



Health Reform Plans	Senate Finance ¹	House Tri-Committee Plan ²	Senate Health, Education, Labor, and Pensions ³
Title and Bill Number	The America's Health Future Act	America's Affordable Health Choices Act (H.R. 3200)	Affordable Health Choices Act (S. 1679)
National Health Exchange	<ul style="list-style-type: none"> Creates state-based web portals or health insurance exchanges (HIEs) that would direct consumers purchasing plans on the individual market to every health coverage option available in their zip code. Would offer standardized health insurance enrollment applications, a standard format companies would use to present their insurance plans, and standardized marketing materials. Would determine eligibility for health care affordability tax credits or public programs and would enable consumers without access to the Internet to enroll through the mail or in person in a variety of locations. 	<ul style="list-style-type: none"> New independent entity to facilitate the offering of health insurance choices to individuals and small employers. The Health Choices Commissioner would establish a process for bids, contracts, and oversight. The exchange would define coverage; set and enforce standards; facilitate enrollments, monitor complaints; and administer credits. States may opt to operate the exchange if they follow federal rules. Health Insurance Exchange Trust Fund to fund the Health Choices Administration 	<ul style="list-style-type: none"> Establish a new American Health Benefit Gateways Set up state-based offices Create a new national website for purchasing Provide a public choice option Secretary will determine the total funding for grants Facilitate the purchase of health insurance States may required additional benefits beyond the essential health benefits A Gateway may operate in more than one state Secretary shall develop standards for providing benefits explanation summary
State Insurance	<ul style="list-style-type: none"> Would maintain oversight authority 		

¹ Finance Committee Chairman's Mark released 09.16.09

² Ways and Means, Energy and Commerce, and Education and Labor Plan released 07.15.09

³ HELP Affordable Choices Act as approved on July 15, 2009

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Commissioners	<ul style="list-style-type: none"> The National Association of Insurance Commissioners (NAIC) would devised model regulations regarding health insurance rating, issuance and marketing requirements. This would be the new federal minimum standard. 		
Keep Coverage You Have	Yes	Yes	Yes
Affordability	<p>Health Care Affordability Tax Credits</p> <ul style="list-style-type: none"> Advanceable, refundable tax credit for low and middle-income individuals to subsidize the purchase of health insurance. Beginning in 2013, tax credits would be available on a sliding scale for individuals and families between 134-300% of FPL (Federal Poverty Level) to help offset the cost of private health insurance premiums. Beginning in 2014, the credits are also available to individuals and families between 100-133% of FPL. A cost-sharing subsidy would be provided to limit the amount of cost-sharing that individuals and families between 100-200% of FPL have to pay. Undocumented immigrants are prohibited from benefiting from the credit. 	<ul style="list-style-type: none"> Sliding scale affordability credits in the exchange for families up to 400% poverty The sliding scale starts at 1.5% of income for those at or below 133% FPL and phasing out at 11% for those at 400% The most recent tax return will serve as income data Cap on annual out-of-pocket spending <p>Small Business Tax Credits</p> <ul style="list-style-type: none"> Provides a tax credit equal to 50% of the amount paid by a small employer for health coverage Phased out in the cases of an employer with 10 to 25 employees and for employers with average wages of \$20,000 and \$40,000 per year 	<ul style="list-style-type: none"> Premium assistance Sliding scale premium assistance for individuals and families with income up to four times the federal poverty level

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	<p>Small Business Health Care Affordability Tax Credits</p> <ul style="list-style-type: none"> • A tax credit to small businesses that offer health insurance to their employees. • In 2011 and 2012, eligible employers can receive a small business credit for up to 35% of their contribution. • Once the exchanges are up and running in 2013, qualified small employers purchasing insurance through the exchanges can receive a tax credit for two years that covers up to 50% of the employer's contribution. Small businesses with 10 or fewer employees and with average taxable wages of \$20,000 or less will be able to claim the full credit amount. • The credit phases out for businesses with more than 10 employees and average taxable wages over \$20,000, with a complete phase out at 25 employees or average taxable wages of \$40,000. 		
Public Plan	<ul style="list-style-type: none"> • The bill does not have a public plan option • Includes Consumer Owned and Oriented Plan (CO-OP) <ul style="list-style-type: none"> ○ Creates authority for the 	<ul style="list-style-type: none"> • Public plan subject to the same market reforms and consumer protections as private plans starting in 2013 • Premiums would be 	<ul style="list-style-type: none"> • A public choice option would be included in the American Health Benefit Exchange • The Secretary would negotiate rates with providers

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	<p>formation of the CO-OP</p> <ul style="list-style-type: none"> ○ These plans can operate at the state, regional or national level to serve as non-profit, member-run health plans to compete in the reformed non-group and small group markets. ○ \$6 billion for seed money 	<p>geographically-adjusted and are required to fully cover the cost of coverage as well as administrative costs</p> <ul style="list-style-type: none"> • Provides \$2 billion to establish the public plan • Secretary shall establish provider rates which are built on Medicare rates with a 5% add on for Medicare providers • Providers would have the option to opt out 	<ul style="list-style-type: none"> •
Role of Public Programs	<p>Medicaid</p> <ul style="list-style-type: none"> • Would standardize Medicaid eligibility for all parents, children, pregnant women and childless adults at or below 133% FPL, or \$30,000 a year for a family of four (\$14,400 for an individual), beginning in 2014. • Individuals between 100% FPL and 133% FPL would be given the choice of enrolling in either Medicaid or in a private health insurance plan offered through a HIE. • The federal government would provide additional funding to states for services for newly eligible Medicaid beneficiaries. • Guarantee prescription drug benefits to all Medicaid beneficiaries. 	<p>Medicaid</p> <ul style="list-style-type: none"> • Expands Medicaid to individuals and families with incomes below 133 1/3% FPL • Expansion would be fully federally funded • Reduce Medicaid DSH by \$10B • Will increase federal funding to increase primary care reimbursement rates • Require Medicaid coverage of preventive services • Allow states to cover family planning services • Medical home pilot • Tobacco cessation • Optional coverage of nurse home visitation • Optional coverage for free-standing birth centers 	

