

Comparison Between the Different Health Care Plans

Taxes

President:

- Excise tax health insurance for individual plan above **\$10,200** and for a family of four plans above **\$27,500** starting on **2018**.
- Adjustment for firms whose health costs are higher due to the age or gender of their workers,
- No longer counting dental and vision benefits as potentially taxable benefits.
- Maintains the Senate bill's permanent adjustment in favor of high-risk occupations such as "first responders."
- Adds a **2.9%** assessment (equal to the combined employer and employee share of the existing HI tax) on **income from interest, dividends, annuities, royalties and rents, other than such income**, which is derived in the ordinary course of a trade or business on taxpayers with respect to **income above \$200,000** for singles and **\$250,000** for married couple filing jointly would be credited to the HI trust fund and the revenues from the tax on unearned income would be credited to the Supplemental Medical Insurance (SMI) trust fund.
- Increases in the fees on **Brand Name Pharmaceuticals** ----- to raise revenue from the assessment of this industry by **\$10 billion over 10 years** starting on **2011**, and makes changes to facilitate administration by the IRS.
- Assessment fees on **health insurers** by **2014** ---- to raise a **\$67 billion** assessment on health insurers over **10 years** to offset some of the cost of enrolling millions of Americans in their plans.
- Assessment by **2014** for limited exemptions for plans that serve critical purposes for the **community**, including **non-profits** that receive more than **80%** of their income from government programs targeting low-income or elderly populations, or those with disabilities, as well as for voluntary employees' beneficiary associations (VEBAs) that are not established by employers.
- Excise tax on **medical devices** (yielding the same revenue) that starts in 2013 to facilitate administration by the IRS.

Senate/House:

- Senate includes a **40%** excise tax health insurance for individual is **\$8,500** and for a family of four is **\$23,000** and starting it in **2013** for all plans.
- Senates Plan: people purchasing the lowest public plan (Bronze plan) under the exchange by 2016 -- 17 out of 50 states will be paying 40% tax on their premiums.
- Senate Plan: people purchasing the lowest public plan (Bronze plan) under the exchange by 2019 -- 24 out of 50 states will be paying 40% tax on their premiums.
- Senate bill includes change in the Hospital Insurance portion of the payroll tax rate for individuals with income above \$200,000 and for families with income above \$250,000 to be raised from 0.5 percent to 0.9 percent by 2012.
- Senate Finance mandates a minimum of 65% actuarial value.
- Taxes worth \$50,000 on Hospital organizations for failure to comply with standards and requirements.
- Increase in the threshold of tax exemption for itemized deduction for medical expenses from current 7.5% to 10% by 2012.
- House requires 70% actuarial value.
- Both the House and Senate bills raise \$20 billion in revenue from fees in Medical Device industry over 10 years.
- House - A 2.5% excise tax on medical devices sold for use in the U.S.
- House - A 5.4% tax **on high-income households to improve** of \$1 million in the case of a joint return (\$500,000 in the case of other returns).
- House - collection of user fees for the approval of biosimilar or interchangeable biological products.
- House 2.5% tax per individual who has no insurance and 8% fees for eligible employers who cannot offer health insurance.

Republican:

- In 2011, the current tax exclusion for employment-based health insurance would be replaced by a refundable tax credit for the purchase of health insurance, either through an employer or on an individual basis. The tax credit initially would be set at \$2,300 per adult and \$1,700 per child, not to exceed \$5,700 per tax-filing unit.
- Increase tax to an employer through repeal of health insurance exclusion.

Breyer:

- **NO TAX INCREASE** because the cost of insurance premium will be decreased for all Americans through an efficient national health delivery structure that reduces medical errors, efficient information dissemination and medical decision for health care providers and patient. The cost of the program will be paid by the savings that the program will generate for the people by the people uniting in the program --- From funds that people currently do not have but will be made available by removing the barriers that increased the cost of health services without sacrificing current benefits and quality of care in the nation.

- *One Central Inter-State Network System (CNS) through the federal government will negotiate for insurance premium discount (20%-30% with credits for prevention) for all Americans (300 Million) providing an efficient system that would help some of the national dissemination needs and coordinate interstate barriers for insurance companies.*
- *Federal (CNS discounts) or State (Preventive Program Savings) government depending on their contribution to the program will receive 20 cents (with tax credit to individuals) for every dollar saved in CNS. The people will have to tax exempt savings similar to 401 K and tax credits for donations to the uninsured and low income beneficiary of Medicaid.*
- *Additional contribution from the savings generated will be placed in the Social Security and Hospital Insurance (Medicare) Trust Fund to address the insolvency the individual's Medicare and Social Security -- unsustainable federal programs. Such programs will be a transition after a specified time point to a more sustainable retirement and health savings program that can be passed from one generation to another (with tax exemption and protection from the government) – a pathway for financial and health care cost independence not only for the current but also for the future generations.*
- *CNS structure will provide efficiency and savings to drug development and research companies, medical device, insurance and other health care providers - savings provided by CNS structure will be translated to lower cost of their products and savings to the consumers.*

