	White House/Congressional Leadership Reconciliation Bill Health Care and Education Affordability Act of 2010 (H.R. 4872)	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
COST CONTAINMENT			
Administrative simplification	• Simplify health insurance administration by adopting a single set of operating rules for eligibility verification and claims status (rules adopted July 1, 2011; effective January 1, 2013), electronic funds transfers and health care payment and remittance (rules adopted July 1, 2012; effective January 1, 2014), and health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization (rules adopted July 1, 2014; effective January 1, 2016). Health plans must document compliance with these standards or face a penalty of no more than $1 per covered life. (Effective April 1, 2014)	• Simplify health insurance administration by adopting a single set of operating rules for eligibility verification and claims status (rules adopted July 1, 2011; effective January 1, 2013), electronic funds transfers and health care payment and remittance (rules adopted July 1, 2012; effective January 1, 2014), and health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization (rules adopted July 1, 2014; effective January 1, 2016). Health plans must document compliance with these standards or face a penalty of no more than $1 per covered life. (Effective April 1, 2014)	• Simplify health insurance administration by adopting standards for financial and administrative transactions, including timely and transparent claims and denial management processes and use of standard electronic transactions. (Effective upon enactment)
Medicare	• *Restructure payments to Medicare Advantage (MA) plans by setting payments to different percentages of Medicare fee-for-service (FFS) rates, with higher payments for areas with low FFS rates and lower payments (95% of FFS) for areas with high FFS rates. Revised payments phased in over 3 years beginning in 2011, for plans in most areas, with payments phased-in over longer periods (4 years and 6 years) for plans in other areas. Provide bonuses to plans receiving 4 or more stars, based on the current 5-star quality rating system for Medicare Advantage plans, beginning in 2012; qualifying plans in qualifying areas receive double bonuses. Modify rebate system with rebates allocated based on a plan's quality rating. Achieve additional savings by further adjusting payments to plans for coding practices related to the health status of enrollees. Cap total payments, including bonuses, at current payment levels. Require Medicare Advantage plans to remit partial payments to the Secretary if the plan has a medical loss ratio*	• Restructure payments to Medicare Advantage (MA) plans (except PACE plans) to base payments on the average of plan bids in each market, phased in over four years beginning in 2012, with bonus payments for quality, performance improvement, and care coordination beginning in 2014. Change plan service areas beginning in 2012. Grandfather the extra benefits in MA plans in areas where plan bids are at or below 75% of traditional fee-for-service Medicare (with requirement that these plans participate in a new competitive bidding process). Provide transitional extra benefits for MA beneficiaries in certain areas if they experience a significant reduction in extra benefits under competitive bidding, authorizing up to $5 billion for the period between 2012 and 2019 for rebates associated with extra benefits. • Reduce annual market basket updates for inpatient hospital, home health, skilled nursing facility, hospice and other Medicare providers, and adjust for productivity. (Effective dates vary)	• Restructure payments to Medicare Advantage plans (except for PACE plans), phasing down to equal 100% of fee-for-services payments by 2013, with bonus payments for higher-quality and improved-quality plans in qualifying counties. (Effective FY 2011). • Reduce market basket updates in Medicare payment rates for providers and incorporate adjustment for expected productivity gains. (Effective dates vary) • Reduce Medicare Disproportionate Share Hospital (DSH) payments to account for reductions in the national rate of uninsurance as a result of the Act, based on recommendation by the Secretary. (Medicare DSH reductions effective 2017) • Conduct Medicare and Medicaid pilot programs to test payment incentive models for accountable care organizations and to assess the feasibility of reimbursing qualified patient-centered medical homes. Adopt these models on a large scale if pilot programs prove successful at reducing costs.