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	<p>CHIP</p> <ul style="list-style-type: none"> • After September 30, 2013, states would be required to provide children between Medicaid eligibility levels and at least 250% FPL with wraparound coverage to supplement the core benefit package available through the HIE. • These additional services would be the early and periodic screening, diagnosis and treatment (EPSDT) services available to children in Medicaid. • Current CHIP cost-sharing protections would continue to apply. 	<p>CHIP</p> <ul style="list-style-type: none"> • CHIP maintenance of effort requirement 	
<p>Standard Benefits Package</p>	<ul style="list-style-type: none"> • Creates four benefit categories for the reformed health insurance market: <ul style="list-style-type: none"> ○ Bronze: actuarial value of 65% with an out-of-pocket limit the HSA current law limit ○ Silver: actuarial value of 70% ○ Gold: actuarial value of 85% ○ Platinum: actuarial value of 90% • No policies (except grandfathered policies) would be issued in the individual or small-employer market that do not comply with one of the four categories. • All insurers would have to offer 	<ul style="list-style-type: none"> • Essential Benefits Package • Health Benefits Advisory Committee, a public-private committee with providers and health care experts, chaired by the Surgeon General would recommend a benefits package based on standards set in law • The package would be the minimal quality standard for employer plans • Package will include hospitalization, outpatient hospital and outpatient clinic services, physician services, equipment and supplies, prescription drugs, rehabilitative 	<ul style="list-style-type: none"> • Essential health care benefits will be determined by the Secretary and include: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse services, prescription drugs, rehabilitative and habilitative care services and devices, laboratory services, preventive and wellness services, and pediatric services, including oral and vision care • Creates a National Independent Commission on Essential Health

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	<p>coverage in the silver and gold categories.</p> <ul style="list-style-type: none"> • All plans would be required to provide primary care and first-dollar coverage for preventive services, emergency services, medical and surgical care, physician services, hospitalization, outpatient services, day surgery and related anesthesia, diagnostic imaging and screenings, including x-rays, maternity and newborn care, pediatric services (including dental and vision care), prescription drugs, radiation and chemotherapy, and mental health and substance abuse services. • Plans would not be allowed to set lifetime limits on coverage or annual limits on any benefits. Plans would have out-of-pocket limits at least equal to the limits for Health Savings Accounts (HSAs), which will be \$5,950 for an individual and \$11,900 for a family in 2010. 	<p>and habilitative services, preventive services, mental health services, maternity benefits, dental and vision for children, and caps the amount of money a person or family can spending in a year</p> <ul style="list-style-type: none"> • Actuarially equivalent to 70% of the package if there is no cost-sharing imposed 	<p>Care Benefits</p> <ul style="list-style-type: none"> • Secretary will award grants to private and public entities to serve as navigators to conduct public education and raise awareness of the program, distribute information on plans, and facilitate enrollment
Market Reforms	<p>Individual Market Reforms</p> <ul style="list-style-type: none"> • Require insurance companies to issue coverage to all individuals regardless of health status; insurers would no longer be allowed to limit coverage based on pre-existing conditions. • Rating based on: 	<ul style="list-style-type: none"> • Guaranteed issue and renewal • Prohibits the use of rescissions except in instances of fraud • No medical underwriting or pre-existing conditions requirements • Rating based on: <ul style="list-style-type: none"> ○ Age (no more than 2:1) ○ Geography 	<ul style="list-style-type: none"> • Guaranteed issue and renewal in the individual and group market • No medical underwriting or pre-existing conditions requirements • Fair premiums based on family structure; community rating

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	<ul style="list-style-type: none"> ○ Tobacco use – 1.5:1 ○ Age – 5:1 ○ Family composition: <ul style="list-style-type: none"> ▪ Single – 1:1 ▪ Adult with child – 1.8:1 ▪ Two adults – 2:1 ▪ Family – 3:1 • Limited variation in premium rates would be permitted for tobacco use, age, and family composition. • Variation in rating would be allowed between geographic areas, but would not differ within a geographic area. <p>Small Group Market Reforms</p> <ul style="list-style-type: none"> • Rating rules for the individual market would also apply to the small group market, as defined by states. • This would include groups of one to 50 employees, but could include companies with up to 100 employees, depending on current state law. <p>Small Group Purchasing Through SHOP Exchanges</p> <ul style="list-style-type: none"> • Small businesses would have access to state-based Small Business Health Options Program (SHOP) exchanges. • These exchanges would be web 	<ul style="list-style-type: none"> ○ Family size • Must have adequate provider networks • Plans must meet a medical loss ratio as defined by the Health Choices Commissioner • Transparency and plan disclosure • Timely internal grievance and appeals mechanisms and external review by independent board 	<p>area; the actuarial value of the benefit; age (no more than 2:1); tobacco use (no more than 1.5:1); adherence or participation in health promotion or prevention program</p> <ul style="list-style-type: none"> • Ensure value in health insurance purchasing • Public reporting of the percentage of total premium revenue on benefits and fees • Provide incentives for healthy behaviors • Coverage of preventive women’s health services • Extension of dependent coverage • No lifetime or annual limits

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	portals that make comparing and purchasing health care coverage easier for small businesses.		
Administrative Simplification	<ul style="list-style-type: none"> • Establish a timeline for accelerating the development, adoption and implementation of a set of operating rules for each HIPAA transaction for which there is an existing standard. • Add the electronic funds transfer (EFT) of health claims payments as a HIPAA transaction and provide for the adoption and enforcement of a standard for EFT. • Require the Secretary to first adopt a single set of operating rules for eligibility verification, claims status, claims remittance/payment, and EFT. • Require the Secretary of HHS to adopt operating rules for eligibility and health plan claims status transactions no later than July 1, 2011, to be effective by January 1, 2013. • Adopt operating rules for EFT and claims remittance/payment no later than July 1, 2012, to be effective by January 1, 2014. • Health plans would be required to comply with any updated standards or operating. 	<ul style="list-style-type: none"> • Establish standardized language and forms • Establish operating rules and companion guides • Increase consistency of claims edits and code corrections 	Secretary shall develop interoperable and secure standards and protocols that facilitate enrollment in programs
Health Choices		<ul style="list-style-type: none"> • Establishes a Health Choices 	

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Administration		<p>Administration to be headed by a Health Choices Commissioner</p> <ul style="list-style-type: none"> • Responsible for carrying out: <ul style="list-style-type: none"> ○ Qualified plan standards ○ HIE ○ Individual affordability credits ○ A study and report describing the differences between insured and self-insured plans ○ Providing recommendations to ensure that the law does not create incentives for small and mid-size businesses to self insure or create adverse selection in the risk pools of insured plans ○ Define marketing standards that qualified plans are required to meet • Includes a Health Insurance Ombudsman 	
Individual Mandate	<p>Yes</p> <ul style="list-style-type: none"> • Creates a personal responsibility requirement for health care coverage, with exceptions provided 	<p>Yes</p> <ul style="list-style-type: none"> • Economic hardship exemption • Penalty based on 2.5% of adjusted gross income above a 	<p>Yes</p>