Insurance Exchange

President:

- *New Health Insurance Rate Authority to provide Federal assistance and oversight to States to review unreasonable rate increases and other unfair practices of insurance plans.*
- *Creates an Insurance Market Exchange that will give Americans without access to affordable insurance on the job, and small businesses one-stop shopping for insurance where they can easily compare options based on price, benefits, and quality.*

Senate/House:

- ***House** – Federal health insurance exchange with public health option; Exchange benefits and penalty starts in 2013 (<25 employees), 2014 (<50 employees) and 2015 (at least 100 employees); States shall refer the individual to the Commissioner for a determination of such eligibility and, with the individual's authorization, provide to the Commissioner information obtained by the State as part of the application process.*
- ***Senate** – State (or multi-states) health insurance exchange with all private insurance; Exchange benefits and penalty starts in 2014*

Republican:

- *It will utilize state-driven exchanges to facilitate real competition between private plans and give Americans—for the first time—a choice of health care plans. States could form voluntary compacts with other state Exchanges.*

Breyer:

- *One Central Federal Inter-State Network System (CNS) - All private insurance but facilitated under one national insurance exchange that will negotiate to all health care providers for 20%- 30% decrease in cost and preventive health savings, while increasing the risk pool through interstate or nationwide enrollment --- portability and ease of access to health care across states. Federal programs such as Medicaid, Medicare, Federal Employees Health Benefit Plans, VA and TriCare could also contribute as well as benefit from the savings and efficient information service structure of this system.*

Public Plan Option

President:

- *Offers a public health insurance option to provide the uninsured and those who can't find affordable coverage with a real choice; will promote competition, hold insurance companies accountable and assure affordable choices. It is completely voluntary; the public option must operate like any private insurance company – it must be self-sufficient and rely on the premiums it collects.*

Senate/House:

- *House =Federal public health option; Senate = No Federal public health option but with State public (& Coop) health option*

Republican:

- *Public-State Plan for Acute Care Medical and Long-Term Medical Assistance. State contribution of 45% for Acute care State Plan; Long Term care allotment depends on the ratio of non-institutional spending to the total long term spending for a given year.*

Breyer:

- All Private Insurance under the federally facilitated insurance exchange program in coordination with state government and the American people.
- Empowering the people through transparency and information on both the health care and financial impact of the system to their future benefits (current Medicare and Retirement Funds)

Health Information Records

President:

- Proposal broadens access to the data bank to quality control and peers review organizations and private plans that are involved in furnishing items or services reimbursed by Federal health care program. It includes criminal penalties for misuse.
- Establishes a comprehensive Medicare and Medicaid sanctions database, overseen by the HHS Inspector General. This database will provide a central storage location, allowing for law enforcement access to information related to past sanctions on health care providers, suppliers and related entities.
- Access to claim data to identify potentially fraudulent payments more quickly. It establishes a system for using technology to provide real- time data analysis of claim and payments under public programs to identify and stop waste, fraud and abuse.

Senate/House:

- Senate Health Information Technology (HIT) Policy Committee and the HIT Standards Committee, the Secretary shall notify States of such standards or protocols; and may require, as a condition of receiving Federal funds for the health information technology investments, that States or other entities incorporate such standards and protocol into such investments.
- Senate: appropriate and feasible, a designated provider shall use health information technology in providing the State with such information.
- House: Center of Comparative Effective Research shall provide for the dissemination of appropriate findings produced by research supported, conducted, or synthesized under this section to health care providers, patients, vendors of health information technology focused on clinical decision support, relevant expert organizations and Federal and private health plans, and other relevant stakeholders.
- House: Assistant Secretary of Health Information will coordinate to public and private entities that collect and disseminate information on health and health care, including foundations; and the head of the Office of the National Coordinator for Health Information Technology to ensure optimal use of health information technology

Republican:

- Information Health Record Trust that will promote the use of software from multiple certified providers to collect Medical Records from patients. Patients/ Participants will be charged for fees and collected medical records can be sold to a third party within the required guidelines.
- Other Source of IHRT Revenues:
 - ❖ charging IHRT participants account fees for use of the trust;
 - ❖ charging authorized EHR data users for accessing electronic health records maintained in the trust;
 - ❖ the sale of information contained in the trust
 - ❖ any other activity determined appropriate by the Federal Trade Commission.

Breyer:

- One major nation-wide Information Health Record Database designed for patient-oriented health and access.
- Similar to the current nationwide validated, highly secured and confidential health electronic database of the VA Medical Center.
- One standard framework that can integrate with new innovative modular software. Clinical consortia can pool records during their study but such records **CANNOT BE SOLD** to a third party and can only be used for its original intent of creation.
- De-identified and processed health information, health trends and risk will be available for patients and providers for access and resource in making empowered health decision.
- **No transaction fees for patients** but federally negotiated nationwide discount for providers to be part of the program.