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COST CONTAINMENT (continued)			
Medicare (continued)	*of less than 85%, beginning 2014. Require the Secretary to suspend plan enrollment for 3 years if the medical loss ratio is less than 85% for 2 consecutive years and to terminate the plan contract if the medical loss ratio is less than 85% for 5 consecutive years. (Effective 2011)* • *Reduce annual market basket updates for inpatient hospital, home health, skilled nursing facility, hospice and other Medicare providers, and adjust for productivity. (Effective dates vary)* • Freeze the threshold for income-related Medicare Part B premiums for 2011 through 2019, and reduce the Medicare Part D premium subsidy for those with incomes above $85,000/individual and $170,000/couple. (Effective January 1, 2011) • Establish an Independent Payment Advisory Board comprised of 15 members to submit legislative proposals containing recommendations to reduce the per capita rate of growth in Medicare spending if spending exceeds a target growth rate. Beginning April 2013, require the Chief Actuary of CMS to project whether Medicare per capita spending exceeds the average of CPI-U and CPI-M, based on a five year period ending that year. If so, beginning January 15, 2014, the Board will submit recommendations to achieve reductions in Medicare spending. Beginning January 2018, the target is modified such that the board submits recommendations if Medicare per capita spending exceeds GDP per capita plus one percent. The Board will submit proposals to the President and Congress for immediate consideration. The Board is prohibited from submitting proposals that would ration care, increase revenues or change benefits,	• Freeze the threshold for income-related Medicare Part B premiums for 2011 through 2019, and reduce the Medicare Part D premium subsidy for those with incomes above $85,000/individual and $170,000/couple. (Effective January 1, 2011) • Establish an Independent Payment Advisory Board comprised of 15 members to submit legislative proposals containing recommendations to reduce the per capita rate of growth in Medicare spending if spending exceeds a target growth rate. Beginning April 2013, require the Chief Actuary of CMS to project whether Medicare per capita spending exceeds the average of CPI-U and CPI-M, based on a five year period ending that year. If so, beginning January 15, 2014, the Board will submit recommendations to achieve reductions in Medicare spending. Beginning January 2018, the target is modified such that the board submits recommendations if Medicare per capita spending exceeds GDP per capita plus one percent. The Board will submit proposals to the President and Congress for immediate consideration. The Board is prohibited from submitting proposals that would ration care, increase revenues or change benefits, eligibility or Medicare beneficiary cost sharing (including Parts A and B premiums), or would result in a change in the beneficiary premium percentage or low-income subsidies under Part D. Hospitals and hospices (through 2019) and clinical labs (for one year) will not be subject to cost reductions proposed by the Board. The Board must also submit recommendations every other year to slow the growth in national health expenditures while preserving quality of care by January 1, 2015. • Reduce Medicare Disproportionate Share Hospital (DSH) payments initially by 75% and	(Implementation of medical home pilots upon enactment; implementation of accountable care organization pilots by January 1, 2012) • Establish the Center for Medicare and Medicaid Innovation to test payment and service delivery models to improve quality and efficiency. Evaluate all models and expand those models that improve quality without increasing spending or reduce spending without reducing quality, or both. (Effective January 1, 2011) • Reduce Medicare payments for potentially preventable hospital readmissions. (Effective October 1, 2011) • Require the Institute of Medicine to conduct studies on geographic variation in Medicare spending and in health care spending across all providers and recommend strategies for addressing these variations by promoting high-value care; require the Secretary to develop an implementation plan and issue regulations to implement the Medicare payment changes unless Congress acts to stop implementation. (Report due one year following enactment; final implementation plan due 240 days following receipt of report; regulations issued by May 31, 2012) • Require the Secretary to negotiate drug prices directly with pharmaceutical manufacturers for Medicare Part D plans. (Effective upon enactment; applies to drug prices beginning on January 1, 2011)

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COST CONTAINMENT (continued)			
Medicare (continued)	eligibility or Medicare beneficiary cost sharing (including Parts A and B premiums), or would result in a change in the beneficiary premium percentage or low-income subsidies under Part D. Hospitals and hospices (through 2019) and clinical labs (for one year) will not be subject to cost reductions proposed by the Board. The Board must also submit recommendations every other year to slow the growth in national health expenditures while preserving quality of care by January 1, 2015. • *Reduce Medicare Disproportionate Share Hospital (DSH) payments initially by 75% and subsequently increase payments based on the percent of the population uninsured and the amount of uncompensated care provided (Effective fiscal year 2014)* • Eliminate the Medicare Improvement Fund. (Effective upon enactment) • Allow providers organized as accountable care organizations (ACOs) that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program. To qualify as an ACO, organizations must agree to be accountable for the overall care of their Medicare beneficiaries, have adequate participation of primary care physicians, define processes to promote evidence-based medicine, report on quality and costs, and coordinate care. (Shared savings program established January 1, 2012) • Create an Innovation Center within the Centers for Medicare and Medicaid Services to test, evaluate, and expand in Medicare, Medicaid, and CHIP different payment structures and methodologies to reduce program expenditures while maintaining or improving quality of care. Payment reform models that improve quality and reduce the rate of cost growth could be expanded throughout the Medicare, Medicaid, and CHIP programs. (Effective January 1, 2011)	subsequently increase payments based on the percent of the population uninsured and the amount of uncompensated care provided. (Effective fiscal year 2015) • Eliminate the Medicare Improvement Fund. (Effective upon enactment) • Allow providers organized as accountable care organizations (ACOs) that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program. To qualify as an ACO, organizations must agree to be accountable for the overall care of their Medicare beneficiaries, have adequate participation of primary care physicians, define processes to promote evidence-based medicine, report on quality and costs, and coordinate care. (Shared savings program established January 1, 2012) • Create an Innovation Center within the Centers for Medicare and Medicaid Services to test, evaluate, and expand in Medicare, Medicaid, and CHIP different payment structures and methodologies to reduce program expenditures while maintaining or improving quality of care. Payment reform models that improve quality and reduce the rate of cost growth could be expanded throughout the Medicare, Medicaid, and CHIP programs. (Effective January 1, 2011) • Reduce Medicare payments that would otherwise be made to hospitals by specified percentages to account for excess (preventable) hospital readmissions. (Effective October 1, 2012) • Reduce Medicare payments to certain hospitals for hospital-acquired conditions by 1%. (Effective fiscal year 2015)	