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	<p>for a variety of reasons including religious conscience and an exemption for undocumented workers.</p> <ul style="list-style-type: none"> Individuals who fail to meet the requirement are subject to a penalty. 	<p>specific level for those who do not obtain coverage</p>	
Employer Mandate	<ul style="list-style-type: none"> Would not require employers to offer health insurance. Effective January 1, 2013, all employers with more than 50 employees who do not offer coverage will have to reimburse the government for each full-time employee receiving a health care affordability tax credit in the exchange equal to 100% of the average exchange subsidy up to a cap of \$400 per total number of employees whether they are receiving a tax credit or not. If an employee is offered employer-provided health insurance coverage, the individual would be ineligible for a health care affordability tax credit for health insurance purchased through a state exchange. An employee who is offered coverage that does not have an actuarial value of at least 65% or who is offered unaffordable 	<ul style="list-style-type: none"> Employers have the option to provide health insurance for their workers or contribute funds on their behalf The fee is based on 8% of the payroll Employers that offer coverage must meet minimum benefit and contribution requirements Small business exemption for those employers with an annual payroll that does not exceed \$250,000. Phases in the 8% payroll tax for those with annual payroll up to \$400,000 	<p>Yes</p> <ul style="list-style-type: none"> For employers that do not provide coverage face an annual \$750 fine per employee after the 25th employee The fine for part time employees is \$375 Adjusted for inflation

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	<p>coverage by their employer, however, can be eligible for the tax credit.</p> <ul style="list-style-type: none"> • Unaffordable is defined as percent of the employee's income. • A Medicaid-eligible individual can always choose to leave the employer's coverage and enroll in Medicaid. In this circumstance, the employer is not required to pay a fee. 		
SNF Payments and provisions	<ul style="list-style-type: none"> • Update the market basket to include adjustments productivity • Medicare Skilled Nursing Facility Value-Based Purchasing (VBP): Direct the Secretary to submit a plan to Congress by 2011 related to home health providers and 2012 related to SNFs outlining how to effectively move these providers into a VBP payment system. • Require disclosure of ownership • Require SNFs and nursing homes to develop and implement compliance and ethics programs to be followed by their employees and agents • Additional information on Nursing Home Compare • Require the reporting of expenditures on wage and benefits • Standardized complaint form 	<ul style="list-style-type: none"> • FY 2010 rates at FY 2009 levels • Productivity adjustment • Case mix adjustment • Revises payment for nontherapy ancillary services and therapy services • Require the disclosure of ownership • Compliance and ethics programs • Quality assurance and performance improvement program • Include more information on Nursing Home Compare • Reporting of direct care expenditures • Standardized complaint form • Ensure staffing accountability • National Independent Monitor Pilot Program 	

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	<ul style="list-style-type: none"> • National Independent Monitor Pilot Program • Regular reporting of staff data • Notification of facility closure • Demos on culture change and IT 		
IRF Payments and provisions	<ul style="list-style-type: none"> • Reduce the market basket update, including adjustments to reflect gains in productivity <ul style="list-style-type: none"> ○ Market basket minus 0.25% reduction in 2010 and 2011 ○ 0.2% market basket reduction from 2012-2019 in addition to the productivity adjustments • Establish quality reporting programs 	<ul style="list-style-type: none"> • Market basket frozen for FY 2010 • Productivity adjustment 	
Inpatient Hospital Payments	<ul style="list-style-type: none"> • Reduce the market basket update, including adjustments to reflect gains in productivity <ul style="list-style-type: none"> ○ Market basket minus 0.25% reduction in 2010 and 2011 ○ 0.2% market basket reduction from 2012-2019 in addition to the productivity adjustments • Require the Secretary to implement quality measure reporting programs • Providers who do not successfully participate in the program would be subject to a reduction in their annual market basket update 	<ul style="list-style-type: none"> • Productivity adjustment • Adjustment to hospital payments for excess readmissions • Provides assistance for transitional care activities 	
Post-Acute Care	National Pilot Program on Payment	<ul style="list-style-type: none"> • Directs Secretary to submit to 	

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Payment Reform	Bundling <ul style="list-style-type: none"> • Would direct the Secretary to develop a voluntary pilot program encouraging hospitals, doctors and post-acute care providers to achieve savings for the Medicare program through increased collaboration and improved coordination of patient care by allowing the providers to share in such savings. • Medicaid bundled payment demo 	Congress a detailed plan on how to implement post-acute bundled payments <ul style="list-style-type: none"> • Converts the Acute Care Episode demonstration project to a pilot program and expand the program 	
DSH Payments	<ul style="list-style-type: none"> • Require the Secretary to update hospital payments to better account for hospitals' uncompensated care costs. • Starting in 2015, hospitals' Medicare DSH payments would be reduced to reflect lower uncompensated care costs relative to increases in the number of insured. 	<ul style="list-style-type: none"> • Medicare DSH Report • Payment adjustments in response to coverage expansion 	
Ambulatory Surgical Centers	<ul style="list-style-type: none"> • Reduce the market basket update, including adjustments to reflect gains in productivity <ul style="list-style-type: none"> ○ Market basket minus 0.25% reduction in 2010 and 2011 ○ 0.2% market basket reduction from 2012-2019 in addition to the productivity adjustments 	Required to submit cost data and other data	
Outpatient Hospital Payment	<ul style="list-style-type: none"> • Reduce the market basket update, including adjustments to reflect gains in productivity 	<ul style="list-style-type: none"> • Productivity adjustment 	

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	<ul style="list-style-type: none"> ○ Market basket minus 0.25% reduction in 2010 and 2011 ○ 0.2% market basket reduction from 2012-2019 in addition to the productivity adjustments 		
Physician Payments	<p>SGR</p> <ul style="list-style-type: none"> • The annual update to the conversion factor used in the determination of the Medicare fee schedule would be a 0.5% increase in 2010. The conversion factor for 2011 and subsequent years would be computed as if the increase in 2010 had never applied. <p>Misvalued RVSS</p> <ul style="list-style-type: none"> • The Secretary would be required to periodically identify physician services as being potentially misvalued, and make appropriate adjustments to the relative values of such services under the Medicare physician fee schedule. <p>Primary Care Bonus</p> <ul style="list-style-type: none"> • Establish a new 10% bonus on select E&M codes under the Medicare fee schedule for five years, beginning January 1, 2011. <p>Physician Value-Based Purchasing</p>	<ul style="list-style-type: none"> • SGR reform • 2010 update is percentage increase in MEI • Accountable Care Organization Pilot Program • Reevaluate codes and RVUs • Modifications to PQRI • Physician payment sunshine provisions 	