Insurance Premiums

President:

- Income for a Family of Four \$22,000 - \$88,000 --- Sliding Scale Tax Credits 2.0% to 9.5%
Cost Sharing Paid by Insurance Plan 94% - 70%

- A new Health Insurance Rate Authority will be created to provide needed oversight at the Federal level and help States determine how rate review will be enforced and monitor insurance market behavior.
- Plan will immediately **cover adult dependents** up to **age 26**, **prohibits rescissions**, mandates that plans have a stronger appeals process, and requires State insurance authorities to conduct annual rate review, backed up by the oversight of the HHS Secretary.
- New protections that prohibit all annual and lifetime limits, ban pre-existing condition exclusions, and prohibit discrimination in favor of highly compensated individuals by 2014 establishments of the exchange.
- **Starting 2018** “grandfathered” plans will cover proven **preventive services** with **no cost sharing**.
- Lowers the flat dollar amounts to **\$325** in **2015** and **\$695** in **2016**, subsequent years are indexed to **\$695**.
- Sets the payment as a **flat dollar amount (\$695)** or **percentage of income (1.0% to 2.5%)**, **whichever is higher** (although not higher than the lowest premium in the area). Includes **hardship exemption** allows individuals who face premiums higher than **8% of income to purchase in the exchange**. The payment exemption to individuals with income below the tax filing threshold --- a married couple with income below \$18,700 will not have to pay the assessment.
- **No mandate on employers** to offer or provide health insurance.
- Improves the transition to the employer responsibility policy for **employers with 50** or more workers by **subtracting** out the **first 30 workers** from the payment calculation (e.g., a firm with 51 workers that does not offer coverage will pay an amount equal to 51 minus 30, or 21 times the applicable per employee payment amount). It changes the applicable payment amount for firms with more than 50 employees that do not offer coverage to **\$2,000**.

Senate/House:

- Income for a Family of Four \$22,000 - \$88,000 --- **Senate Sliding Scale Tax Credits** 2.0% to 9.8%
Cost Sharing Paid by Insurance Plan 90% - 70%
- Income for a Family of Four \$22,000 - \$88,000 --- **House Sliding Scale Tax Credits** 1.5% to 12%
Cost Sharing Paid by Insurance Plan 97% - 70%
- Senate/House ---- “Rate review” meaning that health insurers must submit their proposed premium increases to the State authority or Secretary for review.
- The Senate sets the payment as a flat dollar amount (\$750) or percentage of income (0.5% to 2.0%), whichever is higher (although not higher than the lowest premium in the area). Flat dollar amounts of \$495 in 2015 and \$750 in 2016. Subsequent years are indexed to \$750. Includes hardship exemption allows individuals who face premiums higher than **8% of income** to purchase in the exchange.
- The House allows individuals who face premiums higher than **12% of income** to be eligible to obtain income - based affordability credits in the Exchange. 2014
- **Senate = No mandate** for employers to provide health insurance; requires large employers (i.e., those with more than 50 workers) to make payments only if taxpayers are supporting the health insurance for their workers. Health care fee for employer is **\$3,000 per full-time worker** obtaining tax credits in the exchange if that employer’s coverage is unaffordable, or **\$750 per full-time worker** if the employer has a worker obtaining tax credits in the exchange but doesn’t offer coverage in the first place.
- **House = Requires a payroll tax for insurers** that do not offer health insurance that meets minimum standards. The tax is **8%** generally and phases in for employers with annual payrolls from **\$500,000** to **\$750,000**; according to the Congressional Budget Office (CBO), the assessment for a firm with average wages of **\$40,000** would be **\$3,200 per worker**.

Republican:

- Repeal the current exclusion of employment-based health insurance from income and payroll taxes. Also in 2011, a refundable tax credit would be available that could be used to purchase coverage through an employer or on an individual basis.
- The tax credit initially would be \$2,300 per adult and \$1,700 per child, not to exceed \$5,700 per tax-filing unit.

Breyer:

- Current Medicaid per capita expense is \$15,268. This cost is much higher than the Cadillac private insurance premium for individuals. Provide similar private insurance benefits to Medicaid recipients eliminating while cost shifting to current privately insured Americans.
- Similar minimum benefit package structure for Low-Income, as proposed in the House and the Senate, with a subsidy on premium cost and out-of-pocket expenses but the value and percentage would be determined after competitive bidding that considers all and the optimum premium cost structure (for Low, Middle and High Income Premiums—eliminating the cost shifting) - where several choices that fit the needs of the consumers (Americans – all our people) are available.
- Plan will immediately **cover adult dependents** up to **age 26**,
- Provide an alternative to purchase of health insurance bonds of the specified amount for people who don’t want to buy health care insurance.

Health Savings

President:

- Savings promised at the time of enactment don't materialize, the President will be required to put forth additional savings to ensure that the plan does not add to the deficit.

