markets. (Requirement to report medical loss ratio effective plan year 2010; requirement to provide rebates effective January 1, 2011) • Establish a process for reviewing increases in health plan premiums and require plans to justify increases. Require states to report on trends in premium increases and recommend whether certain plan should be excluded from the Exchange based on unjustified premium increases. Provide grants to states to support efforts to review and approve premium increases. (Effective beginning plan year 2010)	• Limit health plans' medical loss ratio to not less than 85% to be enforced through a rebate back to consumers and prohibit plans from imposing aggregate dollar lifetime limits on coverage. (Effective January 1, 2010) Prohibit insurers from rescinding coverage except in cases of fraud. (Effective July 1, 2010) • Require review of increases in health insurance premiums prior to implementation of the increases. (Effective upon enactment)
Administrative simplification	• Adopt standards for financial and administrative transactions to promote administrative simplification. (Effective dates vary)	• Adopt standards for financial and administrative transactions to promote administrative simplification. (Effective upon enactment)
Dependent coverage	• Provide dependent coverage for children up to age 26 for all individual and group policies. (Effective six months following enactment)	• Provide dependent coverage for children up to age 27 for all individual and group policies. (Effective January 1, 2010)
Insurance market rules	• Prohibit individual and group health plans from placing lifetime limits on the dollar value of coverage and prohibit insurers from rescinding coverage except in cases of fraud. (Effective six months following enactment) Beginning in January 2014, prohibit individual and group health plans from placing annual limits on the dollar value of coverage. Prior to January 2014, plans may only impose annual limits on coverage as determined by the Secretary. • Impose the same insurance market regulations relating to guarantee issue, premium rating, and prohibitions on pre-existing condition exclusions in the individual market, in the Exchange, and in the small	• Prohibit individual and group health plans from placing aggregate dollar lifetime limits on coverage. Prohibit insurers from rescinding coverage except in cases of fraud. (Effective six months following enactment) • Limit pre-existing condition exclusions for group policies prior to implementation of the insurance market reforms by shortening the period plans can look back for pre-existing conditions from six months to 30 days and shortening the period plans can exclude coverage of certain benefits from 12 months to three months. (Effective January 1, 2010) • Prohibit reductions to retiree benefits unless reductions also apply to current employees. (Effective upon enactment)

	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
CHANGES TO PRIVATE INSURANCE (continued)		
Insurance market rules (continued)	group market (See new rating and market rules in Creation of insurance pooling mechanism.) (Effective January 1, 2014) • Require all new policies (except stand-alone dental, vision, and long-term care insurance plans), including those offered through the Exchanges and those offered outside of the Exchanges, to comply with one of the four benefit categories. Existing individual and employer-sponsored plans do not have to meet the new benefit standards. (See description of benefit categories in Creation of insurance pooling mechanism.) (Effective January 1, 2014) • Limit deductibles for health plans in the small group market to $2,000 for individuals and $4,000 for families unless contributions are offered that offset deductible amounts above these limits. This deductible limit will not affect the actuarial value of any plans. (Effective January 1, 2014) • Penalize employers that require a waiting period for coverage of more than 60 days by requiring a payment of $600 for each full-time employee subject to the waiting period. (Effective January 1, 2014) • Create a temporary reinsurance program to collect payments from health insurers in the individual and group markets to provide payments to plans in the individual market that cover high-risk individuals. Finance the reinsurance program through mandatory contributions by health insurers totaling $25 billion over three years. (Effective January 1, 2014 through December 2016) • Allow states the option of merging the individual and small group markets. (Effective January 1, 2014)	• Prohibit coverage purchased through the individual market from qualifying as acceptable coverage for purposes of the individual mandate unless it is grandfathered coverage. Individuals can purchase a qualifying health benefit plan through the Health Insurance Exchange. (Effective January 1, 2013) • Impose the same insurance market regulations relating to guarantee issue, premium rating, and prohibitions on pre-existing condition exclusions in the insured group market and in the Exchange. (See creation of insurance pooling mechanisms.) (Effective January 1, 2013) • Individuals eligible for COBRA continuation coverage may retain COBRA coverage until the Exchange is established or they obtain acceptable coverage. (Effective upon enactment)
Consumer protections	• Establish an internet website to help residents identify health coverage options (effective July 1, 2010) and develop a standard format for presenting information on coverage options (effective 60 days following enactment). • Develop standards for insurers to use in providing information on benefits and coverage. (Standards developed within 12 months following enactment; insurer must comply with standards within 24 months following enactment)	• Improve consumer protections by establishing uniform marketing standards, requiring fair grievance and appeals mechanisms and accurate and timely disclosure of plan information. (Effective January 1, 2013)
Health care choice compacts and national plans	• Permit states to form health care choice compacts and allow insurers to sell policies in any state participating in the compact. Insurers selling policies through a compact would only be subject to the laws and regulations of the state where the policy is written or issued, except for rules pertaining to market conduct, unfair trade practices, network adequacy, and consumer protections. Compacts may only be approved if it is determined that the compact will provide coverage that is at least as comprehensive and affordable as coverage provided through the state Exchanges. (Regulations issued by July 1, 2013, compacts may not take effect before January 1, 2016)	• Permit states to form Health Care Choice Compacts to facilitate the purchase of individual insurance across state lines. (Effective January 1, 2015)

	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
CHANGES TO PRIVATE INSURANCE (continued)		
Health insurance administration	No similar provision.	• Create the Health Choices Administration to establish the qualifying health benefits standards, establish the Exchange, administer the affordability credits, and enforce the requirements for qualified health benefit plan offering entities, including those participating in the Exchange or outside the Exchange.