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	<ul style="list-style-type: none"> • Would strengthen and expand the Physician Quality Reporting Initiative program, including requiring all eligible health professionals to participate by 2011. • It would also improve the Medicare physician feedback program and penalize physicians who utilize significantly more resources than their peers. <p>Physician Payment Sunshine</p> <ul style="list-style-type: none"> • Covers drug, device, biological, or medical supplier that makes a payment to a physician, practice, or hospital with a residency training program 		
LTCH Payments and Provisions	<ul style="list-style-type: none"> • Reduce the market basket update, including adjustments to reflect gains in productivity <ul style="list-style-type: none"> ○ Market basket minus 0.25% reduction in 2010 and 2011 ○ 0.2% market basket reduction from 2012-2019 in addition to the productivity adjustments • Extend the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA, P.L. 110-173), Section 114(c) and (d) by two years. • Require the Secretary to implement quality measure reporting programs 	<ul style="list-style-type: none"> • Productivity adjustment 	

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	<ul style="list-style-type: none"> Providers who do not successfully participate in the program would be subject to a reduction in their annual market basket update Establish quality reporting programs 		
Dialysis Payments and provisions		<ul style="list-style-type: none"> Incorporate a productivity adjustment Extends coverage of immunosuppressive drugs for kidney transplant Apply quality measures Provide OIG access to ownership or compensation agreements between renal dialysis facilities and physicians 	
Medicare Graduate Medical Education (GME)	<ul style="list-style-type: none"> Increase GME training positions through a slot re-distribution program for currently unused training slots and priority would be given to increasing training in primary care and general surgery. The proposal would also encourage additional training in outpatient settings and ensure communities retain vital training slots if a hospital closes. 	<ul style="list-style-type: none"> Distribution of unused residency positions Increase training in non-provider settings Preserve resident cap positions from closed hospitals Increase accountability for approved medical residency training 	
Community Health Centers		Authorizes an additional \$38 billion for use over the next ten years (FY 2010 – FY 2019)	<ul style="list-style-type: none"> Extends programs- will need no further authorization Increases funding
Workforce Issues	<ul style="list-style-type: none"> Would establish a Workforce Advisory Committee made up of 	<ul style="list-style-type: none"> Public health investment fund Increases to the National Health 	<ul style="list-style-type: none"> Expand federal health care workforce development

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	<p>external stakeholders tasked with working with HHS and other relevant federal agencies to develop and implement a national workforce strategy.</p> <ul style="list-style-type: none"> • Establishes competitive demonstration grant programs designed to help low-income individuals obtain the education and training needed for well-paying, high-demand health care jobs. • Includes demonstration grants for up to six states to develop training and certification programs for personal and home care aides. 	<p>Services Corp loan repayment benefits</p> <ul style="list-style-type: none"> • Expand the primary care, nursing and public health workforces • Increase funding for scholarships and loan forgiveness to promote primary care and nursing care • Center for workforce analysis 	<ul style="list-style-type: none"> • Create a National Health Care Workforce Commission • Establish state health care workforce development grants • Federally supported student loan funds • Increase nurse faculty • Demo to integrate quality improvement and patient safety training in clinical education of health professionals
Health IT Training			<ul style="list-style-type: none"> • Creates safe harbors to anti-kickback civil and criminal penalties for HIT and training services
Prevention and Wellness	<ul style="list-style-type: none"> • Provides Medicare beneficiaries with a free visit to their primary care provider every year to create and update a personalized prevention plan to address health risks and chronic health problems and to design a schedule for regular recommended preventive screenings. • Eliminates out-of-pocket costs for recommended preventive services for Medicare beneficiaries. • Encourages states to cover 	<ul style="list-style-type: none"> • Prevention and Wellness Trust • Requires the Secretary to submit a national strategy designed to improve the nation's health through evidence-based clinical and community-based prevention and wellness activities within one year of enactment and at least every two years thereafter • Prevention Task Force • Strengthen State Departments of Health 	<ul style="list-style-type: none"> • Reimburse for essential preventive services • Remove barriers to preventive services • Promote community wellness and strengthen our public health system • Change medical school and residency curricula • Promote the benefits of wellness and prevention • Encourage workplace wellness programs

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	<p>preventive services recommended by the U.S. Preventive Services Task Force (USPSTF) and immunizations recommended by the Advisory Committee on Immunizations (ACIP) to adults enrolled in Medicaid.</p> <ul style="list-style-type: none"> • States that opt to cover recommended services and immunizations without cost-sharing would receive a one percent increase in the federal share of the FMAP reimbursement rate for those services. • All states would be required to provide comprehensive tobacco cessation services to pregnant women enrolled in Medicaid. • Creates a new state option and rewards states for providing chronically ill individuals enrolled in Medicaid with a health home. • Participating enrollees will receive comprehensive care coordination and management, transitional care and, if relevant, referral to community-based programs and social services. • Establishes an initiative that will reward Medicare and Medicaid participants for healthier choices. • Funding will be available to provide participants with incentives for 	<ul style="list-style-type: none"> • Data collection improvements (HIT) • Prevention and Wellness research • Implementation of best practices 	<ul style="list-style-type: none"> • Create a National Prevention, Health Promotion and Public Health Council with members appointed by the President • Establish a prevention and public health fund • Create an independent Prevention Services Task Force • CDC Director shall convene an Independent Community Preventive Services Task Force • Education and outreach campaign on preventive benefits • Secretary shall award grants to States to establish Right Choices Programs through Medicaid provide preventive services • Establishes community transformation grants to implement evidence-based community preventive health activities

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	<p>completing evidence-based, healthy lifestyle programs and improving their health status.</p> <ul style="list-style-type: none"> • Programs will focus on lowering certain risk factors linked to chronic disease such as blood pressure, cholesterol and obesity. 		
Payment Reforms	<p>Hospital Value-Based Purchasing (VBP)</p> <ul style="list-style-type: none"> • Establish a VBP program for hospitals starting in 2012. • A percentage of hospital payment would be tied to hospital performance on quality measures related to common and high-cost conditions, such as cardiac, surgical and pneumonia care. • Quality measures included in the program will be developed and chosen in cooperation with external stakeholders. <p>Physician Value-Based Purchasing</p> <ul style="list-style-type: none"> • Would strengthen and expand the Physician Quality Reporting Initiative (PQRI) program, including requiring all eligible health professionals to participate by 2011. • It would also improve the Medicare physician feedback program and penalize physicians who utilize significantly more resources than their peers. 	<ul style="list-style-type: none"> • Post acute payment reform 	<ul style="list-style-type: none"> • Reduce administrative costs through computerization of routine transactions • Streamline health plan enrollment and documentation • Promote evidence-based medicine • Promote patient-centered health information