Senate/House:

- **House** increases the 10 percent penalty on distributions from health savings accounts that are not used to pay for health related expenditures to 20 percent.
- House provides that nontaxable reimbursements from health flexible spending accounts, health reimbursement arrangements, and health savings accounts do not include a medicine or drug unless the medicine or drug is prescribed or is insulin.
- House limits salary reduction contributions to health flexible spending arrangements to \$2,500 (indexed to the consumer price index).
- Senate Finance Bill will reduce the medical tax deduction by 2.5%, cap the flexible spending account to \$2500 resulting in greater out-of-pocket expenses for individuals by 2010.
- Senate Medical Reimbursement: limited to expenses for medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin by 2010.
- Senate: Increase to 20% the tax on distribution from Health Savings Account (HSAS) and archer MSAM not used for qualified medical expenses by 2010.

Republican:

- Health Savings limitations for a high deductible health plans, the monthly limitation for Individual \$3000 and Household \$ 5970.
- Eligible individual who has coverage under a qualified long-term care insurance contract the lesser of the annual premium for such coverage, or \$1,000.

Breyer:

- More uniform physician fees without cost shifting if everyone is in the same private insurance payment system (Central Network). Provide an integrated payment –treatment-outcome program with the central network where cost efficiency as well as effectiveness of treatment is rewarded with incentives for both short-term and long-term impact to the health of the patient – Personalized Medicine with Patient-Doctor accountability for their health and treatment - electronic health record (e.g., electronic bank accounts) for patient's and doctor's access and information.
- Incentives for students to go to Medical school and to serve in rural areas through the special student loan repayment system.
- Available tax credit for businesses that provide health insurance and matching employee health saving trust funds. Similar subsidy program in the House/Senate could be applied to small businesses.
- Health care network will provide support for efficient and objective information dissemination of available clinical trials and approved drugs through the network with reduced cost for all consumers.
- Individual Savings Account (ISA) will be set up to CNS participants below retirement age. Savings will be designed similar to a 401K (earning interest >4%) with tax exempt contribution, no transaction fees and an investment supported by the government. In return, percentage (5-10%) of the interest earned per dollar will go to Social Security and Medicare Trust Funds in order to meet the retirement and medical needs of the individual and all enrollees. A solution that will enable the nation to address the insolvency of Medicare and Social Security while meeting all the health care and retirement commitments to the people (with no tax increase and decreased in benefits)

Medicaid

States have been partners with the Federal government in creating a health care safety net for low-income and vulnerable populations. They administer and share in the cost of Medicaid and the Children's Health Insurance Program (CHIP).

President:

- President's Proposal requires States to monitor and remediate high-risk billing activity, not limited to prescription drug classes involving a high volume of claims, to improve Medicaid integrity and beneficiary quality of care. States may choose one or more drug classes and must develop or review and update their care plan to reduce utilization and remediate any preventable episodes of care where possible. Requiring States to monitor high-risk billing activity to identify prescribing

and utilization patterns that may indicate abuse or excessive prescription drug utilization will assist in improving Medicaid program integrity and save taxpayer dollars.

- Replaces the variable State support in the Senate bill with uniform 100% Federal support for all States for newly eligible individuals from 2014 through 2017, 95% support for 2018 and 2019, and 90% for 2020 and subsequent years.
- The President's Proposal also recognizes the early investment that some States have made in helping the uninsured by expanding Medicaid to adults with income below 100% of poverty by increasing those States' matching rate on certain health care services by 8% points beginning in 2014. Provides additional assistance to the Territories, raising the Medicaid funding cap by 35%.
- Creating a 5% income disregard for certain Medicaid eligibility determinations to ease the transition from States' current use of income disregards; streamlining the income reconciliation process for determining tax credits and reduced cost sharing; and clarifying the tax treatment of employer contributions for adult dependent coverage.

Senate/House:

- The Senate bill creates a nationwide Medicaid eligibility floor as a foundation for exchanges at \$29,000 for a family of 4 (133% of poverty) – and provides financial support that varies by State to do so.
- Senate will reduce Medicaid and Medicare payments to hospitals that serve a large number of low-income patients, known as disproportionate share hospitals (DSH).
- The House bill provided full support for all States for the first two years, and then 91% support thereafter.

Republican:

- Medicaid enrollees would purchase private health insurance using a combination of a new federal tax credit and a subsidy for low income people. Services for disabled beneficiaries and long-term care would remain in the current Medicaid program, and states would receive block grants for those services.
- Supplemental health care assistance for low income families from \$5000 (AGI<100% FPL) to \$2000 (AGI = 180% -200% FPL); \$1000 per pregnancy and \$500 per child 9<1 yr old); State contributes 50% of a total amount to be paid within 30 days to the Secretary of HHS. Interest will accrue upon failure to pay in a given time.

Breyer:

- Innovative payment and savings system that provides 30% -40% savings to current insurance premium for all groups, non-groups, states and federal health (Medicaid, Medicare, etc.) programs. Additional tax credits for every saving donated to support federal programs (i.e., uninsured, low-income, homeless) Integrated decision on best practices guidelines, risk assessment, experts and provider resources and health record collection in one central unit provides a real-time evaluation of best policies, practices, oversight and rewards.