Anti-trust exemption for health insurers	No similar provision.	• Remove the anti-trust exemption for health insurers and medical malpractice insurers. (Effective upon enactment)
STATE ROLE		
State role	• Create an American Health Benefit Exchange and a Small Business Health Options Program (SHOP) Exchange for individuals and small businesses and provide oversight of health plans with regard to the new insurance market regulations, consumer protections, rate reviews, solvency, reserve fund requirements, premium taxes, and to define rating areas. • Enroll newly eligible Medicaid beneficiaries into the Medicaid program no later than January 2014 (states have the option to expand enrollment beginning in April 2010), coordinate enrollment with the new Exchanges, and implement other specified changes to the Medicaid program. Maintain current Medicaid and CHIP eligibility levels for children until 2019 and maintain current Medicaid eligibility levels for adults until the Exchange is fully operational. A state will be exempt from the maintenance of effort requirement for non-disabled adults with incomes above 133% FPL for any year from January 2011 through December 31, 2013 if the state certifies that it is experiencing a budget deficit or will experience a deficit in the following year. • Establish an office of health insurance consumer assistance or an ombudsman program to serve as an advocate for people with private coverage in the individual and small group markets. (Federal grants available beginning fiscal year 2010) • Permit states to create a Basic Health Plan for uninsured individuals with incomes between 133% and 200% FPL in lieu of these individuals receiving premium subsidies to purchase coverage in the Exchanges. (Effective January 1, 2014) Permit states to obtain a five-year waiver of certain new health insurance requirements if the state can demonstrate that it provides health coverage to all residents that is at least as comprehensive as the coverage required under an Exchange plan and that the state plan does not increase the federal budget deficit. (Effective January 1, 2017)	• Implement the Medicaid eligibility expansions and the specified changes with respect to provider payment rates, benefit enhancements, quality improvement, and program integrity. Maintain Medicaid eligibility standards, methodologies, or procedures that were in place as of June 16, 2009 as a condition of receiving federal Medicaid matching payments and extend the maintenance of eligibility requirement for children in Medicaid-expansion CHIP programs with incomes above 150% FPL. Require CHIP maintenance of eligibility to June 16, 2009 through December 31, 2013. • Establish a Memorandum of Understanding with the Health Insurance Exchange to coordinate enrollment of individuals in Exchange-participating health plans and under the state's Medicaid program. • May determine eligibility for affordability credits through the Health Insurance Exchange.

	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
COST CONTAINMENT		
Administrative simplification	• Simplify health insurance administration by adopting a single set of operating rules for eligibility verification and claims status (rules adopted July 1, 2011; effective January 1, 2013), electronic funds transfers and health care payment and remittance (rules adopted July 1, 2012; effective January 1, 2014), and health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization (rules adopted July 1, 2014; effective January 1, 2016). Health plans must document compliance with these standards or face a penalty of no more than $1 per covered life. (Effective April 1, 2014)	• Simplify health insurance administration by adopting standards for financial and administrative transactions, including timely and transparent claims and denial management processes and use of standard electronic transactions. (Effective upon enactment)
Medicare	• Restructure payments to Medicare Advantage (MA) plans (except PACE plans) to base payments on the average of plan bids in each market, phased in over four years beginning in 2012, with bonus payments for quality, performance improvement, and care coordination beginning in 2014. Change plan service areas beginning in 2012. Grandfather the extra benefits in MA plans in areas where plan bids are at or below 75% of traditional fee-for-service Medicare (with requirement that these plans participate in a new competitive bidding process). Provide transitional extra benefits for MA beneficiaries in certain areas if they experience a significant reduction in extra benefits under competitive bidding, authorizing up to $5 billion for the period between 2012 and 2019 for rebates associated with extra benefits. • Reduce annual market basket updates for inpatient hospital, home health, skilled nursing facility, hospice and other Medicare providers, and adjust for productivity. (Effective dates vary) • Freeze the threshold for income-related Medicare Part B premiums for 2011 through 2019, and reduce the Medicare Part D premium subsidy for those with incomes above $85,000/individual and $170,000/couple. (Effective January 1, 2011) • Establish an Independent Payment Advisory Board comprised of 15 members to submit legislative proposals containing recommendations to reduce the per capita rate of growth in Medicare spending if spending exceeds a target growth rate. Beginning April 2013, require the Chief Actuary of CMS to project whether Medicare per capita spending exceeds the average of CPI-U and CPI-M, based on a five year period ending that year. If so, beginning January 15, 2014, the Board will submit recommendations to achieve reductions in Medicare spending. Beginning January 2018, the target is modified such that the board submits recommendations if Medicare per capita spending exceeds GDP per capita plus one percent. The Board will submit proposals to the President and Congress for immediate consideration. The Board is prohibited from submitting proposals that would ration care, increase revenues or change benefits, eligibility or Medicare beneficiary cost	• Restructure payments to Medicare Advantage plans (except for PACE plans), phasing down to equal 100% of fee-for-services payments by 2013, with bonus payments for higher-quality