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AFFORDABLE HEALTH CARE FOR AMERICA ACT

Over the weekend, a divided U.S. House of Representatives passed the Affordable Health Care for America Act (H.R. 3962). The bill passed on a vote of 220-215, with 219 Democrats and one Republican voting for the bill and 39 Democrats voting against the bill.

The bill would for the first time require every individual to obtain healthcare insurance and would try to make it affordable by creating a national "health insurance exchange" – with an option for states that agree to meet federal standards to run their own exchange with the assistance of federal start-up loans. The bill also calls for the establishment of a public health insurance option which could be purchased through the "health insurance exchange" and provides for federal subsidies to qualified individuals and small employers to assist with their purchase of coverage. The bill also calls for a substantial expansion of those eligible for Medicaid.

Democratic leaders in the Senate are now working to merge the Senate's two bills – from the Senate Finance Committee, the America's Healthy Future Act of 2009 (S. 1796) and from the Senate Health Committee, the Affordable Health Choices Act (S. 1679). Presently, the three bills have much in common, but also have some key distinguishing factors. For example, points in common include:

- **Public Option.** Would establish either a government run plan or consumer-run insurance cooperatives in states, in either case to offer insurance coverage to compete with private sector insurance companies.
- **Health Insurance Exchanges.** Would create either a national exchange or state-based exchanges, where consumers can easily compare coverage and rates.
- **Employer Mandates.** Would require employers to provide health insurance coverage – or contribute to non-employer based coverage, with varying exceptions for "small" employers.
- **Individual Mandates.** Would require nearly everyone to obtain health insurance coverage starting in 2013 and penalize those who did not.
- **Small Employer Subsidies.** Would provide federal financial aid to small employers in the form of tax credits to subsidize employer-sponsored health plans.
- **Individual Subsidies.** Would provide federal financial aid to individuals in the form of tax credits for the payment of premiums.
- **Health Insurance Reform.** Would bar insurers from denying or limiting coverage because of pre-existing conditions and from imposing lifetime limits on coverage – would also end blanket exemption for health insurers from anti-trust laws.
- **Medicaid Expansion.** Would expand Medicaid coverage to those at either 133 percent or 150 percent of the FPL.

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These similarities notwithstanding, the devil is, as they say, in the details. HRO has prepared a high-level table (attached) listing what we believe to be the key issues, and briefly summarizing the current treatment of these issues, as between the House bill and the two Senate bills. Assuming that the Senate is able to reconcile the respective efforts of its Finance and Health Committees, and to pass a resulting bill, we will circulate a second table, revised to reflect the Senate's efforts.

And should the House and Senate be able to reconcile their respective bills, and to offer legislation for the President's signature, HRO will be generating a third iteration of our table. In this way, we hope to be able to assist you, our clients and friends, in keeping track of this administration's sweeping efforts to reform our country's healthcare system.

In the interim, should you have questions concerning how healthcare reform (as currently proposed) is likely to impact your own business efforts, whether as a purchaser, a provider, or an insurer of health care, you may contact any of the members of HRO's Healthcare Practice Group listed on page one.

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**Comparison of Key Issues
Affordable Health Care for America Act – America’s Healthy Future Act of 2009 – Affordable Health Choices Act**