Administrative Structure

President:

- Invests \$11 billion on community health centers.
- Access to comprehensive mental health services in the community setting, but strengthens standards for facilities that seek reimbursement as community mental health centers by ensuring these facilities are not taking advantage of Medicare patients or the taxpayers.
- Access to claim data to identify potentially fraudulent payments more quickly. It establishes a system for using technology to provide real-time data analysis of claim and payments under public programs to identify and stop waste, fraud and abuse.
- Requiring the Internal Revenue Service (IRS) to disclose to CMS those entities that have evaded filing taxes and matching the data against provider billing data, this proposal will enable CMS to better detect fraudulent providers billing the Medicare program.
- Makes anti-competitive and unlawful any agreement in which a generic drug manufacturer receives anything of value from a brand-name drug manufacturer that contains a provision in which the generic drug manufacturer agrees to limit or forego research, development, marketing, manufacturing or sales of the generic drug. This presumption can only be overcome if the parties to such an agreement demonstrate by clear and convincing evidence that the pro-competitive benefits of the agreement outweigh the anti-competitive effects of the agreement. The proposal also requires the Chief Executive Officer of the branded pharmaceutical company to certify to the accuracy and completeness of any agreements required to be filed with the FTC.
- A series of changes to the Senate bill to improve the CLASS program's financial stability and ensure its long-run solvency.
- If necessary, funds will be transferred to the Social Security Trust Funds to ensure that they are held harmless by the Proposal.
- Appropriates \$1 billion for the Administration to implement health insurance reform policies.

- *Delays several of the policies to ensure effective implementation and improve transitions: the therapeutic discovery credit, elimination of the deduction for expenses allocable to the Medicare Part D subsidy, the pharmaceutical and medical device industry fees, and the health insurance industry fee.*

Senate/House:

- *Senate bill increases funding to community health centers for service by \$7 billion and for construction by \$1.5 billion over 5 years*
- *The House bill provides \$12 billion over the same 5 years.*
- ***House and Senate health insurance reform proposals include the Community Living Assistance Services and Supports (CLASS) Program, a voluntary, privately-funded long-term services insurance program. The CLASS Program offers workers an optional payroll deduction for an insurance program that provides a cash benefit if they become disabled.***

Republican:

- *Implementation of CLASS long-term disability insurance with same unsustainable structure as Social Security System?*

Breyer:

- *One Central Inter-State Network System (CNS) - All private insurance but facilitated under one federal insurance exchange that will negotiate to all health care providers for 20%- 30% decrease in cost while increasing the risk pool through interstate or nationwide enrollment.*
- *Federal Funding to States for preventive programs for additional savings to the people. Twenty cents (tax credit) contribution for every dollar saving in combined federal and state initiative goes to respective funds and contributions in Medicaid and low-income subsidy programs.*
- *Unlike Medicare and Social Security, the people's tax exempt savings will be placed in an Individual Savings Trust Fund and invested in a more government secured but similar 401 K plan. A portion of the interest and further savings will be use as the contribution to the Medicare and Social Security Trust Fund of the individual -- resolving future insolvency of these existing unsustainable federal programs.*
- *Cumulative savings in the new Individual Savings Trust Fund can be willed or passed to the next generation or heir, with exemption from gift and death taxes.*
- *Efficiency in coordinating the multiplex structure in health care planning and decision, real-time response and process evaluation are all integrated in one system algorithm design. Multiple intra- interagency oversights over a period of time (i.e., monthly, quarterly, and annually) provides additional checks in the system;*
- *Convergence of the collaborating agencies, academics, business, patients, physicians, experts and other stakeholder roles, resource and responsibilities on one process and site.*

Pre-existing & Insurance Rescission

President:

- *Immediately offers new, low-cost coverage through a national "high risk" pool to protect people with preexisting conditions from financial ruin until the new Exchange is created.*
- ***Prohibits rescissions**, mandates that plans have a stronger appeals process, and requires State insurance authorities to conduct annual rate review, backed up by the oversight of the HHS Secretary.*
- *New protections that prohibit all annual and lifetime limits, ban pre-existing condition exclusions, and prohibit discrimination in favor of highly compensated individuals by 2014.*

Senate/House:

- *House: Prohibiting preexisting condition exclusions;*
- *House prohibits rescission after guaranteed renewability. A health insurance issuer may rescind individual health insurance coverage only upon clear and convincing evidence of fraud.*
- *Senate provides to all eligible individual health insurance coverage that does not impose any preexisting condition exclusion with respect to such coverage;*
- *Senate High Risk Pool: provides health insurance coverage in which the issuer's share of the total allowed costs of benefits provided under such coverage is not less than 65 percent of such costs;*
- *Senate: shall not rescind insurance plan or coverage with respect to an enrollee once the enrollee is covered under such plan or coverage involved, except for individual who has performed an act or practice of fraud or makes an intentional misrepresentation of material fact.*

Republican:

- *Limitation on pre-existing conditions. State Exchange shall ensure that health insurance coverage offered through the Exchange meets the requirements of section 9801 of the Internal Revenue Code of 1986 in the*

same manner as if such coverage was a group health plan. No mandate for individuals to be enrolled in health insurance coverage.