and improved-quality plans in qualifying counties. (Effective FY 2011). • Reduce market basket updates in Medicare payment rates for providers and incorporate adjustment for expected productivity gains. (Effective dates vary) • Reduce Medicare Disproportionate Share Hospital (DSH) payments to account for reductions in the national rate of uninsurance as a result of the Act, based on recommendation by the Secretary. (Medicare DSH reductions effective 2017) • Conduct Medicare and Medicaid pilot programs to test payment incentive models for accountable care organizations and to assess the feasibility of reimbursing qualified patient-centered medical homes. Adopt these models on a large scale if pilot programs prove successful at reducing costs. (Implementation of medical home pilots upon enactment; implementation of accountable care organization pilots by January 1, 2012) • Establish the Center for Medicare and Medicaid Innovation to test payment and service delivery models to improve quality and efficiency. Evaluate all models and expand those models that improve quality without increasing spending or reduce spending without reducing quality, or both. (Effective January 1, 2011) • Reduce Medicare payments for potentially preventable hospital readmissions. (Effective October 1, 2011) • Require the Institute of Medicine to conduct studies on geographic variation in Medicare spending and in health care spending across all providers and recommend strategies for addressing these variations by promoting high-value care; require the Secretary to develop an implementation plan and issue regulations to implement the Medicare payment changes unless Congress acts to stop implementation. (Report due one year following enactment; final implementation plan due 240 days following receipt of report; regulations issued by May 31, 2012)

	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
COST CONTAINMENT (continued)		
Medicare (continued)	sharing (including Parts A and B premiums), or would result in a change in the beneficiary premium percentage or low-income subsidies under Part D. Hospitals and hospices (through 2019) and clinical labs (for one year) will not be subject to cost reductions proposed by the Board. The Board must also submit recommendations every other year to slow the growth in national health expenditures while preserving quality of care by January 1, 2015. • Reduce Medicare Disproportionate Share Hospital (DSH) payments initially by 75% and subsequently increase payments based on the percent of the population uninsured and the amount of uncompensated care provided. (Effective fiscal year 2015) • Eliminate the Medicare Improvement Fund. (Effective upon enactment) • Allow providers organized as accountable care organizations (ACOs) that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program. To qualify as an ACO, organizations must agree to be accountable for the overall care of their Medicare beneficiaries, have adequate participation of primary care physicians, define processes to promote evidence-based medicine, report on quality and costs, and coordinate care. (Shared savings program established January 1, 2012) • Create an Innovation Center within the Centers for Medicare and Medicaid Services to test, evaluate, and expand in Medicare, Medicaid, and CHIP different payment structures and methodologies to reduce program expenditures while maintaining or improving quality of care. Payment reform models that improve quality and reduce the rate of cost growth could be expanded throughout the Medicare, Medicaid, and CHIP programs. (Effective January 1, 2011) • Reduce Medicare payments that would otherwise be made to hospitals by specified percentages to account for excess (preventable) hospital readmissions. (Effective October 1, 2012) • Reduce Medicare payments to certain hospitals for hospital-acquired conditions by 1%. (Effective fiscal year 2015)	• Require the Secretary to negotiate drug prices directly with pharmaceutical manufacturers for Medicare Part D plans. (Effective upon enactment; applies to drug prices beginning on January 1, 2011)
Medicaid	• Increase the Medicaid drug rebate percentage for brand name drugs to 23.1 (except the rebate for clotting factors and drugs approved exclusively for pediatric use increases to 17.1%); increase the Medicaid rebate for non-innovator, multiple source drugs to 13% of average manufacturer price; and extend the drug rebate to Medicaid managed care plans. (Effective January 1, 2010) • Reduce a state's Medicaid DSH allotment by 50% or 25% for low DSH states (and by lesser percentages for states meeting certain criteria) once the state's uninsured rate decreases by at least 45%. DSH allotments will be further reduced, not to fall below 50% of the total	• Increase the Medicaid drug rebate percentage to 23.1% and extend the prescription drug rebate to Medicaid managed care plans. (Effective January 1, 2010) • Reduce Medicaid DSH allotments by a total of $10 billion ($1.5 billion in 2017; $2.5 billion in 2018; and $6 billion in 2019), imposing the largest percentage reductions in state DSH allotments in states with the lowest uninsured rates and those that do not target DSH payments. • Prohibit federal payments to states for Medicaid services related to health care acquired conditions. (Effective January 1, 2010)

	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
COST CONTAINMENT (continued)		
Medicaid (continued)	allotment in 2012 if states' uninsured rates continue to decrease. Exempt any portion of the DSH allotment used to expand Medicaid eligibility through a section 1115 waiver. (Effective October 1, 2011) • Prohibit federal payments to states for Medicaid services related to health care acquired conditions. (Effective July 1, 2011)	• Authorize the Food and Drug Administration to approve generic versions of biologic drugs and grant biologics manufacturers 12 years of exclusive use before generics can be developed. (Effective upon enactment) • Require hospitals and ambulatory surgical centers to report on health care-associated infections to the Centers for Disease Control and Prevention (effective one year following enactment) and refuse Medicaid payments for certain health care-associated conditions. (Effective January 1, 2010)