Key Issue	Sponsor of Version	Comparative Terms
Public Plan or CO-OPs	Affordable Health Care for America Act -- H.R. 3962	<ul style="list-style-type: none"> • Would create a new government insurance plan that would negotiate rates with doctors and hospitals, rather than using Medicare rates set by the government. • The public plan would have to offer different levels of benefits, covering between 70 to 95 percent of health care expenses. • Like private plans, the public plan must offer the same benefits, comply with the same insurance market reforms, follow provider network requirements and other consumer protections. The plan would not provide abortion coverage. • Health care providers would not be required to participate in the plan. But the bill assumes that providers participating in Medicare are participants of the public plan, unless they opt out. • The government would allocate \$2 billion in start-up money but the public plan must be financially self-sustaining. The bill would require premiums, paid by beneficiaries, to cover the plan’s cost. The government would also provide loans to start up nonprofit insurance cooperatives to compete with private insurers and the public plan. • The legislation would also create a public long-term-care program that would provide cash assistance — not less than an average of \$50 per day — to people who become disabled. The program would be financed through premiums deducted from paychecks of people who choose to participate. Workers would have to contribute for at least five years before they can collect benefits.
	America’s Healthy Future Act of 2009 – S. 1796	<ul style="list-style-type: none"> • Would create private, nonprofit, consumer-run insurance cooperatives in states. • The co-ops would be required to meet the same guidelines as private plans regarding benefit levels, insurance market reforms and other consumer protections. • The co-ops would be required to be organized as nonprofit, member corporations and to use their profits to lower premiums and improve benefits and the quality of health care provided to members. • The co-ops could negotiate collectively for better prices, but they would be “explicitly prohibited from setting payment rates for health care facilities and providers.” • The government would provide \$6 billion in loans and grants by 2012 to help doctors, hospitals, businesses and other groups form the cooperatives.
	Affordable Health Choices Act - - S. 1679	<ul style="list-style-type: none"> • Would create a new government insurance plan that would negotiate rates with doctors and hospitals. • The plan must offer the minimum package of benefits prescribed by the government, but states can choose to offer additional benefits. • Like private plans, the public plan must offer the same benefits, comply with the same insurance market reforms, follow provider network requirements and other consumer protections. • Health care providers would not be required to participate in the plan. • The public plan’s cost must be covered by premiums. • The legislation would also create a public long-term-care program that would provide cash assistance to people who become disabled. The program would be financed through premiums deducted from paychecks of people who choose to participate.



Key Issue	Sponsor of Version	Comparative Terms
Insurance Exchange	Affordable Health Care for America Act -- H.R. 3962	<ul style="list-style-type: none"> • Would create a national exchange. Allows states to opt out and operate their own exchange if they follow federal rules. • Open to people who do not have qualifying coverage through an employer or a public program. • Open to employers with 25 or fewer employees in the first year, 50 or fewer in the second year and 100 or fewer in the third year. The exchange could be expanded to larger employers over time, “with the goal of allowing all employers access.” • Until the exchange is established, a temporary program would provide health coverage to “those who have been uninsured for several months or denied a policy because of pre-existing conditions.”
	America’s Healthy Future Act of 2009 – S. 1796	<ul style="list-style-type: none"> • Would create state-based exchanges for individuals and small employers by 2010. • Open to citizens or legal immigrants who do not have qualifying coverage through an employer or a public program. Verification of legal immigration status would be required to buy insurance through a new exchange. • For the first five years, the exchanges would be open to employers with 50 or fewer employees, but states could choose to allow companies with 100 or fewer workers to participate . • Starting in 2015, states must allow businesses with 100 or fewer workers to buy insurance through the exchange. States can choose to allow larger businesses to participate in the exchanges starting in 2017. • Starting in 2015, states would be permitted to opt out of certain requirements set by the legislation through a waiver process, as long as the state plan does not add to the federal deficit and provides coverage that is as comprehensive as the coverage required under an exchange plan.
	Affordable Health Choices Act - - S. 1679	<ul style="list-style-type: none"> • Would create state-based exchanges. Allows states to form regional exchanges. • Open to people who do not have qualifying coverage through an employer or a public program. • Open to employers with 50 or fewer employees.
Key Issue	Sponsor of Version	Comparative Terms
Employer Mandates	Affordable Health Care for America Act -- H.R. 3962	<ul style="list-style-type: none"> • Would require employers with annual payrolls of \$500,000 or more to provide health insurance or pay a new federal tax. • Employers would have to contribute at least 72.5 percent of the premium cost for individuals and 65 percent for families for the lowest cost plan that meets the minimum benefit requirements set by the government. • Penalty: Up to 8 percent of wages in payroll taxes. Employers with payrolls of \$500,000 to \$750,000 would pay 2 percent to 6 percent of wages, and those with payrolls above \$750,000 would pay the full 8 percent. • Employers that offer health insurance must automatically enroll employees into the lowest cost plan available. But employees may opt out of employer coverage.
	America’s Healthy Future Act of 2009 – S.	<ul style="list-style-type: none"> • Would not require employers to provide coverage. Employers with more than 50 workers would have to reimburse the government for some or all of the cost of subsidies provided to full-time employees who work 30 or more hours a week and buy insurance on their own through the exchanges. • Penalty: Up to \$400 for each worker in the company, whether they are receiving subsidies for insurance or not.



