

**Comparing elements of health reform proposals**

**Prepared by the Public Policy Institute**

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<b>Element</b>	<b>Baucus mark</b>	<b>HELP</b>	<b>House</b>
<b>Affordability for 50-64</b>	<p>Subsidies for premiums would be available in the Exchange for those between 100 and 400 percent of poverty. Depending on income, individuals' premium contribution would be limited to 2% to 12% of income. Enrollees' share of premiums held constant over time, which like House E&amp;C indexing will erode subsidy value over time.</p> <p>Subsidies reduce cost sharing for those between 100 and 200 percent of poverty.</p> <p>4:1 age rating</p> <p>OOP limit is same as for high deductible health plan (\$5,800 individuals, \$11,600 families in 2009). Limit is reduced by 1/3 for people between 100% and 200% of poverty, 1/2 for people between 200 and 300% poverty, and 2/3 for people between 300 and 400%</p>	<p>Subsidies for premiums and cost sharing to 400 percent of poverty</p> <p>2:1 age rating</p> <p>OOP limit is set to high deductible health plan (\$5,800 individuals, \$11,600 families in 2009). Lower limit for people with lower incomes.</p>	<p>Subsidies for premiums and cost sharing to 400 percent of poverty. Depending on income, individual's premium contribution limited to 1.5% to 11 (2 committees) or 12% (E&amp;C).</p> <p>2:1 age rating</p> <p>OOP limit is \$5,000 for individuals, \$10,000 for families.</p> <p>Energy and Commerce provides less subsidies through indexing provisions and higher affordability standard.</p> <p>Essential benefits covered in all plans. Four categories of plans with different actuarial values (70%, 85%, 95%, 95% with benefits beyond the essential ones, e.g. dental).</p>

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	<p>of poverty.</p> <p>Essential benefits covered by all plans. Four categories of plans with different actuarial values (65%, 70%, 80%, 90%). Premium subsidies tied to 70% level. A catastrophic plan available for adults 25 and under, and people who would be exempt from the individual mandate because available minimum creditable coverage exceeds 10% of their income.</p> <p>Exchanges have to have a plan that is actuarially equivalent to FEHBP BCBS standard option.</p>		Premium subsidies tied to 70% level.
<b>Doughnut hole</b>	Includes discounts on brand name drugs of 50 percent for most individuals (not LIS or those paying Part B income-related premiums).	Not part of jurisdiction	Gradual closing of doughnut hole plus discounts on brand name drugs of 50 percent for most individuals (not LIS).
<b>Transitional care and care coordination</b>	Includes \$500 M funding for 3 year pilot targeting hospitals with high readmission rates and community partnership organizations to provide evidence-based transitional care services to	<p>Not included directly (some related provisions where might be included); Medicare not in jurisdiction.</p> <p>Includes Community Health</p>	<p>Not included directly.</p> <p>Encourages DSH hospitals with high readmission rates to provide transitional care services;</p>

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	<p>reduce re-hospitalizations for the highest risk Medicare beneficiaries;</p> <p>Medicare Medical Home Pilot model to be tested by CMS Innovation Center; Medicaid Medical Home included as a state option, with enhanced FMAP of 90%.</p> <p>Initiatives for duals, including new office for duals at CMS.</p>	<p>Teams that provide transitional care services to support private sector Medical Homes.</p>	<p>Independence at Home (Energy and Commerce version) provides coordinated care and transitional care services.</p> <p>Medicare Medical Home pilot includes transitional care services; Medicaid Medical Home pilot included.</p> <p>Initiatives for duals, including new office for duals at CMS.</p>
<p><b>Long-term services and supports</b></p>	<p>New initiatives to expand access to HCBS. Include:</p> <p>(1) Targeted enhanced FMAP for HCBS to states that make structural changes in their LTC systems and increases to 300% of SSI the income eligibility limit for Medicaid HCBS state plan option. Sunsets in 5 years.</p> <p>(2) Spousal impoverishment protections for Medicaid HCBS for 5 years.</p> <p>(3) Continued funding and authority for Aging and Disability Resource Centers and Money</p>	<p>CLASS Act provisions create a public insurance program for long-term services and supports.</p> <p>Provides preferred tax-treatment for LTC insurance expenses.</p>	<p>CLASS Act provisions in Energy and Commerce bill create a public insurance program for long-term services and supports.</p> <p>New initiatives to improve nursing home quality/transparency.</p> <p>Establishes program for National and state background checks on LTC employees with direct patient access.</p>

