

Federal Health Care Reform Side-by-Side Proposals

	Senate Finance Committee “America’s Healthy Future Act of 2009” (September 16, 2009)	Senate HELP “Affordable Health Choices Act” (June 9, 2009)	House Tri-Committee “America’s Affordable Health Choices Act of 2009” (June 19, 2009)
Overall Approach to Health Care Reform	Require most US citizens and legal residents to have health insurance. Create a state-based health insurance exchange through which individuals can purchase health coverage, with subsidies available to individuals/families with incomes up to 400% FPL, create a separate exchange for small businesses, expand Medicaid to all individuals with incomes up to 133% FPL and CHIP to 250% FPL.	Require all individuals to have health insurance. Create state-based American Health Benefit Gateways through which individuals and small businesses can purchase health coverage, with subsidies available to individuals/families with incomes up to 400% FPL, and expand Medicaid to all individuals with incomes up to 150% FPL.	Require all individuals to have health insurance. Create a Health Insurance Exchange through which individuals and employers can purchase health coverage, subsidies available to individuals/families with incomes up to 400% FPL. Require employers to provide coverage to employees or pay into a Health Insurance Exchange Trust Fund, with exceptions for certain small employers. Expand Medicaid to 133% FPL.
Proposed Number Insured	95% of uninsured covered, excluding undocumented immigrants.	As amended July 1, 2009, would provide insurance to 90% of Americans, excluding undocumented immigrants.	95% of uninsured covered, excluding undocumented immigrants.
Individual Mandate	<ul style="list-style-type: none"> Requires all US citizens and legal residence to have “qualifying” health coverage enforced through a tax penalty of \$750 for individuals 100-300% FPL, and \$950 for individuals above 300% FPL, unless “hardship,” or unless premium exceeds 10% of income and if the individual has income below 133% FPL. Additional exemptions include 	<ul style="list-style-type: none"> Requires all individuals to have insurance enforced through a tax penalty of \$750 per year, unless “hardship” or unless premium exceeds 10% of income for qualifying coverage. Additional exemptions include members of Indian tribes and undocumented immigrants. 	<ul style="list-style-type: none"> Requires all individuals to have “acceptable health coverage” enforced through a penalty of 2.5% of modified adjusted gross income, unless “hardship.” Additional exemptions include dependents, religious objections and undocumented immigrants.

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	members of Indian tribe, undocumented immigrants and religious reasons.		
Employer Mandate	<ul style="list-style-type: none"> No employer mandate All employers with more than 50 employees who do not offer coverage would have to reimburse the government for each full-time employee receiving an affordability tax credit. Note: employees eligible for the affordability tax-credit will typically be low-wage workers. This may encourage employers to not employ these individuals. 	<ul style="list-style-type: none"> As amended July 1, 2009, employers that do not offer health insurance would be assessed an annual fee of \$750 per full-time worker, or \$375 per part-time worker. Exclusions apply to small firms with fewer than 25 employees. 	<ul style="list-style-type: none"> Employer obligation: 8% of payroll. Require employers to pay at least 72.5% of the lowest cost plan for individual coverage and 65% for family coverage. Eliminate or reduce the pay or play assessment for small employers with annual payroll of less than \$400,000.
Public Programs	<u>Medicaid</u> <ul style="list-style-type: none"> Expand Medicaid to all individuals (children, pregnant women, parents, and childless adults) with incomes up to 133% FPL. <i>To be implemented in 2014</i> Adults between 100-133% FPL will have the option of obtaining coverage through Medicaid or the Exchange, with subsidies. Financing: newly eligible (those who were not previously eligible 	<u>Medicaid</u> <ul style="list-style-type: none"> Expand Medicaid to all individuals with incomes up to 150% FPL. Individuals eligible for Medicaid will be covered through state Medicaid programs and will not be eligible for coverage through American Health Benefit Gateways. <u>CHIP</u> <ul style="list-style-type: none"> Grant individuals eligible for CHIP the option of enrolling in CHIP or 	<u>Medicaid</u> <ul style="list-style-type: none"> Expand Medicaid to all individuals with incomes up to 133% FPL. Newly eligible, non-traditional (childless adults) Medicaid beneficiaries may enroll in coverage through the Exchange if they were enrolled in qualified health coverage during the six months before becoming Medicaid eligible. After five years, states may request that some or all categories of