	1796	<ul style="list-style-type: none"> Employers with 200 or more employees must automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of employer coverage, however, if they are able to demonstrate that they have coverage from another source. Individuals who qualify for Medicaid could choose to leave an employer's insurance plan and enroll in Medicaid, in which case the employer would not be required to pay a fee. Employers who buy coverage for their employees through the proposed exchanges must offer a plan with a deductible that does not exceed \$2,000 for individuals and \$4,000 for families, unless they contribute funds to offset deductibles above these limits.
	Affordable Health Choices Act - S. 1679	<ul style="list-style-type: none"> Would require employers with more than 25 workers to contribute at least 60 percent of the premium costs, or Pay a \$750 penalty for each full-time worker and \$375 for each part-time worker.
Key Issue	Sponsor of Version	Comparative Terms
Subsidies for Employers	Affordable Health Care for America Act -- H.R. 3962	<ul style="list-style-type: none"> Would provide tax credits to employers with 25 or fewer workers and average wages of \$40,000 or less. The credit would not be allowed for employees earning more than \$80,000 a year. The amount, up to 50 percent of premium costs, phases out as firm size and average wages increase. Would spend \$5 billion from 2013 to 2015 to subsidize employer-sponsored health plans covering early retirees ages 55 to 64. The federal government would cover 80 percent of the cost of a retiree's medical claims of more than \$15,000, with a cap at \$90,000 — at which point the employer's plan would pay the rest.
	America's Healthy Future Act of 2009 – S. 1796	<ul style="list-style-type: none"> Would provide tax credits to employers with 25 or fewer workers and average wages of \$40,000 or less. An employer would have to contribute at least 50 percent of the total premium for an employee's coverage or at least 50 percent of the average premium cost for small businesses in the employer's state. The full credit would be available to employers with 10 or fewer workers and average wages of \$20,000 or less. The amount phases out as firm size and average wages increase. In 2011 and 2012, all qualifying employers could receive up to 35 percent of their contribution to a worker's insurance premium. Starting in 2013, only employers buying insurance through the proposed exchanges can receive a tax credit for two years that covers up to 50 percent of their premium contribution. Would spend \$10 billion over 10 years to subsidize employer-sponsored health plans covering early retirees ages 55 to 64. The federal government would cover 80 percent of the cost of a retiree's medical claims between \$15,000 and \$90,000.
	Affordable Health Choices Act - S. 1679	<ul style="list-style-type: none"> Would provide tax credits to employers who have 50 or fewer workers and who pay at least 60 percent of their employees' health insurance premiums. Eligible employers would be able to receive the credit for only three consecutive years. The credit phases out as firm size and average wages increase. Would subsidize employer-sponsored health plans covering early retirees ages of 55 to 64, until the proposed state exchanges are established. The federal government would cover 80 percent of the cost of a retiree's medical claims between \$15,000 and \$90,000.