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COST CONTAINMENT (continued)			
Medicare (continued)	• Reduce Medicare payments that would otherwise be made to hospitals by specified percentages to account for excess (preventable) hospital readmissions. (Effective October 1, 2012) • Reduce Medicare payments to certain hospitals for hospital-acquired conditions by 1%. (Effective fiscal year 2015)		
Medicaid	• *Increase the Medicaid drug rebate percentage for brand name drugs to 23.1 (except the rebate for clotting factors and drugs approved exclusively for pediatric use increases to 17.1%); increase the Medicaid rebate for non-innovator, multiple source drugs to 13% of average manufacturer price; and extend the drug rebate to Medicaid managed care plans. (Effective January 1, 2010)* • *Reduce aggregate Medicaid DSH allotments by $.5 billion in 2014, $.6 billion in 2015, $.6 billion in 2016, $1.8 billion in 2017, $5 billion in 2018, $5.6 billion in 2019, and $4 billion in 2020. Require the Secretary to develop a methodology to distribute the DSH reductions in a manner that imposes the largest reduction in DSH allotments for states with the lowest percentage of uninsured or those that do not target DSH payments, imposes smaller reductions for low-DSH states, and accounts for DSH allotments used for 1115 waivers. (Effective October 1, 2011)* • Prohibit federal payments to states for Medicaid services related to health care acquired conditions. (Effective July 1, 2011)	• Increase the Medicaid drug rebate percentage for brand name drugs to 23.1 (except the rebate for clotting factors and drugs approved exclusively for pediatric use increases to 17.1%); increase the Medicaid rebate for non-innovator, multiple source drugs to 13% of average manufacturer price; and extend the drug rebate to Medicaid managed care plans. (Effective January 1, 2010) • Reduce a state's Medicaid DSH allotment by 50% or 25% for low DSH states (and by lesser percentages for states meeting certain criteria) once the state's uninsured rate decreases by at least 45%. DSH allotments will be further reduced, not to fall below 50% of the total allotment in 2012 if states' uninsured rates continue to decrease. Exempt any portion of the DSH allotment used to expand Medicaid eligibility through a section 1115 waiver. (Effective October 1, 2011) • Prohibit federal payments to states for Medicaid services related to health care acquired conditions. (Effective July 1, 2011)	• Increase the Medicaid drug rebate percentage to 23.1% and extend the prescription drug rebate to Medicaid managed care plans. (Effective January 1, 2010) • Reduce Medicaid DSH allotments by a total of $10 billion ($1.5 billion in 2017; $2.5 billion in 2018; and $6 billion in 2019), imposing the largest percentage reductions in state DSH allotments in states with the lowest uninsured rates and those that do not target DSH payments. • Prohibit federal payments to states for Medicaid services related to health care acquired conditions. (Effective January 1, 2010) • Authorize the Food and Drug Administration to approve generic versions of biologic drugs and grant biologics manufacturers 12 years of exclusive use before generics can be developed. (Effective upon enactment) • Require hospitals and ambulatory surgical centers to report on health care-associated infections to the Centers for Disease Control and Prevention (effective one year following enactment) and refuse Medicaid payments for certain health care-associated conditions. (Effective January 1, 2010)
Prescription drugs	• Authorize the Food and Drug Administration to approve generic versions of biologic drugs and grant biologics manufacturers 12 years of exclusive use before generics can be developed. (Effective upon enactment)	• Authorize the Food and Drug Administration to approve generic versions of biologic drugs and grant biologics manufacturers 12 years of exclusive use before generics can be developed. (Effective upon enactment)	• Enhance competition in the pharmaceutical market by stopping agreements between brand name and generic drug manufacturers that limit, delay, or otherwise prevent competition from generic drugs. (Effective upon enactment)

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COST CONTAINMENT (continued)			
Waste, fraud, and abuse	• *Reduce waste, fraud, and abuse in public programs by allowing provider screening, enhanced oversight periods for new providers and suppliers, including a 90-day period of enhanced oversight for initial claims of DME suppliers, and enrollment moratoria in areas identified as being at elevated risk of fraud in all public programs, and by requiring Medicare and Medicaid program providers and suppliers to establish compliance programs. Develop a database to capture and share data across federal and state programs, increase penalties for submitting false claims, use tax data to identify fraudulent providers; strengthen standards for community mental health centers; and increase funding for anti-fraud activities. (Effective dates vary)*	• Reduce waste, fraud, and abuse in public programs by allowing provider screening, enhanced oversight periods for new providers and suppliers, and enrollment moratoria in areas identified as being at elevated risk of fraud in all public programs, and by requiring Medicare and Medicaid program providers and suppliers to establish compliance programs. Develop a database to capture and share data across federal and state programs, increase penalties for submitting false claims, and increase funding for anti-fraud activities. (Effective dates vary)	• Reduce waste, fraud, and abuse in public programs by allowing provider screening, enhanced oversight periods, and enrollment moratoria in areas identified as being at elevated risk of fraud in all public programs, and by requiring Medicare and Medicaid program providers and suppliers to establish compliance programs. (Effective dates vary)
IMPROVING QUALITY/HEALTH SYSTEM PERFORMANCE			