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	<p>for a full benchmark benefit package or who were eligible for a capped program but were not enrolled) states will receive an increase in FMAP. 27.3% for states that already cover adults with incomes above 100% FPL and 37.3% for other states. FMAP will be adjusted by 2019 for all states to receive 32.3%.</p> <p><u>CHIP</u></p> <ul style="list-style-type: none"> • Expand CHIP up to 250% FPL after 2013. • Once Exchange is operational CHIP enrollees would obtain coverage through the Exchange and states would be required to continue to provide Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). • Require the Secretary to certify that coverage in the exchange is at least comparable to the level of benefits and cost-sharing in the state CHIP plan and procedures to ensure access to the EPSDT wrap-around benefit and cost-sharing 	<p>enrolling in a qualified health plan through a Gateway.</p>	<p>Medicaid beneficiaries obtain coverage through the Exchange provided the state can demonstrate the ability to provide wrap-around coverage and the plans in the Exchange are deemed capable of supporting this population.</p> <ul style="list-style-type: none"> • Provide optional Medicaid coverage to low-income HIV-infected individuals; provide optional Medicaid coverage for family planning services to certain low-income women. • Financing: 100% federal financing for Medicaid coverage expansions through 2014, reducing to 90% federal financing in 2015. <p><u>CHIP</u></p> <ul style="list-style-type: none"> • Require CHIP enrollees to obtain coverage through the Exchange once available. • Amendment: CHIP enrollees may not be enrolled in Exchange until the Secretary certifies that coverage is comparable to coverage under average CHIP plan in 2011. Secretary must also ensure no

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	protections have been established before CHIP enrollees are transitioned into the exchange.		interruption in coverage.
Safety-Net		<ul style="list-style-type: none"> • Authorizes appropriation for the health centers program approx. \$3 billion in 2010, increasing incrementally to \$8.3 billion by 2015, then increasing in line with inflation and patients served for 2016 and following years. • Requires the Secretary to establish a school-based health clinic program through grants to eligible entities. 	<ul style="list-style-type: none"> • Authorizes \$38.8 billion appropriated to the community health centers program from the new Public Health Investment Fund (PHIF) for. • Requires the Secretary to establish a school-based health clinic program through grants to eligible entities. • Amendment: Energy and Commerce committee authorizes guarantee Federal Tort Claims Act (FTCA) protections to physicians and other health professionals who volunteer services at health centers. • Basic exchange plans must contract with “essential community providers,” defined as eligible 340B entities.
Individual Subsidies	<ul style="list-style-type: none"> • Provides refundable and advanceable premium credits to eligible individuals and families with incomes between 133% to 400% FPL in 2013 and individuals 	<ul style="list-style-type: none"> • Provide premium credits on a sliding scale individuals and families with incomes up to 400% FPL. • The premium credits will be based 	<ul style="list-style-type: none"> • Provide affordability premium credits to eligible individuals and families with incomes up to 400% FPL. • The premium credits will be based

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	<p>with income between 100-133% FPL in 2014.</p> <ul style="list-style-type: none"> • Premium credits will be tied to the second lowest-cost silver plan and will be provided on a sliding scale basis from 2% of income for those at 100% FPL to 12% of income for those between 300-400% FPL. • Exclude individuals with incomes below 100% FPL from eligibility for the premium credits. These individuals will be eligible for coverage through the Medicaid program. • Premium credits and cost sharing subsidies are only available to U.S. citizens and legal immigrants who meet income limits. • Requires verification of both income and citizenship status in determining eligibility for the federal premium credits. 	<p>on the average cost of the three lowest cost qualified health plans and will be provided on a sliding scale basis from 12.5% of income for those at 400% FPL and individuals with incomes less than 150% FPL pay 1% of income.</p>	<p>on the average cost of the three lowest cost basic health plans in the area and will be set on a sliding scale such that the premium contributions are limited to the following percentages of income for specified income tiers:</p> <ul style="list-style-type: none"> ○ 133-150% FPL: 1.5 - 3% of income ○ 150-200% FPL: 3 - 5.5% of income ○ 200-250% FPL: 5.5 - 8% of income ○ 250-300% FPL: 8 - 10% of income ○ 300-350% FPL: 10 - 11% of income ○ 350-400% FPL: 11 - 12% of income]
Insurance Exchange	<ul style="list-style-type: none"> • Provide immediate assistance until the new Exchange is created for those with pre-existing conditions by creating a temporary high-risk pool. Individuals who have been denied health coverage due to a 	<ul style="list-style-type: none"> • Create state-based American Health Benefit Gateways, administered by a governmental agency or non-profit organization, through which individuals and small employers can purchase qualified coverage. States 	<ul style="list-style-type: none"> • Create a National Health Insurance Exchange, through which individuals and employers (phasing-in eligibility for employers starting with smallest employers) can purchase qualified insurance,