Key Issue	Sponsor of Version	Comparative Terms
Individual Mandates	Affordable Health Care for America Act -- H.R. 3962	<ul style="list-style-type: none"> • Would include mandate. • Penalty: 2.5 percent of adjusted gross income over a certain level, which is \$9,350 for singles and \$18,700 for couples. • Exempt those with incomes below the above-mentioned thresholds, American Indians, people with religious objections and people who can show financial hardship.
	America's Healthy Future Act of 2009 – S. 1796	<ul style="list-style-type: none"> • Would include mandate. • Penalty would be phased in gradually: \$200 a person in 2014; \$400 in 2015; \$600 in 2016; and \$750 in 2017. • Exempt American Indians, people with religious objections, those who can show financial hardship, households with incomes lower than 133 percent of the federal poverty level (\$29,327 for a family of four) and people who would have to pay more than 8 percent of their income to buy the lowest cost plan available to them.
	Affordable Health Choices Act - S. 1679	<ul style="list-style-type: none"> • Would include mandate. • Penalty: Up to \$750 a person a year. • Exempt American Indians and those who can show financial hardship.
Key Issue	Sponsor of Version	Comparative Terms
Subsidies for Individuals	Affordable Health Care for America Act -- H.R. 3962	<ul style="list-style-type: none"> • Would provide credits for premium costs and other health care expenses to citizens or legal immigrants who buy insurance through the exchange. Verification of legal immigration status would be required to receive subsidies. • Households with incomes up to 400 percent of the federal poverty level (\$88,200 for a family of four) would be eligible to receive premium credits, if they pay specified percentages of their income toward the premium. Premium contributions would range from 3 percent to 12 percent depending on the income. People with insurance from employers would be eligible for the credits if the cost of their premium exceeds 12 percent of their income. • The proposal would also offer cost-sharing subsidies and reduce out-of-pocket spending limits for those under 400 percent of the poverty level.
	America's Healthy Future Act of 2009 – S. 1796	<ul style="list-style-type: none"> • Would provide credits for premium costs and other health care expenses to people who buy insurance through the exchanges. Only citizens or legal immigrants can buy insurance through the exchanges. • Beginning in 2013, households with incomes between 134 and 300 percent of the federal poverty level (\$29, 547 to \$66,150 for a family of four) would be eligible, with those at the lower end receiving more. • Starting in 2014, households with incomes between 100 and 133 percent of the poverty level (\$22,050 to \$29,327 for a family of four) would be eligible for the credits. • People with incomes between 300 and 400 percent of the poverty level (\$66,150 to \$88,200 for a family of four) would not have to pay more than 12 percent of their income in premiums. • The proposal would also make cost-sharing subsidies available for households with incomes between 100 and 200 percent of the poverty level (\$22,050 to \$44,100 for a family of four) and reduce out-of-pocket spending limits for those under 400 percent of the poverty level