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	<p>Follows the Person Rebalancing Demonstration Program.</p> <p>(4) Community First Choice Option – a new Medicaid state plan option, with enhanced FMAP, to provide certain HCBS to disabled Medicaid eligibility persons with institutional level care need. Sunsets in 5 years.</p> <p>New initiatives to improve nursing home quality/transparency. Provides preferred tax-treatment for LTC insurance expenses.</p>		
<b>Expanded coverage for low income Medicare populations</b>	<p>Not included.</p> <p>Would reduce need for LIS population to switch plans due to changes in bids.</p> <p>Waives Part D cost-sharing for full-benefit, dual eligible beneficiaries receiving HCBS.</p>	Not part of jurisdiction	<p>Increases asset levels for LIS and harmonizes them with MSP asset levels so that more people will access both programs.</p> <p>Waives Part D cost-sharing for full-benefit, dual eligible beneficiaries receiving HCBS.</p>
<b>Pathway for generic biologics</b>	Not part of jurisdiction	Included but long (12 year) period of exclusivity	Included in Energy and Commerce bill but long (12 year) period of exclusivity
<b>Physician payment</b>	One year override of SGR formula	Not part of jurisdiction	Changes SGR formula for the future – different updates for primary care and all other

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<p><b>Medicare savings (MA below)</b></p>	<p>Total savings of around \$471 billion (per CBO score), with some new investments; net is \$409B.</p> <p>Adds income relating to Part D premium, freezes threshold for Part B and D premiums (making more people pay income related amounts).</p> <p>New Medicare Commission whose recommendations Congress must consider on a fast track with budget targets.</p> <p>Adds nominal cost sharing to Medigap plans C and F, which currently have none.</p>	<p>Not part of jurisdiction</p>	<p>care.</p> <p>Total savings of around \$550 billion offset by investments of \$284 billion.</p>
<p><b>Medicare Advantage</b></p>	<p>New, phased-in payment approach based on competitive bidding to reflect actual plan costs. In 2014, MA payments based on competitively set bids. Plans bidding below the benchmark set by bids keep 100 percent of the difference between their bid and the benchmark (current law allows them to keep</p>	<p>Not in jurisdiction.</p>	<p>Blended payment in 2011 to move to a payment floor equal to no less than fee-for-service in 2013 while taking into account the phase out of IME.</p> <p>MA plans eligible for “quality bonus payments” (based on performance on specified</p>

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	<p>75 percent of this difference) that would have to be returned to beneficiaries in form of extra benefits.</p> <p>High performing plans eligible for a quality bonus. Additional bonuses for care coordination and management. Efficiency bonus for plans bidding more than 85 percent below fee-for-service costs. 100 percent of this bonus to go to additional benefits.</p> <p>Current annual election period for MA from Jan.-Mar 31 of each year would be eliminated. Annual fall election would be changed from 11/15 -12/32 to 10/15-12/7 starting in 2011.</p> <p>Cost contracts extended through 2013 even if other MA plans in their service areas.</p> <p>Reauthorizes SNPs through 12/13. New frailty adjustment for fully integrated dual eligible SNPs if they offer integrated Medicare</p>		<p>quality measures) that would recognize achievement of high quality (starting in 2011 at 1 percent and increasing to 3 percent in 2013 and thereafter) and improvement (starting at 0.33 per cent in 2011 and increasing to 1 percent after 2013. After 2016, most measures used for quality bonus payments must be outcomes measures.</p> <p>Secretary to rank plans based on quality scores from highest to lowest—those in highest quintile to be designated “high quality MA plan.”</p> <p>MA Regional Plan Stabilization Fund is eliminated.</p> <p>Annual election during the first three months of each year is eliminated.</p> <p>Cost contracts are extended through 2011.</p>