Breyer:

- Immediately offers new, low-cost coverage for people with pre-existing conditions through the Central Network System Insurance Exchange.
- **Prohibits rescissions**, mandates that plans have a stronger appeals process, and requires States Coordinating Authorities, CNS, HHS and GAO for annual review.
- New protections that prohibit all annual and lifetime limits, ban pre-existing condition exclusions, and prohibit discrimination in favor of highly compensated individuals by 2012.

Medicare & Social Security

Medicare stops paying for prescriptions after the plan and beneficiary have spent \$2,830 on prescription drugs, and only starts paying again after out-of-pocket spending hits \$4,550. Donut hole is between \$2830 and \$4550 were seniors pay the full amount.

President:

- Replaces the \$500 Senate/House increase in the initial coverage limit with a \$250 rebate to Medicare beneficiaries who hit the donut hole in 2010. It also closes the donut hole completely by phasing down the coinsurance so it is the standard 25% by 2020 throughout the coverage gap.
- Strong sanctions, including jail time, for individuals who purchase, sell or distribute Medicare beneficiary identification numbers or billing privileges under Medicare or Medicaid – if done knowingly, intentionally, and with intent to defraud.
- Examines the costs and benefits of assigning universal product numbers (UPNs) to selected items and services reimbursed under Medicare. The report must examine whether UPNs could help improve the efficient operation of Medicare and its ability to detect fraud and abuse.
- Requires in the statute that the HHS Secretary extrapolates the error rate found in the risk adjustment data validation (RADV) audits to the entire Medicare Advantage contract payment for a given year when recouping overpayments. Extrapolating risk score errors in MA plans is consistent with the methodology used in the Medicare fee-for-service program and enables Medicare to recover risk adjustment overpayments.
- Modifies these statutory provisions that currently limit random medical review and place statutory limitations on the application of Medicare prepayment review.
- Creates a set of benchmark payments at different percentages of the current average fee-for-service costs in an area. It phases these benchmarks in gradually in order to avoid disruption to beneficiaries, taking into account the relative payments to fee-for-service costs in an area. It
- Provides bonuses for quality and enrollee satisfaction. It adjusts rebates of savings between the benchmark payment and actual plan bid to take into account the transition as well as a plan's quality rating: plans with low quality scores receive lower rebates (i.e., can keep less of any savings they generate).
- Requires a payment adjustment for unjustified coding patterns in Medicare Advantage plans that have raised payments more rapidly than the evidence of their enrollees' health status and costs suggests is warranted, based on actuarial analysis.

Senate/House:

- The Senate bill provides a 50% discount for certain drugs in the donut hole.
- Senate bill provides Medicare's payment rates for physicians' services by 0.5 percent for 2010 was eliminated.
- The House bill fully phases out the donut hole over 10 years.
- Both bills raise the dollar amount before the donut hole begins by \$500 in 2010.
- The Senate bill creates a bidding model for payment rates and phases in changes to limit potential disruptions for beneficiaries.
- The House proposal phase's payments down based on local fee-for-service costs.

Republican:

- Age of eligibility for Medicare would increase incrementally from 65 (for people born before 1956), as it is under current law, to 69 years and 6 months for people born in 2022 and later. Starting in 2021, new enrollees would no longer receive coverage through the current program but, instead, would be given a voucher with which to purchase private health insurance.
- In 2021, when enrollees would first receive the voucher, the average voucher for 65-year-olds would be worth \$5,900 (in 2010 dollars).

- Medicare's payment rates for physicians and the parameters governing the alternative minimum tax continue as under 2009 laws except that they are indexed for inflation and that significant tax reductions scheduled to expire at the end of 2010 are extended.

Breyer:

- Adjustment on drug cost will be realized once nationwide and interstate insurance exchange is in place. Efficient infrastructure for communication will provide savings for both health providers and patients including Medicare participants. Similar savings and best practices protocol in CNS will bend the spending curve of Medicare. The donut hole by 2011 will be closed and drug pricing will be set in consideration with other all the groups. One drug price discount for all groups (300 Million Americans).

No. of Uninsured Covered

President: 30 Million uninsured will be covered leaving 24 Million uninsured by 2019

Senate/House:

- House will cover 36 Million leaving 18 Million uninsured by 2019.
- Senate will cover 31 Million leaving 23 Million uninsured by 2019.

Republican:

- Rep. Ryan's Patient's Choice Act impact on uninsured after 2019 is not measured by CBO.

Breyer:

- Programs are set up to cover 54 Million uninsured by 2019

Cost of the Reform

President: Not reviewed by CBO for Cost.