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	<p>Medicare Home Health Agency and Skilled Nursing Facility VBP</p> <ul style="list-style-type: none"> • Directs the Secretary to submit a plan to Congress by 2011 related to home health providers and 2012 related to SNFs outlining how to effectively move these providers into a VBP payment system. <p>Quality Reporting for Other Providers</p> <ul style="list-style-type: none"> • Require the Secretary to implement quality measure reporting programs for long-term care hospitals, inpatient rehabilitation facilities, PPS-exempt cancer hospitals and hospice providers • Providers who do not successfully participate in the program would be subject to a reduction in their annual market basket update. 		
Physician Owned Hospitals	<ul style="list-style-type: none"> • Only hospitals meeting certain requirements would be exempt from the prohibition on self-referral • Agreement prior to November 1, 2009 • Submit annual reports with ownership • Patient disclosure • Could not increase capacity 	<ul style="list-style-type: none"> • Prohibits physician ownership in hospitals that are new as of Jan. 1, 2009 • Allows for growth of existing physician-owned hospitals within certain parameters 	
Geographic inequities adjustment factors		<ul style="list-style-type: none"> • IOM will report to CMS on the validity and effects of the 	

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under Medicare		geographic adjusters and recommend improvements <ul style="list-style-type: none"> • CMS is instructed to address geographic inequities 	
Medicare Part D Reforms	<ul style="list-style-type: none"> • Medicare beneficiaries who enroll in the Medicare Part D prescription drug program will receive significant help purchasing prescription drugs when they hit the coverage gap portion • Instead of paying 100% of their drug costs in the gap, Part D beneficiaries with low to moderate incomes will receive a 50% discount on the price of brand-name drugs covered by their plan. • Reduces the premium subsidy under Part D for beneficiaries with incomes at or above the Part B income thresholds. • Simplification of election periods 	<ul style="list-style-type: none"> • Requires manufacturers to provide drug rebates for certain full premium subsidy eligible individuals • Phases-in elimination of the coverage gap by 2023 • Incorporates voluntary PhRMA agreement to provide discounts of 50% for brand-name drugs in the coverage gap • Permits mid-year changes in enrollment for formulary changes 	
Medicare Rural Access Protections	<ul style="list-style-type: none"> • Extends the Rural Hospital Flexibility (FLEX) Grant program through 2012, and will add a new component that Flex grant funding to be used to support rural hospitals' efforts to implement delivery system reform programs. • Extend Hospital Outpatient Department Hold Harmless for Small Rural Hospitals by ensuring that small rural hospitals receive 85% of 	<ul style="list-style-type: none"> • Telehealth expansion • Extension of geographic floor for work 	

Health Reform Plans	Senate Finance ¹	House Tri-Committee Plan ²	Senate Health, Education, Labor, and Pensions ³
	<p>the payment difference in 2010 and 2011.</p> <ul style="list-style-type: none"> • Reinstates reasonable cost reimbursement, thus improving access to laboratory services for those in rural communities. • Extends the Extend Rural Community Hospital Demonstration Program for two years and expands eligible sites to additional rural states. • Extends the Medicare Dependent Hospital Program for an additional two years. • Temporarily increase payment for certain low-volume hospitals, ensuring that rural hospitals are adequately reimbursed for serving their communities. • Expands the Community Health Integration Models in Certain Rural Counties demonstration project to more eligible counties, and will also allow physicians to participate in the demonstration project. 		
Low-Income Beneficiary Provisions	<ul style="list-style-type: none"> • Extend MIPPA Section 119 and provide \$45 million for outreach and education activities related to Medicare low-income assistance programs, including the Part D low-income subsidy (LIS) program and the Medicare Savings Program (MSP) • Establish a new office in CMS, the 	<ul style="list-style-type: none"> • Improves assets test for Medicare Savings Program and LIS program • Eliminates Part D cost-sharing for certain non-institutionalized full benefit dual eligibles • Reduces barriers to enrollment • Intelligent assignment in 	

Health Reform Plans	Senate Finance ¹	House Tri-Committee Plan ²	Senate Health, Education, Labor, and Pensions ³
	Office of Coordination of Dual Eligible Beneficiaries	enrollment	
Therapy Caps	Extend the exceptions process for therapy caps through December 31, 2011.	Extends therapy cap exception through December 31, 2011	
Therapeutic Classes of Part D Drugs	<ul style="list-style-type: none"> • Remove the criteria, specified in Section 176 of MIPPA, that would have been used by the Secretary to identify protected classes of drugs. • Authorize the Secretary to identify classes of clinical concern as defined by the Secretary. • Codify the current six classes of clinical concern as they are currently specified through sub-regulatory guidance until the Secretary issues a rule regarding classes of clinical concern to be protected on plan formularies. 		
Improving Coordination and Collaboration	<p>Payment for Accountable Care</p> <ul style="list-style-type: none"> • Allow for Accountable Care Organizations, high-quality providers that coordinate care across a range of health care settings to share in savings they achieve to the Medicare program. <p>CMS Innovation Center</p> <ul style="list-style-type: none"> • Would establish an Innovation Center at CMS that would have the authority to test new patient-centered payment models 	<ul style="list-style-type: none"> • Rewards for efficient providers <ul style="list-style-type: none"> ○ Accountable care organization pilot ○ Payment bundling ○ Medical home pilot • Increase primary care payments by 5% • Increase rates for certified nurse-midwives • Waive Medicare cost-sharing for preventive services 	<ul style="list-style-type: none"> • Chronic disease management • Grants to establish community health teams to support patient-centered medical homes • Grants to implement medication management services in treatment of chronic diseases • Establish a program to facilitate shared decision making

Health Reform Plans	Senate Finance ¹	House Tri-Committee Plan ²	Senate Health, Education, Labor, and Pensions ³
	<p>that encourage evidence-based, coordinated care.</p> <ul style="list-style-type: none"> • Payment reforms that are shown to improve quality and reduce costs could be expanded throughout the Medicare program. 		
Reducing Medical Errors and HAI	<ul style="list-style-type: none"> • Directs CMS to track national and hospital-specific data on the readmission rates of Medicare participating hospitals for certain high-cost conditions that have high rates of potentially avoidable hospital readmissions. • Starting in 2012, hospitals with readmission rates above a certain threshold would have payments for the original hospitalization reduced by 20% if a patient with a selected condition is rehospitalized with a preventable readmission within seven days or by 10% if a patient with a selected condition is re-hospitalized with a preventable readmission within 15 days. • Prohibit Medicaid payments for HAI 	Requires hospitals and ASCs to report public health information on healthcare-associated infections to the Centers for Disease Control and Prevention.	<ul style="list-style-type: none"> • Reduce preventable hospital readmissions • Establish procedures for hospital disclosure • Quality improvement program for hospitals with high severity adjusted readmission rate • GAO and IOM Reports on readmissions • Establish a Patient Safety and Clinical Delivery Institute within AHRQ • Create grants to identify and disseminate best practices
Quality Infrastructure	<ul style="list-style-type: none"> • Additional resources would be provided to HHS to strengthen the quality measure development processes for purposes of improving quality, informing patients and 	<p>Quality Measures</p> <ul style="list-style-type: none"> • Establish national priorities and performance measures for quality improvement • Develop patient-centered and 	<ul style="list-style-type: none"> • Establish a national strategy and priorities to improve the delivery of health care • President shall convene an interagency working group on