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	<p>and Medicaid benefits via contracts with CMS and state Medicaid agency and include long-term care.</p> <p>New beneficiary protections would limit cost sharing for certain services added; new restrictions plans use of rebates and bonuses.</p>		Reauthorizes SNPs.
<p><b>Financing (in addition to Medicare savings, individual/employer mandates)</b></p>	<p>Excise tax on costly employee plans, with an exception for non-group buyers. Cost threshold for excise tax raised for retirees over age 55 and high risk occupations (so fewer will be taxed).</p> <p>Raise expense threshold for itemized medical deduction from 7.5% to 10% of AGI.</p> <p>Limits contributions to flexible spending accounts to \$2,500. Narrows definition of medical expense for FSAs, HRAs and HSAs to exclude most over-the-counter drugs.</p> <p>Eliminates the tax deduction for</p>	Not part of jurisdiction	Tax on high income individuals.

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	<p>employer expenses also subsidized under the Part D retiree drug subsidy program.</p> <p>Adds fees on a variety of providers.</p> <p>Enhances corporate tax compliance.</p>		
<b>Other drug affordability provisions</b>	Would codify Part D's current six "protected classes" on formularies, which could raise costs.	Expands use of federal fee schedule.	Energy and Commerce version includes Secretarial negotiation, all versions include expansion of use of Federal fee schedule.
<b>Territories</b>	Would increase Medicaid spending	Not part of jurisdiction	Would increase Medicaid spending
<b>Individual mandate</b>	<p>Individuals must have qualifying coverage. Grandfathered, and public coverage (e.g. Medicare, VA, IHS) would satisfy mandate.</p> <p>Penalty of \$950 per person without coverage up to maximum of \$3,800 per family (\$750/\$1,500 for those under 300% of poverty).</p> <p>Exemptions if lowest cost coverage isn't affordable (defined as premium after subsidy &gt;10% of</p>	<p>Individuals must have qualifying coverage. Grandfathered coverage and public coverage (e.g. Medicare, VA, IHS) would satisfy mandate.</p> <p>Penalty amount to be set in regulation at minimum amount to accomplish goal of encouraging participation, but can't be less than ½ the average annual premium for</p>	<p>Individuals must have qualifying coverage. Grandfathered coverage would satisfy (grandfathered employer coverage has 5 year grace period to meet standards for qualifying coverage).</p> <p>Penalty is lower of national average premium or 2.5% tax on modified adjusted gross income.</p>

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	income); for hardship; those below 100% of poverty; religious conscience.	basic plan. Exemptions if affordable coverage is not available.	Exemptions for religious conscience and hardship. Sec. to define.
<b>Employer mandate</b>	Includes the “free rider” policy where employers repay government for subsidies. Exempts smallest employers and some could get tax credits.	Included. Employers pay \$750 per year if they do not offer qualifying coverage. Smallest employers exempt and some could get tax credits.	Included. Employers pay 8 % of payroll if they do not offer coverage. Small employers pay less and get tax credits as well. Smallest employers exempt.
<b>Public plan</b>	Not included – cooperative instead. Fall back public option might be added in an amendment.	Included	Included, and cooperative included also in Energy and Commerce version.
<b>Exchange</b>	Included. Interstate compacts and national plans permitted also.	Included (called Gateways)	Included
<b>Consumer protections</b>	Included	Included	Included
<b>Reduce fraud and abuse</b>	Requires review of providers before granting billing privileges, leveraging technology to better evaluate claims, educating providers to promote compliance with program requirements, monitoring programs more vigilantly, closing loop holes, strengthening sanctions for fraud and increasing funding for enforcement by \$100 M;  Requires disclosure and reporting	Reduces waste, fraud and abuse in public and private health care programs by appointing Senior Advisors on Fraud & Abuse to HHS & DOJ; Establishes a Coordinating Council to plan and oversee enforcement in public and private sectors; Requires uniform reporting form for private insurers to state insurance departments; Strengthens sanctions for	Expands HHS authority to combat waste, fraud and abuse in public programs; increases funding for enforcement by \$100 M; enhances penalties for a range of fraudulent activities, such as false statements by providers; requires billing agents and clearing houses that submit provider claims to register; requires disclosure and reporting by