Prescription drugs	• Authorize the Food and Drug Administration to approve generic versions of biologic drugs and grant biologics manufacturers 12 years of exclusive use before generics can be developed. (Effective upon enactment)	• Enhance competition in the pharmaceutical market by stopping agreements between brand name and generic drug manufacturers that limit, delay, or otherwise prevent competition from generic drugs. (Effective upon enactment)
Waste, fraud, and abuse	• Reduce waste, fraud, and abuse in public programs by allowing provider screening, enhanced oversight periods for new providers and suppliers, and enrollment moratoria in areas identified as being at elevated risk of fraud in all public programs, and by requiring Medicare and Medicaid program providers and suppliers to establish compliance programs. Develop a database to capture and share data across federal and state programs, increase penalties for submitting false claims, and increase funding for anti-fraud activities. (Effective dates vary)	• Reduce waste, fraud, and abuse in public programs by allowing provider screening, enhanced oversight periods, and enrollment moratoria in areas identified as being at elevated risk of fraud in all public programs, and by requiring Medicare and Medicaid program providers and suppliers to establish compliance programs. (Effective dates vary)
IMPROVING QUALITY/HEALTH SYSTEM PERFORMANCE		
Comparative effectiveness research	• Support comparative effectiveness research by establishing a non-profit Patient-Centered Outcomes Research Institute to identify research priorities and conduct research that compares the clinical effectiveness of medical treatments. The Institute will be overseen by an appointed multi-stakeholder Board of Governors and will be assisted by expert advisory panels. Findings from comparative effectiveness research may not be construed as mandates, guidelines, or recommendations for payment, coverage, or treatment or used to deny coverage. (Funding available beginning fiscal year 2010) Terminate the Federal Coordinating Council for Comparative Effectiveness Research that was founded under the American Recovery and Reinvestment Act. (Effective upon enactment)	• Support comparative effectiveness research by establishing a Center for Comparative Effectiveness Research within the Agency for Healthcare Research and Quality to conduct, support, and synthesize research on outcomes, effectiveness, and appropriateness of health care services and procedures. An independent CER Commission will oversee the activities of the Center. Provides that comparative effectiveness research findings may not be construed as mandates for payment, coverage, or treatment or used to deny or ration care. Establish the Comparative Effectiveness Research Trust Fund. (Effective FY 2010)
Medical malpractice	• Award five-year demonstration grants to states to develop, implement, and evaluate alternatives to current tort litigations. Preference will be given to states that have developed alternatives in consultation with relevant stakeholders and that have proposals that are likely to enhance patient safety by reducing medical errors and adverse events and are likely to improve access to liability insurance. (Funding appropriated for five years beginning in fiscal year 2011)	• Provide incentive payments to states that enact alternative medical liability laws that make the medical liability system more reliable through the prevention of or prompt and fair resolution of disputes, encourage the disclosure of health care errors, and maintain access to affordable liability insurance. (Effective upon enactment)

	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
IMPROVING QUALITY/HEALTH SYSTEM PERFORMANCE (continued)		
Medicare	• Establish a national Medicare pilot program to develop and evaluate paying a bundled payment for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care that begins three days prior to a hospitalization and spans 30 days following discharge. If the pilot program achieves stated goals of improving or not reducing quality and reducing spending, develop a plan for expanding the pilot program. (Establish pilot program by January 1, 2013; expand program, if appropriate, by January 1, 2016) • Create the Independence at Home demonstration program to provide high-need Medicare beneficiaries with primary care services in their home and allow participating teams of health professionals to share in any savings if they reduce preventable hospitalizations, prevent hospital readmissions, improve health outcomes, improve the efficiency of care, reduce the cost of health care services, and achieve patient satisfaction. (Effective January 1, 2012) • Establish a hospital value-based purchasing program in Medicare to pay hospitals based on performance on quality measures and extend the Medicare physician quality reporting initiative beyond 2010. (Effective October 1, 2012) Develop plans to implement value-based purchasing programs for skilled nursing facilities, home health agencies, and ambulatory surgical centers. (Reports to Congress due January 1, 2011)	• Require the Secretary to develop a plan to reform Medicare payments for post-acute services, including bundled payments, to improve the coordination, quality and efficiency of such services and improve outcomes. (Effective January 1, 2011) • Create the Independence at Home demonstration program to provide high-need Medicare beneficiaries with primary care services in their home and allow participating teams of health professionals to share in any savings if they reduce preventable hospitalizations, prevent hospital readmissions, improve health outcomes, improve the efficiency of care, reduce the cost of health care services, and achieve patient satisfaction. (Effective January 1, 2012) • Require the Institute of Medicine to conduct a study on geographic adjustment factors in Medicare and require the Secretary to issue regulations to revise the geographic adjustment factors based on the recommendations. (Report due one year following enactment; proposed regulations issued following submission of report)