	Affordable Health Choices Act - S. 1679	<ul style="list-style-type: none"> • Would provide credits for premium costs to citizens or legal immigrants who buy insurance through the exchanges. • Households with incomes up to 400 percent of the federal poverty level would be eligible, with those at the lower end receiving more. • People with insurance from employers would be eligible for the credit if the cost of their premium exceeds 12.5 percent of their income.
Key Issue	Sponsor of Version	Comparative Terms
Expanding Medicaid	Affordable Health Care for America Act -- H.R. 3962	<ul style="list-style-type: none"> • Would include all individuals with incomes up to 150 percent of the federal poverty level (\$33,075 for a family of four). The program currently covers millions of low-income older Americans, people with disabilities, pregnant women, children and some parents. Childless adults are generally not eligible. • The federal government would pay all the costs for those who are newly eligible for the first two years and 91 percent of the costs after that. • The legislation would end the Children's Health Insurance Program, which benefits children of the working poor. Children with family incomes up to 150 percent of the poverty level would receive coverage through Medicaid. Families with higher incomes would receive subsidies to buy coverage through the exchange.
	America's Healthy Future Act of 2009 – S. 1796	<ul style="list-style-type: none"> • Would include all individuals with incomes up to 133 percent of the poverty level, starting in 2014. • The federal government would pay most of the new costs — anywhere from 77 percent to 95 percent — with a higher share in poorer states, until 2019. • In “high-need states,” where the percentage of Medicaid enrollment is below the national average and unemployment rates were 12 percent or higher in 2009, the federal government would pay 100 percent of the new costs until 2019. Only four states meet the criteria: Michigan, Nevada, Oregon and Rhode Island. • States would have the option to create a “basic health plan” for people earning between 133 and 200 percent of the poverty level (\$29,327 to \$44,100 for a family of four), who are not eligible for Medicare or Medicaid and who do not receive coverage through an employer. States could develop or expand various existing insurance programs that now typically cover people who qualify for Medicaid; small states could develop joint plans. Qualifying individuals living in states that choose to operate these plans could not receive the proposed federal subsidies through the exchanges. States would receive 85 percent of the money that would have been paid as subsidies to finance the plans.
	Affordable Health Choices Act - S. 1679	<ul style="list-style-type: none"> • Assumes expansion of Medicaid to include individuals with incomes up to 150 percent of the poverty level. The committee does not have authority over Medicare and Medicaid, which are under the Finance Committee's jurisdiction.
Key Issue	Sponsor of Version	Comparative Terms
Scope of Benefits	Affordable Health Care for America	<ul style="list-style-type: none"> • Would require the basic benefits package to cover 70 percent of the health care spending covered by the plan. Consumers would pay the remainder, in deductibles, co-payments and other charges. The plan would cap out-of-pocket health care spending to \$5,000 for an individual and \$10,000 for a family.



	Act -- H.R. 3962	<ul style="list-style-type: none"> • Insurers could choose to cover or not cover abortion as they see fit. But people who receive federal subsidies to buy insurance cannot choose a plan that includes abortion coverage. Federal tax dollars can only be used for abortion as allowed by current law, in case of rape or incest or if the life of a pregnant woman is in danger. • Insurers could not deny coverage because of a person’s pre-existing conditions. Variation in premiums is limited. Maximum difference in premiums based on age is 2 to 1 (for oldest group, compared with young adults). • The legislation would also revoke the exemption from federal antitrust law that health insurance companies have long enjoyed. It would outlaw price-fixing, bid rigging and “market allocations” by companies that sell health insurance or medical malpractice insurance. • Insurance plans covering children and their parents would have to continue “dependent coverage” for children through age 26. Rules and age limits for dependents under employer plans currently vary by state. • Besides the basic plan, the legislation would create three other levels of coverage to be offered through the health insurance exchange, covering up to 95 percent of costs. The Congressional Budget Office says the actuarial value of policies bought in the individual insurance market now averages 55 percent to 60 percent.
	America’s Healthy Future Act of 2009 – S. 1796	<ul style="list-style-type: none"> • Would require the basic benefits package to cover 65 percent of the health care spending covered by the plan. The plan would cap out-of-pocket health care spending to \$5,950 for an individual and \$11,900 for a family. • The basic plan would not be required to provide abortions but insurers could choose to cover or not cover abortion as they see fit. Health plans that chose to cover abortion could use only the premium money and co-payments contributed by beneficiaries to cover the procedure, and not any federal subsidies. Tax dollars could not be used to pay for abortions except in cases of rape or incest or if the life of a pregnant woman was in danger. • Insurers could not deny coverage because of a person’s pre-existing conditions. Variation in premiums is limited. Maximum difference in premiums based on age is 4 to 1. • Besides the basic plan, the legislation would create three other levels of coverage to be offered through the health insurance exchange, covering between 70 percent to 90 percent of costs. The proposal would also offer the option of lower-cost insurance to those 25 and younger, with protection only against the costs of catastrophic illness.
	Affordable Health Choices Act - S. 1679	<ul style="list-style-type: none"> • Would require the basic benefits package to cover 76 percent of the health care spending covered by the plan. The plan would cap out-of-pocket health care spending to \$5,950 for an individual and \$11,900 for a family. • Insurers could not deny coverage because of a person’s pre-existing conditions. Variation in premiums is limited. Maximum difference in premiums based on age is 2 to 1. • Insurance plans covering children and their parents would have to continue “dependent coverage” for children through age 25. Rules and age limits for dependents under employer plans currently vary by state. • Besides the basic plan, the legislation would create two other levels of coverage to be offered through the exchanges, covering 84 percent and 93 percent of the costs of the plans.
Key Issue	Sponsor of Version	Comparative Terms
Estimated Program Costs per CBO	Affordable Health Care for America Act -- H.R.	<ul style="list-style-type: none"> • About \$1.05 trillion, according to the Congressional Budget Office, to provide coverage to 36 million people. The costs would be fully offset by cuts in the growth of Medicare and by new fees and taxes. The bill would reduce projected federal budget deficits by \$104 billion over 10 years. • Earlier versions of the bill in the House included provisions to avert cuts in Medicare fees to doctors, scheduled to occur