Health Reform Plans	Senate Finance ¹	House Tri-Committee Plan ²	Senate Health, Education, Labor, and Pensions ³
	<p>purchasers, and updating payments under federal health programs.</p> <ul style="list-style-type: none"> • Directs the Secretary to develop a national quality strategy; establish an interagency working group on health care quality; provide additional resources for quality measure development and endorsement; and establish a process for HHS to work with external stakeholders. • Provides patients with information about physician-industry relationships, close loopholes in physician self-referral laws that allow conflicts of interest, and provide patients and families with more information about nursing home facilities and hospital charges to help them make better decisions. • Requires drug manufacturers and distributors to report information they already collect regarding the number and type of drug samples given to physicians. • Requires the nation's hospitals to make their average charge information for commercial payers and self-pay patients available to the public • Develop quality measures for Medicaid 	<p>population-based measures</p> <ul style="list-style-type: none"> • GAO evaluation of data collection process for quality measurement • Multi-stakeholder pre-rulemaking input into selection of quality measures • Application of quality measures 	<p>health care quality</p> <ul style="list-style-type: none"> • Grants for quality measurement development • Secretary shall develop a process for disseminating measures and implement a reporting system • GAO shall evaluate data collection process • Establish a pilot program to develop, validate, and improve methods used to support the quality measurement and reporting strategy • Health care delivery system research • Grants to trauma care centers • Standardized format for prescription drug benefit and risk information • Establish an Office of Women's Health in the Office of the Secretary at HHS and the CDC • Data collection on race, gender, geographic location

Health Reform Plans	Senate Finance ¹	House Tri-Committee Plan ²	Senate Health, Education, Labor, and Pensions ³
	<ul style="list-style-type: none"> • Create a CMS Innovation Center 		
Employer-Sponsored Wellness Programs			<ul style="list-style-type: none"> • A group health plan may offer incentives to individual who voluntarily participates in wellness programs • Technical assistance for these programs • National worksite health policies and programs study
Medicare Advantage Reforms and Part D	<ul style="list-style-type: none"> • Transitions current MA payments which are based on statutory benchmarks to payments based on competitive bids from the insurers. • Eliminates overpayments to MA plans and addresses the inequitable distribution of rebates paid to plans by making any extra payment contingent on plan performance. • Plans would be eligible for bonus payments based on their performance on quality measures and the operation of evidence-based care management programs. • Plans that provide care at lower costs than traditional Medicare would also be eligible for an efficiency bonus. • Rebates and bonuses paid to MA plans would need to be used to provide additional benefits that are not covered under Medicare. • Preserve plans' ability to offer 	<ul style="list-style-type: none"> • Phase-in of payment based on fee-for-service cost over 3 years • Quality-based payment adjustment • Improve risk adjustment system • Simplification of annual beneficiary election periods • Eliminate MA regional plan stabilization fund • Enrollment reforms 	

Health Reform Plans	Senate Finance ¹	House Tri-Committee Plan ²	Senate Health, Education, Labor, and Pensions ³
	<p>benefit packages that differ from or supplement traditional Medicare.</p> <ul style="list-style-type: none"> • Add important protections and transparency for beneficiaries by limiting cost sharing for certain services, like chemotherapy and skilled nursing care, and by creating more consistency in the extra benefits. 		
Special Needs Plans	<ul style="list-style-type: none"> • Extend SNP authority through December 31, 2013. • By January 1, 2013, SNPs would need to have beneficiaries enrolled in their plans that meet the definitions for each type of SNP. • Require all dual-eligible SNPs to have established contracts with state Medicaid programs by January 1, 2013, in order to operate and serve dual-eligible beneficiaries. • Give the Secretary discretion to require SNPs to be certified or otherwise approved by NCQA in order to participate in the Medicare Advantage program. • Beginning in 2011, the Secretary would use a risk score for new enrollees in SNPs that reflects the known underlying risk profile and chronic health status of each enrollee • Secretary would evaluate and revise 	<ul style="list-style-type: none"> • Limit SNP enrollment to open enrollment period • Extends SNPs through 2012 and certain fully integrated dual eligible SNPs through 2015 	

Health Reform Plans	Senate Finance ¹	House Tri-Committee Plan ²	Senate Health, Education, Labor, and Pensions ³
	<p>the methodology used to risk adjust MA plan payments in order to as accurately as possible account for higher medical and care coordination costs associated with frailty, persons with multiple, co-morbid chronic conditions, enrollees with a mental illness diagnosis and also to account for costs that may be associated with higher concentrations of beneficiaries with these conditions.</p>		
Public Program Integrity	<ul style="list-style-type: none"> • Require the Secretary to conduct provider screening • Impose new disclosure requirements on providers and suppliers enrolling in Medicare • Require CMS to complete development of the comprehensive Integrated Data Repository (IDR). • Consolidate and Expand Existing Provider Databases • Provider compliance and penalties • Would expand the Recovery Audit Contractor Program to Medicare Parts C and D and Medicaid • Program integrity funding and reporting requirements • Expand the number of areas in DME competitive bidding 		