Dual eligibles	• Improve care coordination for dual eligibles by creating a new office within the Centers for Medicare and Medicaid services, the Federal Coordinated Health Care Office, to more effectively integrate Medicare and Medicaid benefits and improve coordination between the federal government and states in order to improve access to and quality of care and services for dual eligibles. (Effective March 1, 2010)	• Require the Secretary to improve coordination of care for dual eligibles through a new office or program within the Centers for Medicare and Medicaid Services. (Report of activities due within one year of enactment)
Medicaid	• Create a new Medicaid state plan option to permit Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a health home. Provide states taking up the option with 90% FMAP for two years. (Effective January 1, 2011) • Create new demonstration projects in Medicaid to pay bundled payments for episodes of care that include hospitalizations (effective January 1, 2012 through December 31, 2016); to make global capitated payments to safety net hospital systems (effective fiscal years 2010 through 2012); to allow pediatric medical providers organized as accountable care organizations to share in cost-savings (effective January 1, 2012 through December 31, 2016); and to provide Medicaid payments to institutions of mental disease for adult enrollees who require stabilization of an emergency condition (effective October 1, 2011 through December 31, 2015).	• Expand the role of the Medicaid and CHIP Payment and Access Commission (MACPAC) to include all individuals and require MACPAC to report to Congress on nursing facility payment policies by January 1, 2012 and pediatric sub-specialist payment policies by January 1, 2011. Require reports on the implementation of health reform that relate to Medicaid and CHIP, including the effect of implementation on access. ($11.8 million in additional funds appropriated beginning January 1, 2010)

	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
IMPROVING QUALITY/HEALTH SYSTEM PERFORMANCE (continued)		
Medicaid (continued)	• Expand the role of the Medicaid and CHIP Payment and Access Commission to include assessments of adult services (including those dually eligible for Medicare and Medicaid). ($11 million in additional funds appropriated for fiscal year 2010)	
Primary care	No similar provision.	• Strengthen primary care and care coordination by increasing Medicaid payments for primary care providers to 100% of Medicare rates (phased-in beginning in 2010 through 2012) and providing Medicare bonus payments to primary care practitioners (with larger bonuses paid to primary care practitioners serving in health professional shortage areas) beginning January 1, 2011.
National quality strategy	• Develop a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health. Create processes for the development of quality measures involving input from multiple stakeholders and for selecting quality measures to be used in reporting to and payment under federal health programs. (National strategy due to Congress by January 1, 2011) • Establish the Community-based Collaborative Care Network Program to support consortiums of health care providers to coordinate and integrate health care services, for low-income uninsured and underinsured populations. (Funds appropriated for five years beginning in FY 2011)	• Establish the Center for Quality Improvement to identify, develop, evaluate, disseminate, and implement best practices in the delivery of health care services. Develop national priorities for performance improvement and quality measures for the delivery of health care services. (Effective dates vary) • Establish the Community-based Collaborative Care Network Program to support consortiums of health care providers to coordinate and integrate health care services, manage chronic conditions, and reduce emergency department use for low-income uninsured and underinsured populations. (Funds appropriated for five years beginning FY 2011)
Financial disclosure	• Require disclosure of financial relationships between health entities, including physicians, hospitals, pharmacists, other providers, and manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies. (Report due to Congress April 1, 2013)	• Require disclosure of financial relationships between health entities, including physicians, hospitals, pharmacists, and other providers, and manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies. (Effective March 2011)
Disparities	• Require enhanced collection and reporting of data on race, ethnicity, sex, primary language, disability status, and for underserved rural and frontier populations. Also require collection of access and treatment data for people with disabilities. Require the Secretary to analyze the data to monitor trends in disparities. (Effective two years following enactment)	• Reduce racial and ethnic disparities by conducting a study on the feasibility of developing Medicare payment systems for language services, providing Medicare demonstration grants to reimburse culturally and linguistically appropriate services and developing standards for the collection of data on race, ethnicity, and primary language. (Report due to Congress one year following enactment)
PREVENTION/WELLNESS		
National strategy	• Establish the National Prevention, Health Promotion and Public Health Council to coordinate federal prevention, wellness, and public health activities. Develop a national strategy to improve the nation's health. (Strategy due one year following enactment) Create a Prevention and Public Health Fund to expand and sustain funding for prevention and public health programs. (Initial appropriation in fiscal year 2010) Create task forces on Preventive Services and Community Preventive Services to develop, update, and disseminate evidenced-based recommendations on the use of clinical and community prevention services. (Effective upon enactment)	• 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 Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
PREVENTION/WELLNESS (continued)		