	3962	under existing law. Those provisions, which would cost more than \$200 billion over 10 years, were put into a separate bill.
	America's Healthy Future Act of 2009 – S. 1796	<ul style="list-style-type: none"> • About \$829 billion, according to the budget office. The costs would be fully offset by cuts in the growth of Medicare and by new fees and taxes. The bill would reduce projected federal budget deficits by \$81 billion over 10 years. • The government would spend \$11 billion to avert the scheduled cuts in Medicare fees to doctors.
	Affordable Health Choices Act - S. 1679	<ul style="list-style-type: none"> • About \$611 billion, according to an early, incomplete estimate by the budget office. The Finance Committee is expected to propose expansions to Medicaid that would add several hundred billion dollars to the legislation's cost, depending on how it is designed.
Key Issue	Sponsor of Version	Comparative Terms
Estimated Sources of Revenues to Finance Program	Affordable Health Care for America Act -- H.R. 3962	<ul style="list-style-type: none"> • Would raise \$460 billion over 10 years by imposing an income surtax on high-income people — couples with adjusted gross incomes over \$1 million a year and individuals over \$500,000 — at a rate of 5.4 percent. • Would raise about \$100 billion with various other revenue provisions, which include a 2.5 percent excise tax on the medical devices sold for use in the United States, a \$2,500 cap on contributions to health care flexible spending accounts and elimination of the tax deduction for employers who receive federal subsidies for providing retiree prescription drug coverage.
	America's Healthy Future Act of 2009 – S. 1796	<ul style="list-style-type: none"> • Would impose \$13 billion in new annual fees on some sectors of the health care industry. The fees, allocated by market share, would include: \$6.7 billion a year on insurance companies, \$4 billion a year on manufacturers of medical devices and \$2.3 billion a year on drug makers. • Impose an excise tax of 40 percent on insurance companies and insurance administrators for any health insurance plan that is above \$8,000 for individuals and \$21,000 for families, applied to premium amounts over the threshold
	Affordable Health Choices Act - S. 1679	<ul style="list-style-type: none"> • Does not include financing proposals. The health committee does not have authority over taxes, Medicare or Medicaid.
Key Issue	Sponsor of Version	Comparative Terms
Impact on Costs of Care	Affordable Health Care for America Act -- H.R. 3962	<ul style="list-style-type: none"> • Would raise more than \$400 billion over 10 years by trimming Medicare payments to hospitals and most other health care providers. Cut nearly \$200 billion in subsidies for insurers that offer the elderly private plans through Medicare Advantage. (The government pays about 14 percent more for the private plans than it would pay for the same people in traditional Medicare.) Demand better prices from drug makers participating in Medicare and Medicaid. • The Institute of Medicine at the National Academy of Sciences would conduct two studies and recommend changes to the current Medicare reimbursement system. In the first, the institute would analyze geographical disparities in Medicare rates and send recommendations to be implemented by the secretary of health and human services. The other would assess whether to tie Medicare payments to quality of care. Those recommendations would be subject to a vote in Congress.