Comparative effectiveness research	• Support comparative effectiveness research by establishing a non-profit Patient-Centered Outcomes Research Institute to identify research priorities and conduct research that compares the clinical effectiveness of medical treatments. The Institute will be overseen by an appointed multi-stakeholder Board of Governors and will be assisted by expert advisory panels. Findings from comparative effectiveness research may not be construed as mandates, guidelines, or recommendations for payment, coverage, or treatment or used to deny coverage. (Funding available beginning fiscal year 2010) Terminate the Federal Coordinating Council for Comparative Effectiveness Research that was founded under the American Recovery and Reinvestment Act. (Effective upon enactment)	• Support comparative effectiveness research by establishing a non-profit Patient-Centered Outcomes Research Institute to identify research priorities and conduct research that compares the clinical effectiveness of medical treatments. The Institute will be overseen by an appointed multi-stakeholder Board of Governors and will be assisted by expert advisory panels. Findings from comparative effectiveness research may not be construed as mandates, guidelines, or recommendations for payment, coverage, or treatment or used to deny coverage. (Funding available beginning fiscal year 2010) Terminate the Federal Coordinating Council for Comparative Effectiveness Research that was founded under the American Recovery and Reinvestment Act. (Effective upon enactment)	• Support comparative effectiveness research by establishing a Center for Comparative Effectiveness Research within the Agency for Healthcare Research and Quality to conduct, support, and synthesize research on outcomes, effectiveness, and appropriateness of health care services and procedures. An independent CER Commission will oversee the activities of the Center. Provides that comparative effectiveness research findings may not be construed as mandates for payment, coverage, or treatment or used to deny or ration care. Establish the Comparative Effectiveness Research Trust Fund. (Effective FY 2010)

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IMPROVING QUALITY/HEALTH SYSTEM PERFORMANCE (continued)			
Medical malpractice	• Award five-year demonstration grants to states to develop, implement, and evaluate alternatives to current tort litigations. Preference will be given to states that have developed alternatives in consultation with relevant stakeholders and that have proposals that are likely to enhance patient safety by reducing medical errors and adverse events and are likely to improve access to liability insurance. (Funding appropriated for five years beginning in fiscal year 2011)	• Award five-year demonstration grants to states to develop, implement, and evaluate alternatives to current tort litigations. Preference will be given to states that have developed alternatives in consultation with relevant stakeholders and that have proposals that are likely to enhance patient safety by reducing medical errors and adverse events and are likely to improve access to liability insurance. (Funding appropriated for five years beginning in fiscal year 2011)	• Provide incentive payments to states that enact alternative medical liability laws that make the medical liability system more reliable through the prevention of or prompt and fair resolution of disputes, encourage the disclosure of health care errors, and maintain access to affordable liability insurance. (Effective upon enactment)
Medicare	• Establish a national Medicare pilot program to develop and evaluate paying a bundled payment for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care that begins three days prior to a hospitalization and spans 30 days following discharge. If the pilot program achieves stated goals of improving or not reducing quality and reducing spending, develop a plan for expanding the pilot program. (Establish pilot program by January 1, 2013; expand program, if appropriate, by January 1, 2016) • Create the Independence at Home demonstration program to provide high-need Medicare beneficiaries with primary care services in their home and allow participating teams of health professionals to share in any savings if they reduce preventable hospitalizations, prevent hospital readmissions, improve health outcomes, improve the efficiency of care, reduce the cost of health care services, and achieve patient satisfaction. (Effective January 1, 2012)	• Establish a national Medicare pilot program to develop and evaluate paying a bundled payment for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care that begins three days prior to a hospitalization and spans 30 days following discharge. If the pilot program achieves stated goals of improving or not reducing quality and reducing spending, develop a plan for expanding the pilot program. (Establish pilot program by January 1, 2013; expand program, if appropriate, by January 1, 2016) • Create the Independence at Home demonstration program to provide high-need Medicare beneficiaries with primary care services in their home and allow participating teams of health professionals to share in any savings if they reduce preventable hospitalizations, prevent hospital readmissions, improve health outcomes, improve the efficiency of care, reduce the cost of health care services, and achieve patient satisfaction. (Effective January 1, 2012)	• Require the Secretary to develop a plan to reform Medicare payments for post-acute services, including bundled payments, to improve the coordination, quality and efficiency of such services and improve outcomes. (Effective January 1, 2011) • Create the Independence at Home demonstration program to provide high-need Medicare beneficiaries with primary care services in their home and allow participating teams of health professionals to share in any savings if they reduce preventable hospitalizations, prevent hospital readmissions, improve health outcomes, improve the efficiency of care, reduce the cost of health care services, and achieve patient satisfaction. (Effective January 1, 2012) • Require the Institute of Medicine to conduct a study on geographic adjustment factors in Medicare and require the Secretary to issue regulations to revise the geographic adjustment factors based on the recommendations. (Report due one year following enactment; proposed regulations issued following submission of report)

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IMPROVING QUALITY/HEALTH SYSTEM PERFORMANCE (continued)			
Medicare (continued)	• Establish a hospital value-based purchasing program in Medicare to pay hospitals based on performance on quality measures and extend the Medicare physician quality reporting initiative beyond 2010. (Effective October 1, 2012) Develop plans to implement value-based purchasing programs for skilled nursing facilities, home health agencies, and ambulatory surgical centers. (Reports to Congress due January 1, 2011)	• Establish a hospital value-based purchasing program in Medicare to pay hospitals based on performance on quality measures and extend the Medicare physician quality reporting initiative beyond 2010. (Effective October 1, 2012) Develop plans to implement value-based purchasing programs for skilled nursing facilities, home health agencies, and ambulatory surgical centers. (Reports to Congress due January 1, 2011)	