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	<p>by manufacturers of all payments of value (over \$10) to physicians and teaching hospitals;</p> <p>Requires manufacturers and distributors to report drug samples given to physicians and hospitals;</p> <p>Tightens up rules on physician ownership of hospitals;</p> <p>Requires hospitals to publicly disclose their charges to Medicare and private payers for each DRG.</p>	<p>abuses by MEWAs.</p>	<p>manufacturers and distributors of all payments of value (over \$5) to providers, suppliers, PBMs, insurers, plans, researchers, medical schools, patient advocacy groups and professional organizations; requires disclosure of ownership interest by physicians in hospitals; requires public disclosure via internet of this info.</p> <p>Preempts state laws that require reporting of the same types of payments of value or physician relationships.</p> <p>Tightens up rules on physician ownership of hospitals.</p>
<b>Workforce investments</b>	<p>Provides \$200 million for a 4-year demonstration project for Medicare Graduate Nursing Education funding.</p> <p>It provides grants to states to recruit more economically disadvantaged people into health</p>	<p>Includes policies that support nursing education.</p> <p>Establishes national commission on workforce.</p> <p>Geriatric education center funding; many other grants,</p>	<p>Includes policies that support nursing education.</p> <p>Other policies would increase the numbers of primary care physicians by increasing the flexibility of GME slots and redistribution of unused slots.</p>

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	<p>professions including nursing.</p> <p>Creates a health workforce commission that would look at workforce needs and propose solutions.</p> <p>Other policies would increase the numbers of primary care physicians by increasing the flexibility of GME slots and redistribution of unused slots.</p> <p>Would give a 10% increase in Medicare reimbursement to primary care physicians.</p>	<p>initiatives, and policy changes to stimulate workforce, including direct care workers.</p>	<p>Would give a 5% increase in Medicare reimbursement to primary care physicians and those in shortage areas.</p>
<b>Medicaid expansion</b>	<p>New optional coverage category for childless adults (nonelderly) in 2011 at current state FMAPs; in 2014, increases eligibility for all groups except pregnant women to 133% FPL (unclear if mandatory or optional);</p> <p>Makes 133 percent of FPL the new mandatory minimum Medicaid income eligibility for parents, kids, and childless adults (under 65).</p>	<p>Not in jurisdiction</p>	<p>Expands Medicaid up to 1331/3% FPL with phased-in state contribution of 10% after 5 years.</p>

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	<p>Bars people with income at or below 100% FPL from the exchange. Noncategorical adults between 100-133% FPL can choose between Medicaid and exchange coverage; States contribute to cost of adults choosing exchange coverage and provide EPSDT wrap;</p> <p>Includes a MOE requirement until state-based exchanges are fully operational (2014); provides 100% federal funding for the “newly eligible” for 5 years for “high need” states.</p> <p>Clarifies that states can offer Medicaid to those with income greater than 133% MAGI either outright or through a wrap. If those individuals are only getting a wrap, they are also eligible for subsidies in the exchange.</p> <p>Rescinds \$700 million in funds available in the Medicaid Improvement Fund.</p>		
<b>Quality improvement and value-based purchasing</b>	CMS to develop and/or implement	Secretary would establish	Includes process that

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	<p>value-based purchasing programs for hospitals, physicians, hospices, home health agencies, SNFs, and other facilities to pay bonuses or reductions for reporting &amp; improvement or attained quality, depending on the provider. Programs would use measures consistent with national goals and priorities developed in partnership with a range of public/private stakeholders.</p> <p>Explicit attention paid to hospital acquired conditions in which outliers would see payment reductions after 2014 and also avoidable hospital readmissions (the latter of which are already subject to selective non-payment.)</p>	<p>national QI improvement strategy and identify national priorities after consultation with consensus (NQF) body. Financial support for measure development and public reporting. Establishes center at AHRQ to conduct research to inform QI activities, with an explicit focus on patient safety, delivery improvement, greater efficiency.</p>	<p>recognizes consensus-based entity to identify national priorities, measure gaps, selection of measures for public reporting and public health..</p> <p>Funding provided.</p> <p>Quality provisions elsewhere in bill not necessarily linked to provisions in quality measurements section.</p> <p>Prioritize HAI, patient safety in surgical procedures; ERs, OB.</p> <p>Bureau of Health Information to report key health indicator.</p>
<p><b>Initiatives to reduce disparities</b></p>	<p>Establishes uniform categories for collecting data (by CMS) on race, ethnicity, gender and primary language. Also requires CMS to collect data on persons with disabilities.</p> <p>Requires federally-funded surveys to collect data on racial and ethnic</p>	<p>HHS Secretary initiatives around data collection and reporting. OMB standards to be used for race and ethnicity measures.</p> <p>CDC to award <i>Community Transformation Grants</i> to entities to promote evidence-based community preventive</p>	<p>HHS study on access to LEP services in Medicare. New authority to seek remedies against MA plans that fail to provide language access to enrolled beneficiaries.</p> <p>CMS demonstration project to test provider communication with LEP racial and ethnic</p>