National strategy (continued)	• Establish a grant program to support the delivery of evidence-based and community-based prevention and wellness services aimed at strengthening prevention activities, reducing chronic disease rates and addressing health disparities, especially in rural and frontier areas. (Funds appropriated for five years beginning in FY 2010)	• Establish a grant program to support the delivery of evidence-based and community-based prevention and wellness services aimed at reducing health disparities. Train community health workers to promote positive health behaviors in medically underserved communities. Provide grants to plan and implement programs to prevent obesity among children and their families. (Funds appropriated for five years beginning FY 2011)
Coverage of preventive services	• Improve prevention by covering only proven preventive services and eliminating cost-sharing for preventive services in Medicare and Medicaid. (Effective January 1, 2011) For states that provide Medicaid coverage for and remove cost-sharing for preventive services recommended by the US Preventive Services Task Force and recommended immunizations, provide a one percentage point increase in the FMAP for these services. Increase Medicare payments for certain preventive services to 100% of actual charges or fee schedule rates. (Effective January 1, 2011) • Provide Medicare beneficiaries access to a comprehensive health risk assessment and creation of a personalized prevention plan. (Health risk assessment model developed within 18 months following enactment) Provide incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs. (Effective January 1, 2011 or when program criteria is developed, whichever is first) Require Medicaid coverage for tobacco cessation services for pregnant women. (Effective October 1, 2010) • Require qualified health plans to provide at a minimum coverage without cost-sharing for preventive services rated A or B by the U.S. Preventive Services Task Force, recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women. (Effective six months following enactment)	• Improve prevention by covering only proven preventive services and eliminating cost-sharing for preventive services in Medicare and Medicaid. (Effective July 1, 2010) Increase Medicare payments for certain preventive services to 100% of actual charges or fee schedule rates. (Effective January 1, 2011)
Wellness programs	• Provide grants for up to five years to small employers that establish wellness programs. (Funds appropriated for five years beginning in fiscal year 2011) • Provide technical assistance and other resources to evaluate employer-based wellness programs. Conduct a national worksite health policies and programs survey to assess employer-based health policies and programs. (Conduct study within two years following enactment) • Permit employers to offer employees rewards—in the form of premium discounts, waivers of cost-sharing requirements, or benefits that would otherwise not be provided—of up to 30% of the cost of coverage for participating in a wellness program and meeting certain health-related standards. Employers must offer an alternative standard for individuals for whom it is unreasonably difficult or inadvisable to meet the standard.	• Provide wellness grants for up to three years to small employers for up to 50% of costs incurred for a qualified wellness program. (Effective July 1, 2010)

	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
PREVENTION/WELLNESS (continued)		
Wellness programs (continued)	The reward limit may be increased to 50% of the cost of coverage if deemed appropriate. (Effective January 1, 2014) Establish 10-state pilot programs by July 2014 to permit participating states to apply similar rewards for participating in wellness programs in the individual market and expand demonstrations in 2017 if effective. Require a report on the effectiveness and impact of wellness programs. (Report due three years following enactment)	
Nutritional information	• Require chain restaurants and food sold from vending machines to disclose the nutritional content of each item. (Proposed regulations issued within one year of enactment)	• Require chain restaurants and food sold from vending machines to disclose the nutritional content of each item. (Proposed regulations issued within one year of enactment)
LONG-TERM CARE		
CLASS Act	• Establish a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program). Following a five-year vesting period, the program will provide individuals with functional limitations a cash benefit of not less than an average of $50 per day to purchase non-medical services and supports necessary to maintain community residence. The program is financed through voluntary payroll deductions: all working adults will be automatically enrolled in the program, unless they choose to opt-out. (Effective January 1, 2011)	• Establish a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program). Following a five-year vesting period, the program will provide individuals with functional limitations a cash benefit of not less than an average of $50 per day to purchase non-medical services and supports necessary to maintain community residence. The program is financed through voluntary payroll deductions: all working adults will be automatically enrolled in the program, unless they choose to opt-out. (Effective 2010)
Medicaid	• Extend the Medicaid Money Follows the Person Rebalancing Demonstration program through September 2016 (effective 30 days following enactment) and allocate $10 million per year for five years to continue the Aging and Disability Resource Center initiatives (funds appropriated for fiscal years 2010 through 2014). • Provide states with new options for offering home and community-based services through a Medicaid state plan rather than through a waiver for individuals with incomes up to 300% of the maximum SSI payment and who have a higher level of need and permit states to extend full Medicaid benefits to individual receiving home and community-based services under a state plan. (Effective October 1, 2010) • Establish the Community First Choice Option in Medicaid to provide community-based attendant supports and services to individuals with disabilities who require an institutional level of care. Provide states with an enhanced federal matching rate of an additional six percentage points for reimbursable expenses in the program. Sunset the option after five years. (Effective October 1, 2010)	No similar provision.