Dual eligibles	• Improve care coordination for dual eligibles by creating a new office within the Centers for Medicare and Medicaid services, the Federal Coordinated Health Care Office, to more effectively integrate Medicare and Medicaid benefits and improve coordination between the federal government and states in order to improve access to and quality of care and services for dual eligibles. (Effective March 1, 2010)	• Improve care coordination for dual eligibles by creating a new office within the Centers for Medicare and Medicaid services, the Federal Coordinated Health Care Office, to more effectively integrate Medicare and Medicaid benefits and improve coordination between the federal government and states in order to improve access to and quality of care and services for dual eligibles. (Effective March 1, 2010)	• Require the Secretary to improve coordination of care for dual eligibles through a new office or program within the Centers for Medicare and Medicaid Services. (Report of activities due within one year of enactment)
Medicaid	• Create a new Medicaid state plan option to permit Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a health home. Provide states taking up the option with 90% FMAP for two years. (Effective January 1, 2011) • Create new demonstration projects in Medicaid to pay bundled payments for episodes of care that include hospitalizations (effective January 1, 2012 through December 31, 2016); to make global capitated payments to safety net hospital systems (effective fiscal years 2010 through 2012); to allow pediatric medical providers organized as accountable care organizations to share in cost-savings (effective January 1, 2012 through December 31, 2016); and to provide Medicaid payments to institutions	• Create a new Medicaid state plan option to permit Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a health home. Provide states taking up the option with 90% FMAP for two years. (Effective January 1, 2011) • Create new demonstration projects in Medicaid to pay bundled payments for episodes of care that include hospitalizations (effective January 1, 2012 through December 31, 2016); to make global capitated payments to safety net hospital systems (effective fiscal years 2010 through 2012); to allow pediatric medical providers organized as accountable care organizations to share in cost-savings (effective January 1, 2012 through December 31, 2016); and to provide Medicaid payments to institutions	• Expand the role of the Medicaid and CHIP Payment and Access Commission (MACPAC) to include all individuals and require MACPAC to report to Congress on nursing facility payment policies by January 1, 2012 and pediatric sub-specialist payment policies by January 1, 2011. Require reports on the implementation of health reform that relate to Medicaid and CHIP, including the effect of implementation on access. ($11.8 million in additional funds appropriated beginning January 1, 2010)

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IMPROVING QUALITY/HEALTH SYSTEM PERFORMANCE (continued)			
Medicaid (continued)	of mental disease for adult enrollees who require stabilization of an emergency condition (effective October 1, 2011 through December 31, 2015). • Expand the role of the Medicaid and CHIP Payment and Access Commission to include assessments of adult services (including those dually eligible for Medicare and Medicaid). ($11 million in additional funds appropriated for fiscal year 2010)	of mental disease for adult enrollees who require stabilization of an emergency condition (effective October 1, 2011 through December 31, 2015). • Expand the role of the Medicaid and CHIP Payment and Access Commission to include assessments of adult services (including those dually eligible for Medicare and Medicaid). ($11 million in additional funds appropriated for fiscal year 2010)	
Primary care	No similar provision.	No similar provision.	• Strengthen primary care and care coordination by increasing Medicaid payments for primary care providers to 100% of Medicare rates (phased-in beginning in 2010 through 2012) and providing Medicare bonus payments to primary care practitioners (with larger bonuses paid to primary care practitioners serving in health professional shortage areas) beginning January 1, 2011.
National quality strategy	• Develop a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health. Create processes for the development of quality measures involving input from multiple stakeholders and for selecting quality measures to be used in reporting to and payment under federal health programs. (National strategy due to Congress by January 1, 2011) • Establish the Community-based Collaborative Care Network Program to support consortiums of health care providers to coordinate and integrate health care services, for low-income uninsured and underinsured populations. (Funds appropriated for five years beginning in FY 2011)	• Develop a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health. Create processes for the development of quality measures involving input from multiple stakeholders and for selecting quality measures to be used in reporting to and payment under federal health programs. (National strategy due to Congress by January 1, 2011) • Establish the Community-based Collaborative Care Network Program to support consortiums of health care providers to coordinate and integrate health care services, for low-income uninsured and underinsured populations. (Funds appropriated for five years beginning in FY 2011)	• Establish the Center for Quality Improvement to identify, develop, evaluate, disseminate, and implement best practices in the delivery of health care services. Develop national priorities for performance improvement and quality measures for the delivery of health care services. (Effective dates vary) • Establish the Community-based Collaborative Care Network Program to support consortiums of health care providers to coordinate and integrate health care services, manage chronic conditions, and reduce emergency department use for low-income uninsured and underinsured populations. (Funds appropriated for five years beginning FY 2011)

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IMPROVING QUALITY/HEALTH SYSTEM PERFORMANCE (continued)			
Financial disclosure	• Require disclosure of financial relationships between health entities, including physicians, hospitals, pharmacists, other providers, and manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies. (Report due to Congress April 1, 2013)	• Require disclosure of financial relationships between health entities, including physicians, hospitals, pharmacists, other providers, and manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies. (Report due to Congress April 1, 2013)	• Require disclosure of financial relationships between health entities, including physicians, hospitals, pharmacists, and other providers, and manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies. (Effective March 2011)