Senate/House:

- House – Estimated Cost = \$891 Billion without \$298 Billion Physician Fee for Service
- Senate – Estimated Cost - \$871 Billion without \$298 Billion Physician Fee for Service

Republican:

- **Budget for 10 years** > \$1,092,634,303,472
- **Funding for Forum for Quality and Effectiveness in Health Care** appropriation for fiscal years 2010 through 2014 or from 2010 until 2019 is not known.
- **Detection of Medicare Fraud and Abuse appropriation of \$50,000,000**, for each of fiscal years 2010 through 2014 (Total = \$250,000) 2010 to 2019 for 10 years program (Total = \$500,000);

Breyer:

- Initial Budget Cost for the establishment of CNS, promotion grant from CDC and State support for the program, funds for oversight collaboration and review HHS, GAO and other participating agencies.
- 10-Year Benefits for 216 Million Americans: est. \$2.3 Trillion savings excluding tax credits
 - provide affordable insurance to current 25 Million uninsured and pathways for affordable insurance for the other 25 Million currently uninsured.
- Insurance and related Businesses: Savings to health care providers and supplier for 10 years est. > \$4.8 Trillion
- Government: - est. \$2.8 Trillion savings in 34 M Medicaid recipients and current 25 M uninsured. Preventive health savings for the people and their declared states of residence.
- More savings for federal government if TriCare, VA, FEHBP, and Medicare are included.
- More savings for the states if the State Health Benefit plans are also included in the program.

Fraud, Abuse and Oversight

President:

- Establishes a comprehensive Medicare and Medicaid sanctions database, overseen by the HHS Inspector General. This database will provide a central storage location, allowing for law enforcement access to information related to pass sanctions on health care providers, suppliers and related entities.
- Reducing the number of individuals and agencies with a history of fraudulent activities participating in Federal health care programs.
- Proposal broadens access to the data bank to quality control and peers review organizations and private plans that are involved in furnishing items or services reimbursed by Federal health care program. It includes criminal penalties for misuse.

- Holds Medicare Administrative Contractors accountable for Federal payment for individuals or entities excluded from the Federal programs or items or services for which payment is denied.
- Assist in recovering overpayments made to providers and suppliers and return such funds to the Medicare Trust Fund. It prevents fraudulent health care providers from discharging through bankruptcy amounts due to the Secretary from overpayments.

Senate/House:

- Senate Medicaid, Medicare, SCHIP Integrity Provision: Secretary shall determine the level of screening conducted according to the risk of fraud, waste, and abuse, as determined by the Secretary, with respect to the category of provider of medical or other items or services or supplier. Such screening shall include a licensure check, which may include such checks across States; and may, as the Secretary determines appropriate based on the risk of fraud.
- Senate: funds available to the Secretary or to the Inspector General of the Department of Health and Human Services for a purpose related to combating health care fraud, waste, or abuse shall be available to the extent necessary for operating the Healthcare Integrity and Protection Data Bank during the transition period, including systems testing and other activities necessary to ensure that information formerly reported to the Healthcare Integrity and Protection Data Bank will be accessible through the National Practitioner Data Bank after the end of such transition period.
- Senate: No more than \$250, 000 for false or fraudulent in addition to any other penalties that may be prescribed by law.
- House: Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish core elements for a compliance program such as written policies, procedures, and standards of conduct, a designated compliance officer and a compliance committee; effective training and education pertaining to fraud, waste, and abuse disciplinary guidelines for enforcement of standards; internal monitoring and auditing procedures, including monitoring and auditing of contractors; procedures for ensuring prompt responses to detected offenses and development of corrective action initiatives, including responses to potential offenses; and procedures to return all identified overpayments to the programs.

Republican:

- Sale of confidential patient information database (raw information) to the third party have issues on potential breach or questions regarding ownership of intellectual properties on innovative technologies and algorithms. Very serious issues on patients privacy, security and potential practices that may lead not well-informed patient signing a form while unknowingly releasing their rights to all third party purchase of their health records;
- Oversight of 50 Insurance Exchanges and multiple, if not hundreds, of medical IT software.

Breyer:

- Annual health care insurance enrollment of low-income and underserved groups that are integrated to their preventive health program and manage care.
- Real-time evaluation algorithm can monitor the progress and immediately detect problems in the system providing faster response time in cases of emergency and, fraud. Provides guideline of risk assessments based on best practices to minimize medical mistakes, and access to experts and resources for all stake holders.
- Use of secure and validated, over time and states, Health Information Technology Database for nationwide application with flexibility for modular integration of new health care related software, process and systems.
- Intra and inter-agencies oversight (i.e., monthly, quarterly and annual).
- Transparency, education and information, efficiency in implementing the change, empowering the individual patients and physicians to decide what is best for their health and treatment should be set up in a nationwide network system. Instead of just a panel of experts or bureaucratic agency deciding for all, the network will provide a nationwide evaluation process so the best practices are transparent to the patients and the physicians (without comprising the identity and any personal information of the patients and physicians).
- Inter-individual variations in drug and treatment response occurs, thus the outcome based criteria on good quality of health rather than rigid protocol based on reduced cost should be adopted.

Tort Reform

President:

- Secretary of Health and Human Services to move forward on awarding medical malpractice demonstration grants to states funded by the Agency for Healthcare Research and Quality as soon as possible.

Senate/House:

- **Senate:** States should be encouraged to develop and test alternatives to the existing civil litigation system as a way of improving patient safety, reducing medical errors, 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;

- **Senate:** Congress should consider establishing a State demonstration program to existing civil litigation system with respect to the resolution of medical malpractice claims.