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	<p>subgroups.</p> <p>Requires HHS to share disparities data with other federal agencies.</p> <p>Includes privacy protections for such data.</p>	<p>health activities aimed at reducing disparities and chronic disease.</p> <p>Contains provisions to increase diversity in health care workforce.</p>	<p>minorities.</p> <p>IOM study on the impact of language access services on the health and health care of LEP populations.</p>
<b>End of life initiatives</b>	Not included	Not included	Would allow Medicare providers to bill for end of life consultations. Calls for development of new measures for PQRI.
<b>Prevention and wellness initiatives</b>	<p>Exchange plans cannot charge cost sharing for prevention. Employers cannot charge cost sharing for prevention (unless they use value-based insurance design).</p> <p>Beginning in 2011, comprehensive health risk assessment (HRA) added to Medicare. Beneficiaries eligible for wellness visit annually w/out co-payment or deductible. No Medicare cost sharing (deductible and coinsurance) for covered preventive services. Secretary can modify (adding or deleting) coverage of existing</p>	<p>Insurers in individual and group markets must provide incentives through reimbursement for wellness and health promotion activities; for culturally and linguistically appropriate health care; to cover A and B-rated USPSTF-recommended preventive services, ACIP-recommended immunizations, and HRSA-recommended screenings for infants, children, and adolescents with no or minimal cost-sharing.</p> <p>Many charges to HHS to confer</p>	<p>Included preventive services in the essential benefits package. No cost sharing under the essential benefits package for prevention.</p> <p>In 2010, requires Medicaid to provide A and B-rated USPSTF-recommended screenings and ACIP-recommended immunizations. No enhanced match and no cost sharing for preventive services in Medicaid.</p> <p>In 2011, no Medicare cost</p>

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	<p>preventive services following USPSTF recommendations. \$100 million over 5 years for incentives to Medicare beneficiaries who successfully complete healthy lifestyle programs.</p> <p>Funding for provider education and patient awareness of covered preventive services. GAO study to identify barriers to use of covered preventive services.</p> <p>States must cover comprehensive tobacco cessation services for pregnant women under Medicaid without cost-sharing. New state option to provide Medicaid coverage for recommended preventive services and immunizations. FMAP enhanced for states that eliminate cost-sharing. Authorizes grants to states to conduct Healthy Lifestyles programs.</p> <p>New funding for childhood obesity demonstration project. Incentives</p>	<p>with expert groups and create interagency efforts to collect data and promote healthy policies at federal level, including workplace wellness initiatives.</p> <p>Grants to states to establish <i>Right Choices</i> programs for low income uninsured not in public health programs.</p> <p>Amends HIPAA to increase amount of premium discount for engaging in healthy behaviors.</p> <p>Establishes nutrition labeling for chain restaurants.</p>	<p>sharing (deductible and coinsurance) for covered preventive services. Waives deductible for colorectal cancer screening in 2011 regardless of screening outcome. Covers vaccines under Medicare Part B.</p> <p>Many charges to HHS to confer with expert groups and create interagency efforts to collect data and promote healthy policies at federal level, including workplace wellness initiatives.</p> <p>Establishes nutrition labeling for chain restaurants.</p>

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	<p>for people who participant in (as opposed to complete) wellness programs.</p> <p>\$200 million for 5-year grants to small business (&lt;100) for evidence-based workplace wellness programs.</p> <p>Codifies the HIPAA provisions related to employer-sponsored wellness programs.</p>		