	America's Healthy Future Act of 2009 – S. 1796	<ul style="list-style-type: none"> • Would reduce Medicare payments to hospitals and most other health care providers. Cut subsidies to private Medicare Advantage plans. • The proposal would link Medicare payments to the quality of care provided, under a new system of “value-based purchasing.”
	Affordable Health Choices Act - - S. 1679	<ul style="list-style-type: none"> • Does not include financing proposals. The health committee does not have authority over taxes, Medicare or Medicaid.
Key Issue	Sponsor of Version	Comparative Terms
Bundled Payments / Accountable Care Organizations	Affordable Health Care for America Act -- H.R. 3962	<ul style="list-style-type: none"> • Post-acute care bundling. Promotes bundled payments that encourage providers to coordinate a patient's care across the entire spectrum, from the doctor's office, to the hospital, through a rehabilitative or nursing facility stay, and back to home. • Accountable Care Organization program. Establishes a new program that allows providers to share in Medicare savings they help create through care coordination and quality improvement initiatives. Ensures that doctors can join with hospitals and others when forming these organizations. • Medical home pilot program. Creates a pilot program to reward providers who agree to provide services necessary to make their practice a “medical home” by ensuring full access to patients and providing for coordinated and comprehensive care.
	America's Healthy Future Act of 2009 – S. 1796	<ul style="list-style-type: none"> • Provides for “accountable care organizations” comprising groups of providers who work together to improve the quality of care they deliver to Medicare beneficiaries and which groups would be able to keep half of the savings they achieve for the Medicare program over a three-year period. • Provides for a Medicaid demonstration project to evaluate the use of bundled payments for acute and post-acute care and/or concurrent physician services in up to eight states.
	Affordable Health Choices Act - - S. 1679	<ul style="list-style-type: none"> • Would not change current law.
Key Issue	Sponsor of Version	Comparative Terms



Health Information Technology	Affordable Health Care for America Act -- H.R. 3962	<ul style="list-style-type: none"> • Study and Report on methods to increase Electronic Health Records (EHR) use by small health care providers. • Integration of physician quality reporting and EHR reporting. • Implementation of best practices through new Center for Quality Improvement, including demonstration of meaningful use of certified EHRs.
	America's Healthy Future Act of 2009 – S. 1796	<ul style="list-style-type: none"> • Healthcare consumer operated and oriented plans (“CO-OPs”) would be permitted to enter into group purchasing arrangements for health information technology. • Would extend HHS Secretary’s grant-making authority to long-term care facilities to promote adoption and qualified use of certified EHRs. • Would provide for integration of physician quality reporting and EHR meaningful use reporting. • Would expand Medicare EHR stimulus funding to cover physicians working in “free clinics”.
	Affordable Health Choices Act - - S. 1679	<ul style="list-style-type: none"> • Would provide for grants to states and instrumentalities to support development of interoperable and secure standards and protocols that facilitate enrollment of individuals in federal and state health and human services programs. • Would provide for grants to “qualified entities” to support the collection, aggregation and analysis of data for quality and resource use measures. • Would provide for grants to eligible quality data entities to support the development of nationally consistent methods for quality measurement and reporting. • Would provide for grants and contracts for analysis of “federal health care data.”
Key Issue	Sponsor of Version	Comparative Terms
Comparative Effectiveness Research	Affordable Health Care for America Act -- H.R. 3962	<ul style="list-style-type: none"> • Would creates a new Center at the Agency for Healthcare Research and Quality, supported by a combination of public and private funding that will conduct, support and synthesize CER. An independent stakeholder Commission makes recommendations to the Center on research priorities, study methods, and ways to disseminate research. The Commission has its own source of funding and is responsible for evaluating the processes of the Center and is authorized to make reports directly to Congress. A majority of the Commission members would be required to be physicians, other health care practitioners, consumers or patients.
	America's Healthy Future Act of 2009 – S. 1796	<ul style="list-style-type: none"> • Would create a nonprofit institute to set a research agenda and provide for the conduct of comparative effectiveness research, per the Patient-Centered Outcomes Research Act of 2009. The institute would be governed by a multi-stakeholder board that is appointed by the Comptroller General. Once fully implemented, the 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. This proposal would also include patient safeguards and provisions to prohibit the Secretary from using the research to ration care through any federal program. • Would simplify the administration of health care by accelerating the development, adoption and implementation of standard, consensus-based operating rules for four HIPAA transactions: eligibility verification, claims status, payment/electronic funds transfer, and remittance advice. The Secretary would be permitted to use interim final rule making to adopt operating standards if they are deemed consensus-based by the National Committee for Vital and Health Statistics (“NCVHS”). Health