Republican:

- State-based Tort Reform - Review of State Court after exhaustion of Remedy (Impact to the relative time or statute of limitation for State Law Suit is not addressed). Remedies are Expert Panel and Health Tribunal to review the cases.

Tort Reform on Noneconomic Damage on a Medical Errors needs to be Reviewed Very Carefully. Definition of Non-economic and Economic Losses based on the Congress:

“NON-ECONOMIC DAMAGES.—The term ‘non-economic damages’ means losses for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), injury to reputation, and all other non-pecuniary losses of any kind or nature, to the extent permitted under State law.

NET ECONOMIC LOSS.—The term ‘net economic loss’ means— ‘(A) reasonable expenses incurred for products, services and accommodations needed for health care, training and other remedial treatment and care of an injured individual; ‘(B) reasonable and appropriate expenses for rehabilitation treatment and occupational training; ‘(C) 100 percent of the loss of income from work that an injured individual would have performed if not injured, reduced by any income from substitute work actually performed; and ‘(D) reasonable expenses incurred in obtaining ordinary and necessary services to replace services an injured individual would have performed for the benefit of the individual or the family of such individual if the individual had not been injured.’ HR 2520

Breyer:

- Tort-reform is integrated in a standard, nationwide, secured, validated technology and health-care delivery. Access to expert panels throughout the nation for case evaluation and support compound by real-time data collection, validation, evaluation and response.
- Best Practices Database and Experts (individuals, professional associations and panels) across the nation to provide a resource in reducing errors and malpractice law suits.
- Provide standardized laboratory tests across the nation (to eliminate errors in diagnosis) on most common and routine tests. Include interactive algorithms that provide physicians an opportunity to evaluate risk but the flexibility to personalize treatment. Easy access to expert collaborators (across the nation) for support and guidance on high risk decisions. Streamline nationwide access to new innovative technologies and treatments that would not only improve patient’s health but also reduce cost. As in the current situation, physicians around the nation evaluate the best treatment protocol that fits their patient population by evaluating their own outcome.
- Evaluate and promote TORT Reforms that are proven to effectively reduce frivolous law suits. Provide initial panels of experts (physicians, lawyer and patients) who can provide preliminary screening on frivolous law suits, and careful evaluation on the value of non-economic losses..
- Reward the best hospitals that provide reduced cost and improve outcome in terms of tax credits. Inspire innovation and creativity by rewarding health provider’s contribution in the network database and its impact to the nation.
- The Lilly Ledbetter rule states the statute of limitation to be reset every time that a new discriminatory act is performed. In health care, as in other employment situations, the patients may not know for several years (due to confidential medical information - a patient will not know immediately what is acceptable to all and discriminatory to his/her case) after the performance or end of the discriminatory act. Therefore, knowledge of the discriminatory act should also be considered as the starting date and as another alternative for other cases not covered by Lilly Ledbetter Case. Provide the same mechanism as the Tort Reform system to screen for frivolous law suit.

Preventive Care

President:

- Requires “grandfathered” plans to cover proven preventive services with no cost sharing by 2018.

Senate/House:

- Senate: A group health plan and a health insurance issuer offering group or individual health insurance coverage shall provide coverage for and shall not impose any cost sharing requirements for preventive care.
- House: Basic Required Benefits includes preventive services, including those services recommended with a grade of A or B by the Task Force on Clinical Preventive Services; No cost-sharing under the essential benefits package

Republican:

- Secretary may adjust (under procedures established by the Secretary) the amount of such premium for an individual based on whether or not the individual participates in certain healthy behaviors, such as weight management, exercise, nutrition counseling, refraining from tobacco; Pre- and post-treatment disclosure by 2011.

Breyer:

- Requires plans to cover proven preventive services with no cost sharing by 2011 or at the establishment of CNS insurance exchange. Integrate best practices and preventive care practices from multiple expert Medical and Health Associations.
- Annual health care insurance enrollment of low-income and underserved groups that are integrated to their preventive health program and manage care.

Homeless & Non-documented Alien

President:

Senate/House:

- 'Eligible individual' shall not include any alien individual who is not a lawful permanent resident of the United States. Non-documented Aliens are not allowed to buy private insurance but will still default in current program that caters to their emergency needs - higher cost shifted to privately insured individual.

Republican:

- 'Eligible individual' shall not include any alien individual who is not a lawful permanent resident of the United States. Non-documented Aliens are not allowed to buy private insurance but will still default in current program that caters to their emergency needs - higher cost shifted to privately insured individual.

Breyer:

- Provide access for everyone to purchase affordable private insurance (all private funds and no tax payer cost burden or subsidy). Burden of high cost of health care will be further reduced if we could eliminate unnecessary and unpaid emergency room expenses due to people without insurance. Since both House and Senate proposal did not directly address this problem, ignoring it will default into the current problem being unsolved, where currently insured people are paying hidden costs.
- Annual health care insurance enrollment of low-income and underserved groups that are integrated to their preventive health program and manage care.
- An incentive-based structure and program that promote good health and rewards efficiency and best practices at all levels and stakeholders.