Health Reform Plans	Senate Finance ¹	House Tri-Committee Plan ²	Senate Health, Education, Labor, and Pensions ³
Long-Term Care Services and Supports	<ul style="list-style-type: none"> • Would allow a cafeteria plan to offer as a qualified benefit contributions to a qualified long-term care insurance contract to the extent the amount of such contributions does not exceed the eligible long-term care premiums for such contract. • Reimbursement for employee-paid premiums for a qualified long-term care insurance contract through a FSA is similarly excludible from gross income. 		<ul style="list-style-type: none"> • Includes CLASS Act provisions • Create a new financing alternative for long-term services and supports • Promote individual choice and independence through self-determination • Ensure fiscally responsible and affordable premiums • Reduce dependence on Medicaid for long-term care • Retain the role of private insurance for long-term care
Health Disparities	Requires federal health programs to collect uniform data on race, ethnicity, gender and disability to help program administrators and researchers work to end disparities among these groups.	<ul style="list-style-type: none"> • Require HHS to study use of language services • Promote access to services for those with limited English proficiency • IOM Report on impact of language services 	<ul style="list-style-type: none"> • Account for subpopulations when developing quality measures • Expand scholarship and loan repayment programs to minorities • Improve shared decision-making
Reducing Fraud and Abuse	Combat fraud, waste, and abuse by requiring the review of health care providers prior to granting billing privileges, leveraging technology to better evaluate claims, educating providers to promote compliance with program requirements, monitoring programs more vigilantly, and penalizing fraudulent activity swiftly and sufficiently.	<ul style="list-style-type: none"> • Increase funding for Health Care Fraud and Abuse Control Account (\$100 million annually) • Increases penalties for false statements on provider or supplier enrollment applications • Increases penalties for false Medicare, Medicaid, or CHIP data • Increases penalties for delaying inspector general investigations 	<ul style="list-style-type: none"> • Secretary shall appoint a Senior Advisory on Health Care Fraud, a senior level positions at HHS and DOJ to coordinate anti-fraud activities • Establish at Fraud, Waste, and Abuse Commission • Establish a Health Care Program Integrity Coordinating Council • Address unauthorized and

Health Reform Plans	Senate Finance ¹	House Tri-Committee Plan ²	Senate Health, Education, Labor, and Pensions ³
		<ul style="list-style-type: none"> • Increases penalties for MA and Part marketing violations • Require providers and suppliers to adopt programs to reduce waste, fraud, and abuse • Require physicians to provide documentation on referrals to programs at high risk of waste and abuse • Require repayments of Medicare and Medicaid overpayments • OIG Access to certain information on renal dialysis facilities 	<p>sham health insurance plans</p> <ul style="list-style-type: none"> • Develop a model of uniform report form on fraud and abuse
Repeal Trigger		Repeal MMA Trigger	
Follow on biologics			<ul style="list-style-type: none"> • Includes language from the 2007 HELP committee follow-on biologic compromise
340 B Program		Extends the section 340B discounts for certain rural and other hospitals to inpatient as well as outpatient drugs.	<ul style="list-style-type: none"> • Extends 340 B pricing to inpatient drugs • Improve program integrity • GAO study to make recommendations on improvements
Comparative Effectiveness Research (CER)	<p>Patient-Centered Outcomes Research</p> <ul style="list-style-type: none"> • Creates a non-profit institute to set a research agenda and provide for the conduct of CER, per the Patient-Centered Outcomes Research Act of 2009. • The institute would be governed by a 	<ul style="list-style-type: none"> • Establish a CER center in AHRQ to conduct, support, and synthesize research with respect to outcomes, effectiveness, and appropriateness of health care services and procedures • Creates an independent CER 	<ul style="list-style-type: none"> • Create the Center for Health Outcomes Research and Evaluation to coordinate, conduct, support, and synthesize research relevant to comparative health outcomes • Creates an Advisory

Health Reform Plans	Senate Finance ¹	House Tri-Committee Plan ²	Senate Health, Education, Labor, and Pensions ³
	<p>multi-stakeholder board that is appointed by the Comptroller General.</p> <ul style="list-style-type: none"> • Institute would be funded with \$600 million per year which would come from multiple sources including mandatory appropriations, the Medicare trust funds, and a fee on health plans. • Includes patient safeguards and provisions to prohibit the Secretary from using the research to ration care through any federal program. 	<p>commission, Comparative Effectiveness Research Commission, to determine research priorities</p> <ul style="list-style-type: none"> • Dissemination of information • CER Trust Fund with contributions from Medicare and private health insurance plans 	<p>Commission for the Center</p> <ul style="list-style-type: none"> • May appoint expert advisory panels • Allow for stakeholder input
Vaccines	<p>Require a GAO study and report to Congress on the impact of the coverage of adult immunizations under Part D on access to those immunizations by Medicare beneficiaries.</p>	<ul style="list-style-type: none"> • Transfers coverage from Medicare Part D to Medicare Part B for all Medicare-covered vaccines. • Vaccines but for influenza will be paid for according to the average sales price methodology. 	<ul style="list-style-type: none"> • Secretary may negotiate and enter into contracts with manufacturers of vaccines • Demonstration to improve immunization coverage
National Medical Device Registry		<ul style="list-style-type: none"> • Establishes a national directory for class III medical devices and class II devices that are permanently implantable, life-supporting, or life-sustaining. • Device information in the registry would be linked with patient safety and outcomes data from various public and private databases to facilitate analyses of post-market device 	

Health Reform Plans	Senate Finance ¹	House Tri-Committee Plan ²	Senate Health, Education, Labor, and Pensions ³
		safety and effectiveness.	
Medicare Commission	<ul style="list-style-type: none"> • Creates a 15-member, independent Medicare Commission tasked with presenting Congress with comprehensive proposals to reduce excess cost growth and improve quality of care for Medicare beneficiaries. • In years when Medicare costs are projected to be unsustainable, the Commission’s proposals will take effect unless Congress passes an alternative measure. • Congress would be allowed to consider an alternative proposal on a fast-track basis. • The Commission would be prohibited from making proposals that ration care, raise taxes, or change Medicare benefit or eligibility standards. 		
Medical Malpractice	<ul style="list-style-type: none"> • Expresses the Sense of the Senate that health care reform presents an opportunity to address issues related to medical malpractice and medical liability insurance. • Expresses the Sense of the Senate that states should be encouraged to develop and test alternatives to the current civil litigation system as a way of improving patient safety, reducing medical errors, 		

Health Reform Plans	Senate Finance ¹	House Tri-Committee Plan ²	Senate Health, Education, Labor, and Pensions ³
	<p>encouraging the efficient resolution of disputes, increasing the availability of prompt and fair resolution of disputes, and improving access to liability insurance, while preserving an individual's right to seek redress in court.</p> <ul style="list-style-type: none"> Expresses the Sense of the Senate that Congress should consider establishing a state demonstration program to evaluate alternatives to the current civil litigation system. 		
Revenue Raisers			
High Cost Insurance Excise Tax	<ul style="list-style-type: none"> Beginning in 2013, this proposal would levy a nondeductible excise tax of 35 percent on insurance companies and plan administrators for any health insurance plan that is above the threshold of \$8,000 for singles and \$21,000 for family plans. The tax would apply to the amount of the premium in excess of the threshold. The tax would apply to self-insured plans and plans sold in the group market, but not to plans sold in the individual market. The threshold would be indexed for inflation, and a transition rule would increase the threshold for the 17 		