		insurance plans would be required to comply with consensus operating standards by 2014 or face a penalty. Finally, the proposal would create a process for periodic review and updates to all HIPAA standards.
	Affordable Health Choices Act - S. 1679	<ul style="list-style-type: none"> • Would require establishment of national priorities for quality improvement in health care, taking into account outcomes measures, comparative effectiveness information and data aggregation techniques. • Would establish an Health and Human Services (HHS) Center for Health Outcomes Research and Evaluation to coordinate, conduct, support, and synthesize research relevant to the comparative health outcomes and effectiveness of the full spectrum of health care treatments, including pharmaceuticals, medical devices, medical and surgical procedures, screening and diagnostics, behavioral health care, oral health, and other health interventions.
Key Issue	Sponsor of Version	Comparative Terms
Hospital Requirements Re: Tax-Exemption	Affordable Health Care for America Act -- H.R. 3962	<ul style="list-style-type: none"> • Would not change current law.
	America's Healthy Future Act of 2009 – S. 1796	<ul style="list-style-type: none"> • Would add an IRC § 501(c)(r) to establish new requirements applicable to IRC § 501(c)(3) hospitals. The requirements would include: a periodic community needs assessment; a qualified financial assistance policy; new limitations of “charges,” and billing and collections policies. • Would provide for the imposition of excise taxes on hospitals failing to meet the requirements of IRC § 501(c)(r). • Would require the review, at least once every three years, of hospital compliance with IRC § 501(c)(r). • Would require annual reports by the Treasury Secretary of levels of charity care and related statistics.
	Affordable Health Choices Act - S. 1679	<ul style="list-style-type: none"> • Would not change current law.
Key Issue	Sponsor of Version	Comparative Terms
Patient-Centered Medical Homes	Affordable Health Care for America Act -- H.R. 3962	<ul style="list-style-type: none"> • Would create a pilot program to reward providers who agree to provide services necessary to make their practice a “medical home” by ensuring full access to patients and providing for coordinated and comprehensive care. • Medicaid. Would establish a five-year pilot program to evaluate medical home models for beneficiaries including medically fragile children. A total of \$1.235 billion would be made available for increased federal matching for administrative costs.
	America's Healthy Future Act of 2009 – S.	<ul style="list-style-type: none"> • Would create a new Medicaid state plan option under which Medicaid beneficiaries with chronic conditions could designate a provider as their medical home. Qualifying providers would have to demonstrate that they have the systems and infrastructure in place to provide comprehensive and timely high-quality care either in-house or by contracting with a team of health professionals. Designated providers would be required to report to the state on all applicable quality measures in the



	1796	state Medicaid program
	Affordable Health Choices Act - - S. 1679	<ul style="list-style-type: none">• Would establish a program to provide grants to eligible entities to establish community-based interdisciplinary, inter-professional teams (referred to in this section as “health teams”) to support primary care practices, including obstetrics and gynecology practices, within the hospital service areas served by the eligible entities.