Disparities	• Require enhanced collection and reporting of data on race, ethnicity, sex, primary language, disability status, and for underserved rural and frontier populations. Also require collection of access and treatment data for people with disabilities. Require the Secretary to analyze the data to monitor trends in disparities. (Effective two years following enactment)	• Require enhanced collection and reporting of data on race, ethnicity, sex, primary language, disability status, and for underserved rural and frontier populations. Also require collection of access and treatment data for people with disabilities. Require the Secretary to analyze the data to monitor trends in disparities. (Effective two years following enactment)	• Reduce racial and ethnic disparities by conducting a study on the feasibility of developing Medicare payment systems for language services, providing Medicare demonstration grants to reimburse culturally and linguistically appropriate services and developing standards for the collection of data on race, ethnicity, and primary language. (Report due to Congress one year following enactment)
PREVENTION/WELLNESS			
National strategy	• Establish the National Prevention, Health Promotion and Public Health Council to coordinate federal prevention, wellness, and public health activities. Develop a national strategy to improve the nation's health. (Strategy due one year following enactment) Create a Prevention and Public Health Fund to expand and sustain funding for prevention and public health programs. (Initial appropriation in fiscal year 2010) Create task forces on Preventive Services and Community Preventive Services to develop, update, and disseminate evidenced-based recommendations on the use of clinical and community prevention services. (Effective upon enactment) • Establish a grant program to support the delivery of evidence-based and community-based prevention and wellness services aimed at strengthening prevention activities, reducing chronic disease rates and addressing health disparities, especially in rural and frontier areas. (Funds appropriated for five years beginning in FY 2010)	• Establish the National Prevention, Health Promotion and Public Health Council to coordinate federal prevention, wellness, and public health activities. Develop a national strategy to improve the nation's health. (Strategy due one year following enactment) Create a Prevention and Public Health Fund to expand and sustain funding for prevention and public health programs. (Initial appropriation in fiscal year 2010) Create task forces on Preventive Services and Community Preventive Services to develop, update, and disseminate evidenced-based recommendations on the use of clinical and community prevention services. (Effective upon enactment) • Establish a grant program to support the delivery of evidence-based and community-based prevention and wellness services aimed at strengthening prevention activities, reducing chronic disease rates and addressing health disparities, especially in rural and frontier areas. (Funds appropriated for five years beginning in FY 2010)	• Develop a national strategy to improve the nation's health through evidenced-based clinical and community-based prevention and wellness activities. Create task forces on Clinical Preventive Services and Community Preventive Services to develop, update, and disseminate evidenced-based recommendations on the use of clinical and community prevention services. • Establish a grant program to support the delivery of evidence-based and community-based prevention and wellness services aimed at reducing health disparities. Train community health workers to promote positive health behaviors in medically underserved communities. Provide grants to plan and implement programs to prevent obesity among children and their families. (Funds appropriated for five years beginning FY 2011)

	White House/Congressional Leadership Reconciliation Bill Health Care and Education Affordability Act of 2010 (H.R. 4872)	Senate Bill Patient Protection and Affordable Care Act (H.R. 3590)	House Bill Affordable Health Care for America Act (H.R. 3962)
PREVENTION/WELLNESS (continued)			
Coverage of preventive services	• Improve prevention by covering only proven preventive services and eliminating cost-sharing for preventive services in Medicare and Medicaid. (Effective January 1, 2011) For states that provide Medicaid coverage for and remove cost-sharing for preventive services recommended by the US Preventive Services Task Force and recommended immunizations, provide a one percentage point increase in the FMAP for these services. Increase Medicare payments for certain preventive services to 100% of actual charges or fee schedule rates. (Effective January 1, 2011) • Provide Medicare beneficiaries access to a comprehensive health risk assessment and creation of a personalized prevention plan. (Health risk assessment model developed within 18 months following enactment) Provide incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs. (Effective January 1, 2011 or when program criteria is developed, whichever is first) Require Medicaid coverage for tobacco cessation services for pregnant women. (Effective October 1, 2010) • Require qualified health plans to provide at a minimum coverage without cost-sharing for preventive services rated A or B by the U.S. Preventive Services Task Force, recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women. (Effective six months following enactment)	• Improve prevention by covering only proven preventive services and eliminating cost-sharing for preventive services in Medicare and Medicaid. (Effective January 1, 2011) For states that provide Medicaid coverage for and remove cost-sharing for preventive services recommended by the US Preventive Services Task Force and recommended immunizations, provide a one percentage point increase in the FMAP for these services. Increase Medicare payments for certain preventive services to 100% of actual charges or fee schedule rates. (Effective January 1, 2011) • Provide Medicare beneficiaries access to a comprehensive health risk assessment and creation of a personalized prevention plan. (Health risk assessment model developed within 18 months following enactment) Provide incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs. (Effective January 1, 2011 or when program criteria is developed, whichever is first) Require Medicaid coverage for tobacco cessation services for pregnant women. (Effective October 1, 2010) • Require qualified health plans to provide at a minimum coverage without cost-sharing for preventive services rated A or B by the U.S. Preventive Services Task Force, recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women. (Effective six months following enactment)	• Improve prevention by covering only proven preventive services and eliminating cost-sharing for preventive services in Medicare and Medicaid. (Effective July 1, 2010) Increase Medicare payments for certain preventive services to 100% of actual charges or fee schedule rates. (Effective January 1, 2011)

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PREVENTION/WELLNESS (continued)			