Health Reform Plans	Senate Finance ¹	House Tri-Committee Plan ²	Senate Health, Education, Labor, and Pensions ³
	highest cost states for the first three years.		
Increasing Transparency in Employer W-2 Reporting of Value of Health Benefits	<ul style="list-style-type: none"> • This proposal would require employers to disclose the value of the benefit provided by the employer for each employee's health insurance coverage on the employee's annual Form W-2. • This would be effective beginning in 2010. 		
Limit Health FSA Contributions	<ul style="list-style-type: none"> • This proposal would limit the amount of contributions to health Flexible Spending Accounts (FSAs) to \$2,000 per year, beginning in 2013. 		
Eliminate Deduction for Employer Part D Subsidy	<ul style="list-style-type: none"> • This proposal would eliminate the deduction for the subsidy for employers who maintain prescription drug plans for their Medicare Part D eligible retirees. • This would be effective beginning in 2011. 		
Standardize the Definition of Qualified Medical Expenses	<ul style="list-style-type: none"> • Beginning in 2011, this proposal would conform the definition of qualified medical expenses for Health Savings Accounts (HSAs), health FSAs, and HRAs to the definition used for the itemized deduction. • An exception to this rule would allow amounts paid for over-the-counter medicine with a prescription to still qualify as medical expenses. 		

Health Reform Plans	Senate Finance ¹	House Tri-Committee Plan ²	Senate Health, Education, Labor, and Pensions ³
Increase the Penalty for Use of HSA Funds for Non-qualified Medical Expenses	<ul style="list-style-type: none"> This proposal would increase the additional tax for HSA withdrawals prior to age 65 that are not used for qualified medical expenses from 10 percent to 20 percent, beginning in 2010. 		
Corporate Information Reporting	<ul style="list-style-type: none"> This proposal would require businesses that pay any amount greater than \$600 during the year to corporate providers of property and services to file an information report with each provider and with the IRS. Information reporting already is required on payments for services to non-corporate providers. This applies to payments made after December 31, 2011. 		
Non-profit Hospitals	<ul style="list-style-type: none"> This proposal would establish new requirements applicable to nonprofit hospitals beginning in 2010. The requirements would include a periodic community needs assessment. 		
Pharmaceutical Manufacturers Fee	<ul style="list-style-type: none"> This proposal would impose an annual flat fee of \$2.3 billion on the pharmaceutical manufacturing sector, beginning in 2010. This nondeductible fee would be allocated across the industry according to market share and would not apply to companies with sales of branded pharmaceuticals of 		

Health Reform Plans	Senate Finance ¹	House Tri-Committee Plan ²	Senate Health, Education, Labor, and Pensions ³
	\$5 million or less.		
Medical Device Manufacturers Fee	<ul style="list-style-type: none"> • This proposal would impose an annual flat fee of \$4 billion on the medical devices manufacturing sector, beginning in 2010. • This nondeductible fee would be allocated across the industry according to market share and would not apply to companies with sales of medical devices in the U.S. of \$5 million or less. • The fee does not apply to sales of Class I products under the FDA product classification system. 		
Health Insurance Provider Fee	<ul style="list-style-type: none"> • This proposal would impose an annual flat fee of \$6 billion on the health insurance sector, beginning in 2010. • This non-deductible fee would be allocated across the industry according to market share. 		
Clinical Laboratories Fee	<ul style="list-style-type: none"> • This proposal would impose an annual flat fee of \$0.75 billion on clinical laboratories, beginning in 2010. • This non-deductible fee would be allocated across the industry according to market share and would not apply to clinical laboratories with revenue of \$500,000 or less. 		
Other Health Care		<ul style="list-style-type: none"> • Extends current rules for 	

Health Reform Plans	Senate Finance ¹	House Tri-Committee Plan ²	Senate Health, Education, Labor, and Pensions ³
Related Revenue Raisers		<p>Medicaid payments to pharmacists for multiple source drugs through December 31, 2010.</p> <ul style="list-style-type: none"> • Thereafter, limits Medicaid payments for such drugs to 130% of the weighted average manufacturer price (AMP). • Redefines AMP to exclude certain price concessions, including those provided to pharmacy benefit managers, not passed through to retail pharmacies. • Prescription drug rebates to 22.1% • Extend prescription drug discounts to enrollees of Medicaid managed care organizations • Clarifies that State Medicaid programs may receive federal matching payments for the costs of graduate medical education. • Medicare non-payment for certain health care-acquired conditions • Minimum medical loss ratio for Medicaid managed care organizations • Making QI program permanent 	

Health Reform Plans	Senate Finance ¹	House Tri-Committee Plan ²	Senate Health, Education, Labor, and Pensions ³
Health Care Surcharge		<p>The health care surcharge would be imposed at progressive rates for married household:</p> <ul style="list-style-type: none"> • Income in excess of \$350,000 and below \$500,000 would be subject to a surcharge of 1%, • Income in excess of \$500,000 and below \$1 million would be subject to a surcharge of 1.5% • Income in excess of \$1 million would be subject to a surcharge of 5.4%. • The first two rates would be increased to 2% and 3%, respectively, in the event that certain health cost savings are not achieved. 	
Delay Implementation of worldwide allocation of interest		<p>Delay phase-in of an election to take advantage of a liberalized rule for allocating interest expense between United States sources and foreign sources for purposes of determining a taxpayer's foreign tax credit limitation for two years.</p>	
Limitation on treaty benefits for certain deductible payments		<p>Would prevent foreign multinational corporations incorporated in tax haven countries from avoiding tax on income earned in the US by routing their income through structures in which a US subsidiary of the foreign multinational corporation makes a deductible</p>	

Health Reform Plans	Senate Finance ¹	House Tri-Committee Plan ²	Senate Health, Education, Labor, and Pensions ³
		<p>payment to a country with which the US has a tax treaty before ultimately repatriating these earning in the tax haven country.</p>	
<p>Clarification of the economic substance doctrine</p>		<ul style="list-style-type: none"> • The bill would clarify the manner in which the economic substance doctrine should be applied by the courts. • Under the provision, in any case in which the economic substance doctrine is relevant to a transaction, the economic substance doctrine would be satisfied only if: <ol style="list-style-type: none"> (1) the transaction changes in a meaningful way (apart from federal income tax consequences) the taxpayer's economic position (2) the taxpayer has a substantial non-federal tax purpose for entering into such transaction. • The provision also imposes a 20% penalty on understatements attributable to a transaction lacking economic substance (penalty increased to 40% in the case of transactions in which the relevant facts affecting the tax treatment of the transaction are not 	

Health Reform Plans	Senate Finance¹	House Tri-Committee Plan²	Senate Health, Education, Labor, and Pensions³
		adequately disclosed).	