	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
LONG-TERM CARE (continued)		
Medicaid (continued)	• Create the State Balancing Incentive Program to provide enhanced federal matching payments to eligible states to increase the proportion of non-institutionally-based long-term care services. Selected states will be eligible for FMAP increases for medical assistance expenditures for non-institutionally-based long-term services and supports. (Effective October 1, 2011 through September 30, 2015)	
Demonstration programs	No similar provision.	• Establish a three-year demonstration program in four states to evaluate the effectiveness of recommended core competencies for personal and home care aides and training curriculum and methods to provide long-term services and supports. (Demonstration program established within 180 days of issuance of recommendations)
Skilled nursing facility requirements	• Require skilled nursing facilities under Medicare and nursing facilities under Medicaid to disclose information regarding ownership, accountability requirements, and expenditures. Publish standardized information on nursing facilities to a website so Medicare enrollees can compare the facilities. (Effective dates vary)	• Improve transparency of information about skilled nursing facilities and nursing facilities. (Disclosure reporting regulations issued within two years of enactment; reporting of information required 90 days after regulations are issued)
OTHER INVESTMENTS		
Medicare	• Make improvements to the Medicare program: – Increase the Part D initial coverage limit by $500 for 2010 to reduce the size of the coverage gap (Effective January 1, 2010); – Provide a 50% discount on brand-name prescriptions filled in the Medicare Part D coverage gap for enrollees, other than those who receive low-income subsidies and those with incomes above $85,000/individual and $170,000/couple (Effective July 1, 2010); – Make Part D cost-sharing for full-benefit dual eligible beneficiaries receiving home and community-based care services equal to the cost-sharing for those who receive institutional care (Effective no earlier than January 1, 2012); – Expand Medicare coverage to individuals who have been exposed to environmental health hazards from living in an area subject to an emergency declaration made as of June 17, 2009 and have developed certain health conditions as a result (Effective upon enactment); – Provide a 10% bonus payment to primary care physicians and to general surgeons practicing in health professional shortage areas, from 2011 through 2015; and – Prohibit Medicare Advantage plans from imposing higher cost-sharing requirements for some Medicare covered benefits than is required under the traditional fee-for-service program. (Effective January 1, 2011)	• Make improvements to the Medicare program: – Modify the initial coverage limit and catastrophic thresholds to reduce the coverage gap by $500 in 2010 and eventually eliminate the Medicare Part D coverage gap by 2019; require drug manufacturers to provide a 50% discount on brand-name prescriptions filled in the coverage gap. (Effective January 1, 2010). – Increase the asset test threshold for Medicare Savings Program and Part D Low-Income Subsidies to $17,000 per individual and $34,000 per couple. (Effective 2012) – Cover through Medicaid the Part B deductible and cost-sharing for Medicare beneficiaries under age 65 with incomes below 150% FPL (and resources at or below two times the SSI level); finance these costs with 100% federal funding in 2013 and 2014 and 91% federal funding in subsequent years. (Effective January 1, 2013)

	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
OTHER INVESTMENTS (continued)		
Workforce	• Improve workforce training and development: – Establish a multi-stakeholder Workforce Advisory Committee to develop a national workforce strategy. (Appointments made by September 30, 2010) – Increase the number of Graduate Medical Education (GME) training positions by redistributing currently unused slots, with priorities given to primary care and general surgery and to states with the lowest resident physician-to-population ratios (effective July 1, 2011); increase flexibility in laws and regulations that govern GME funding to promote training in outpatient settings (effective July 1, 2010); and ensure the availability of residency programs in rural and underserved areas. Establish Teaching Health Centers, defined as community-based, ambulatory patient care centers, including federally qualified health centers and other federally-funded health centers that are eligible for Medicare payments for the expenses associated with operating primary care residency programs. (Initial appropriation in fiscal year 2010) – Increase workforce supply and support training of health professionals through scholarships and loans; support primary care training and capacity building; provide state grants to providers in medically underserved areas; train and recruit providers to serve in rural areas; establish a public health workforce loan repayment program; provide medical residents with training in preventive medicine and public health; promote training of a diverse workforce; and promote cultural competence training of health care professionals. (Effective dates vary) Support the development of interdisciplinary mental and behavioral health training programs (effective fiscal year 2010) and establish a training program for oral health professionals. (Funds appropriated for six years beginning in fiscal year 2010) • Address the projected shortage of nurses and retention of nurses by increasing the capacity for education, supporting training programs, providing loan repayment and retention grants, and creating a career ladder to nursing. (Initial appropriation in fiscal year 2010) Provide grants for up to three years to employ and provide training to family nurse practitioners who provide primary care in federally qualified health centers and nurse-managed health clinics. (Funds appropriated for five years beginning in fiscal year 2011) • Support the development of training programs that focus on primary care models such as medical homes, team management of chronic disease, and those that integrate physical and mental health services. (Funds appropriated for five years beginning in fiscal year 2010)	• Improve workforce training and development: – Establish a multi-stakeholder Advisory Committee on Health Workforce Evaluation and Assessment to develop and implement a national health workforce strategy. (Funds appropriated beginning FY 2011) – Reform Graduate Medical Education to increase training of primary care providers by redistributing residency positions and promote training in outpatient settings, including through a Teaching Health Center demonstration project. (Effective July 1, 2011) – Support training of health professionals through scholarships and loans; establish a primary care training and capacity building program; establish a loan repayment program for professionals who work in health professions needs areas; establish a public health workforce corps; promote training of a diverse workforce; and provide cultural competence training for health care professionals. Support the development of interdisciplinary mental and behavioral health training programs and establish a training program for oral health professionals. (Funds appropriated beginning FY 2011) – Address the projected shortage of nurses and retention of nurses by increasing the capacity for education, supporting training programs, providing loan repayment and retention grants, and creating a career ladder to nursing. – Support the development of interdisciplinary health training programs that focus on team-based models, including medical home models and models that integrate physical, mental, and oral health services. (Funds appropriated beginning FY 2011)

	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
OTHER INVESTMENTS (continued)		
Community health centers and school-based health centers	• Improve access to care by increasing funding for community health centers and the National Health Service Corps (effective fiscal year 2011); establishing new programs to support school-based health centers (effective fiscal year 2011) and nurse-managed health clinics (effective fiscal year 2010).	• Improve access to care by increasing funding by $12 billion over five years for community health centers; establish new programs to support school-based health centers (effective July 1, 2010) and nurse-managed health centers (effective 2011), and set criteria for the certification of federally qualified behavioral health centers.