Wellness programs	• Provide grants for up to five years to small employers that establish wellness programs. (Funds appropriated for five years beginning in fiscal year 2011) • Provide technical assistance and other resources to evaluate employer-based wellness programs. Conduct a national worksite health policies and programs survey to assess employer-based health policies and programs. (Conduct study within two years following enactment) • Permit employers to offer employees rewards—in the form of premium discounts, waivers of cost-sharing requirements, or benefits that would otherwise not be provided—of up to 30% of the cost of coverage for participating in a wellness program and meeting certain health-related standards. Employers must offer an alternative standard for individuals for whom it is unreasonably difficult or inadvisable to meet the standard. The reward limit may be increased to 50% of the cost of coverage if deemed appropriate. (Effective January 1, 2014) Establish 10-state pilot programs by July 2014 to permit participating states to apply similar rewards for participating in wellness programs in the individual market and expand demonstrations in 2017 if effective. Require a report on the effectiveness and impact of wellness programs. (Report due three years following enactment)	• Provide grants for up to five years to small employers that establish wellness programs. (Funds appropriated for five years beginning in fiscal year 2011) • Provide technical assistance and other resources to evaluate employer-based wellness programs. Conduct a national worksite health policies and programs survey to assess employer-based health policies and programs. (Conduct study within two years following enactment) • Permit employers to offer employees rewards—in the form of premium discounts, waivers of cost-sharing requirements, or benefits that would otherwise not be provided—of up to 30% of the cost of coverage for participating in a wellness program and meeting certain health-related standards. Employers must offer an alternative standard for individuals for whom it is unreasonably difficult or inadvisable to meet the standard. The reward limit may be increased to 50% of the cost of coverage if deemed appropriate. (Effective January 1, 2014) Establish 10-state pilot programs by July 2014 to permit participating states to apply similar rewards for participating in wellness programs in the individual market and expand demonstrations in 2017 if effective. Require a report on the effectiveness and impact of wellness programs. (Report due three years following enactment)	• Provide wellness grants for up to three years to small employers for up to 50% of costs incurred for a qualified wellness program. (Effective July 1, 2010)
Nutritional information	• Require chain restaurants and food sold from vending machines to disclose the nutritional content of each item. (Proposed regulations issued within one year of enactment)	• Require chain restaurants and food sold from vending machines to disclose the nutritional content of each item. (Proposed regulations issued within one year of enactment)	• Require chain restaurants and food sold from vending machines to disclose the nutritional content of each item. (Proposed regulations issued within one year of enactment)

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LONG-TERM CARE			
CLASS Act	• Establish a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program). Following a five-year vesting period, the program will provide individuals with functional limitations a cash benefit of not less than an average of $50 per day to purchase non-medical services and supports necessary to maintain community residence. The program is financed through voluntary payroll deductions: all working adults will be automatically enrolled in the program, unless they choose to opt-out. (Effective January 1, 2011)	• Establish a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program). Following a five-year vesting period, the program will provide individuals with functional limitations a cash benefit of not less than an average of $50 per day to purchase non-medical services and supports necessary to maintain community residence. The program is financed through voluntary payroll deductions: all working adults will be automatically enrolled in the program, unless they choose to opt-out. (Effective January 1, 2011)	• Establish a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program). Following a five-year vesting period, the program will provide individuals with functional limitations a cash benefit of not less than an average of $50 per day to purchase non-medical services and supports necessary to maintain community residence. The program is financed through voluntary payroll deductions: all working adults will be automatically enrolled in the program, unless they choose to opt-out. (Effective 2010)
Medicaid	• Extend the Medicaid Money Follows the Person Rebalancing Demonstration program through September 2016 (effective 30 days following enactment) and allocate $10 million per year for five years to continue the Aging and Disability Resource Center initiatives (funds appropriated for fiscal years 2010 through 2014). • Provide states with new options for offering home and community-based services through a Medicaid state plan rather than through a waiver for individuals with incomes up to 300% of the maximum SSI payment and who have a higher level of need and permit states to extend full Medicaid benefits to individual receiving home and community-based services under a state plan. (Effective October 1, 2010) • *Establish the Community First Choice Option in Medicaid to provide community-based attendant supports and services to individuals with disabilities who require an institutional level of care. Provide states with an enhanced federal matching rate of an additional six percentage points for reimbursable expenses in the program. Sunset the option after five years. (Effective October 1, 2011)*	• Extend the Medicaid Money Follows the Person Rebalancing Demonstration program through September 2016 (effective 30 days following enactment) and allocate $10 million per year for five years to continue the Aging and Disability Resource Center initiatives (funds appropriated for fiscal years 2010 through 2014). • Provide states with new options for offering home and community-based services through a Medicaid state plan rather than through a waiver for individuals with incomes up to 300% of the maximum SSI payment and who have a higher level of need and permit states to extend full Medicaid benefits to individual receiving home and community-based services under a state plan. (Effective October 1, 2010) • Establish the Community First Choice Option in Medicaid to provide community-based attendant supports and services to individuals with disabilities who require an institutional level of care. Provide states with an enhanced federal matching rate of an additional six percentage points for reimbursable expenses in the program. Sunset the option after five years. (Effective October 1, 2010)	No similar provision.