Trauma care	No similar provision.	• Establish a new trauma center program to strengthen emergency department and trauma center capacity and to establish new trauma centers in urban areas with substantial trauma related to violent crimes. Create an Emergency Care Coordination Center within HHS; develop demonstration programs to design, implement, and evaluate innovative models for emergency care systems. (Funds appropriated for five years beginning in FY 2011)
Public health and disaster preparedness	• Establish a commissioned Regular Corps and a Ready Reserve Corps for service in time of a national emergency. (Funds appropriated for five years beginning in fiscal year 2010)	• Provide grants to each state health department to address core public health infrastructure needs. (Funds appropriated for five years beginning FY 2011) • Establish the Public Health Investment Fund for financing designated public health provisions. (Initial appropriation in FY 2011)
Requirements for non-profit hospitals	• Impose additional requirements on non-profit hospitals to conduct a community needs assessment every three years and adopt an implementation strategy to meet the identified needs, adopt and widely publicize a financial assistance policy that indicates whether free or discounted care is available and how to apply for the assistance, limit charges to patients who qualify for financial assistance to the amount generally billed to insured patients, and make reasonable attempts to determine eligibility for financial assistance before undertaking extraordinary collection actions. Impose a tax of $50,000 per year for failure to meet these requirements. (Effective for taxable years following enactment)	No similar provision.
American Indians	• Reauthorize and amend the Indian Health Care Improvement Act. (Effective dates vary)	• Reauthorize and amend the Indian Health Care Improvement Act. (Effective dates vary)
FINANCING		
Financing	The Congressional Budget Office estimates the cost of the coverage components of the Patient Protection and Affordable Care Act to be $871 billion over ten years. These costs are financed through a combination of savings from Medicare and Medicaid and new taxes and fees. The net savings from Medicare and Medicaid are estimated to be $438 billion over ten years and the primary sources of these savings include reductions in updates in Medicare payment rates for hospitals, home health agencies and other providers (other than physicians), reductions in payments to	The Congressional Budget Office estimates the net cost of the proposal (less payments from employers and uninsured individuals) to be $894 billion over ten years. These costs are financed through a combination of savings from Medicare and Medicaid and new taxes and fees. The net savings from Medicare and Medicaid are estimated to be $426 billion over ten years and the primary sources of these savings include incorporating productivity improvements into Medicare market basket updates, reducing payments to Medicare Advantage plans, changing the Medicaid drug rebate provisions, and cutting Medicaid and Medicare DSH payments.

	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
FINANCING (continued)		
Financing (continued)	issued by a new Independent Payment Advisory Board, and increases in Medicare Parts B and D premiums for higher income Medicare beneficiaries, changing the Medicaid drug rebate provisions, and cutting Medicaid and Medicare DSH payments. (See descriptions of cost savings provisions in Cost containment.) The largest source of new revenue will come from an excise tax on high-cost insurance, which CBO estimates will raise $149 billion over ten years. Additional revenue provisions include fees on certain manufacturers and insurers, an increase in hospital insurance contributions for high high-income taxpayers, and other provisions that will generate $264 billion over the same time period. (See Tax changes related to health insurance.) CBO estimates the proposal will reduce the deficit by $132 billion over ten years.	(See descriptions of cost savings provisions in Cost containment.) The largest source of new revenue will come from a 5.4% surcharge imposed on families with incomes above $1,000,000 and individuals with incomes above $500,000, which is projected to raise $461 billion in revenue. Additional revenue provisions will generate $97 billion over the same time period. (See Tax changes related to health insurance.) CBO estimates the proposal will reduce the deficit by $104 billion over ten years.
Sources of information	http://www.democrats.senate.gov/	http://democraticleader.house.gov/members/health_care.cfm