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LONG-TERM CARE (continued)			
Medicaid (continued)	• Create the State Balancing Incentive Program to provide enhanced federal matching payments to eligible states to increase the proportion of non-institutionally-based long-term care services. Selected states will be eligible for FMAP increases for medical assistance expenditures for non-institutionally-based long-term services and supports. (Effective October 1, 2011 through September 30, 2015)	• Create the State Balancing Incentive Program to provide enhanced federal matching payments to eligible states to increase the proportion of non-institutionally-based long-term care services. Selected states will be eligible for FMAP increases for medical assistance expenditures for non-institutionally-based long-term services and supports. (Effective October 1, 2011 through September 30, 2015)	No similar provision.
Demonstration programs	No similar provision.	No similar provision.	• Establish a three-year demonstration program in four states to evaluate the effectiveness of recommended core competencies for personal and home care aides and training curriculum and methods to provide long-term services and supports. (Demonstration program established within 180 days of issuance of recommendations)
Skilled nursing facility requirements	• Require skilled nursing facilities under Medicare and nursing facilities under Medicaid to disclose information regarding ownership, accountability requirements, and expenditures. Publish standardized information on nursing facilities to a website so Medicare enrollees can compare the facilities. (Effective dates vary)	• Require skilled nursing facilities under Medicare and nursing facilities under Medicaid to disclose information regarding ownership, accountability requirements, and expenditures. Publish standardized information on nursing facilities to a website so Medicare enrollees can compare the facilities. (Effective dates vary)	• Improve transparency of information about skilled nursing facilities and nursing facilities. (Disclosure reporting regulations issued within two years of enactment; reporting of information required 90 days after regulations are issued)

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OTHER INVESTMENTS			
Medicare	• Make improvements to the Medicare program: – *Provide a $250 rebate to Medicare beneficiaries who reach the Part D coverage gap in 2010 (Effective January 1, 2010);* – *Phase down gradually the beneficiary coinsurance rate in the Medicare Part D coverage gap from 100% to 25% by 2020:* • *For brand-name drugs, require pharmaceutical manufacturers to provide a 50% discount on prescriptions filled in the Medicare Part D coverage gap beginning in 2011, in addition to federal subsidies of 25% of the brand-name drug cost by 2020 (phased in beginning in 2013)* • *For generic drugs, provide federal subsidies of 75% of the generic drug cost by 2020 for prescriptions filled in the Medicare Part D coverage gap (phased in beginning in 2011);* – Make Part D cost-sharing for full-benefit dual eligible beneficiaries receiving home and community-based care services equal to the cost-sharing for those who receive institutional care (Effective no earlier than January 1, 2012); – Expand Medicare coverage to individuals who have been exposed to environmental health hazards from living in an area subject to an emergency declaration made as of June 17, 2009 and have developed certain health conditions as a result (Effective upon enactment); – Provide a 10% bonus payment to primary care physicians and to general surgeons practicing in health professional shortage areas, from 2011 through 2015; and – Prohibit Medicare Advantage plans from imposing higher cost-sharing requirements for some Medicare covered benefits than is required under the traditional fee-for-service program. (Effective January 1, 2011)	• Make improvements to the Medicare program: – Increase the Part D initial coverage limit by $500 for 2010 to reduce the size of the coverage gap (Effective January 1, 2010); – Provide a 50% discount on brand-name prescriptions filled in the Medicare Part D coverage gap for enrollees, other than those who receive low-income subsidies and those with incomes above $85,000/individual and $170,000/couple (Effective July 1, 2010); – Make Part D cost-sharing for full-benefit dual eligible beneficiaries receiving home and community-based care services equal to the cost-sharing for those who receive institutional care (Effective no earlier than January 1, 2012); – Expand Medicare coverage to individuals who have been exposed to environmental health hazards from living in an area subject to an emergency declaration made as of June 17, 2009 and have developed certain health conditions as a result (Effective upon enactment); – Provide a 10% bonus payment to primary care physicians and to general surgeons practicing in health professional shortage areas, from 2011 through 2015; and – Prohibit Medicare Advantage plans from imposing higher cost-sharing requirements for some Medicare covered benefits than is required under the traditional fee-for-service program. (Effective January 1, 2011)	• Make improvements to the Medicare program: – Modify the initial coverage limit and catastrophic thresholds to reduce the coverage gap by $500 in 2010 and eventually eliminate the Medicare Part D coverage gap by 2019; require drug manufacturers to provide a 50% discount on brand-name prescriptions filled in the coverage gap. (Effective January 1, 2010). – Increase the asset test threshold for Medicare Savings Program and Part D Low-Income Subsidies to $17,000 per individual and $34,000 per couple. (Effective 2012) – Cover through Medicaid the Part B deductible and cost-sharing for Medicare beneficiaries under age 65 with incomes below 150% FPL (and resources at or below two times the SSI level); finance these costs with 100% federal funding in 2013 and 2014 and 91% federal funding in subsequent years. (Effective January 1, 2013)