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	<p>pre-existing medical condition and who have been uninsured for at least six months will be eligible to enroll in the high-risk pool and receive subsidized premiums. The high-risk pool will exist until 2013.</p> <ul style="list-style-type: none"> • Create state-based exchanges for the individual market and small business health options program (SHOP) exchanges for the small group market. • Create four benefit categories of plans plus a separate “young invincible plan” to be offered through the exchange, and in the individual and small group markets. • Prohibit abortion coverage from being required as part of the minimum benefits package; require segregation of public subsidy funds from private premium payments for plans that choose to cover abortion services beyond Hyde—which allows coverage for abortion services to save the life of the woman and in cases of rape or incest; and require 	<p>may form regional Gateways or allow more than one Gateway to operate in a state as long as each Gateway serves a distinct geographic area.</p> <ul style="list-style-type: none"> • Create four benefit categories of plans to be offered through the Exchange. • Restrict access to coverage through the Gateways to individuals who are not incarcerated and who are not eligible for employer-sponsored coverage that meets minimum qualifying criteria and affordability standards, Medicare, Medicaid, TRICARE, or the Federal Employee Health Benefits Program. 	<p>including from private health plans and the public health insurance option.</p> <ul style="list-style-type: none"> • Create four benefit categories of plans to be offered through the Exchange. • Restrict access to coverage through the Exchange to individuals who are not enrolled in qualified or grandfathered employer or individual coverage, Medicare, Medicaid (with some exceptions), TRICARE, or VA coverage (with some exceptions). • Allow states to operate state-based exchanges if they demonstrate the capacity to meet the requirements for administering the Exchange. • Amendment: Prohibit abortion coverage from being required as part of the essential benefits package; require segregation of public subsidy funds from private premium payments for plans that choose to cover abortion services beyond Hyde—which allows coverage for abortion services to save the life of the woman and in

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	<p>there be no effect on state or federal laws on abortions.</p> <ul style="list-style-type: none"> Restrict access to coverage through the exchanges to U.S. citizens and legal immigrants. 		<p>cases of rape or incest; and require there be no effect on state or federal laws on abortions.</p> <ul style="list-style-type: none"> Amendment: facilitate the establishment of non-for-profit, member run health insurance cooperatives to provide insurance through the Exchange.
Public Plan Option	<ul style="list-style-type: none"> Create the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of non-profit, member-run health insurance companies in all 50 states and District of Columbia. To be eligible to receive funds, organizations must not be an existing organization, substantially all of its activities must consist of the issuance of qualified health benefit plans in each state in which it is licensed, governance of the organization must be subject to a majority vote of its members, must operate with a strong consumer focus, and any profits must be used to lower premiums, improve benefits, or improve the quality of health care 	<ul style="list-style-type: none"> Create a community health insurance option to be offered through state Gateways that complies with the requirements of being a qualified health plan. Require that the costs of the community health insurance plan be financed through revenues from premiums, require the plan to negotiate payment rates with providers, and contract with qualified nonprofit entities to administer the plan. 	<ul style="list-style-type: none"> Create a new public health insurance option to be offered through the Health Insurance Exchange that must meet the same requirements as private plans regarding benefit levels, provider networks, consumer protections, and cost-sharing. Require that costs of the public plan be financed through revenues from premiums. Require the public health insurance option to negotiate rates with providers so that the rates are not lower than Medicare rates and not higher than the average rates paid by other qualified health benefit plan offering entities. Permit the public plan to develop innovative payment mechanisms,

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	<p>delivered to its members.</p> <ul style="list-style-type: none"> Require CO-OPs to meet the same requirements as private insurance plans in the exchanges related to solvency, licensure, provider payments, network adequacy, and any applicable state premium assessments. 		<p>including medical home and other care management payments, value-based purchasing, bundling of services, performance based payments, or partial capitation.</p>
Insurance Reforms	<ul style="list-style-type: none"> Require guarantee issue and renewability and allow rating variation based only on age, tobacco use, family composition, and geography (not health status) in the non-group, micro-group (2-10 employees), and small group markets. Require risk adjustment in all markets. Require all state-licensed insurers in the non-group and small group markets to participate in the Health Insurance Exchange. Require all insurers to issue policies in each of the four new benefit categories. Allow states the option of merging the non-group and small group markets. Impose an excise tax in 2013 on 	<ul style="list-style-type: none"> Require guarantee issue and renewability of health insurance policies in the individual and small group markets; prohibit pre-existing condition exclusions; and allow rating variation based only on family structure, geography, the actuarial value of the health plan benefit, and age (with only 2 to 1 variation). Require health insurers to: report cost information; to meet medical loss ratios established by the Secretary or provide rebates to enrollees; to provide incentives to providers to better coordinate care, reduce hospital readmissions and reduce medical errors. Require insurers to provide coverage for preventive care 	<ul style="list-style-type: none"> Require guarantee issue and renewability and allow rating variation based only on age (limited to a 2 to 1 ratio), premium rating area, and family enrollment in the small group market and the Exchange. Prohibit imposition of any pre-existing condition exclusions. Require all insurers to offer coverage that meets the essential benefits package requirements. Standardize health care claims forms, operating rules for using and processing health care transactions, and quality reporting requirements and increase electronic exchange of administrative and clinical data.

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	insurers for employer-sponsored health plans with aggregate values that exceed \$8,000 for individual coverage and \$21,000 for family coverage.	services without cost sharing. <ul style="list-style-type: none"> • Provide dependent coverage for children up to age 26. 	
Benefit Coverage	<ul style="list-style-type: none"> • Essential Health Benefits must include: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; medical and surgical care; mental health and substance abuse; prescription drugs; rehabilitative, habilitative, and laboratory services; preventative and wellness services; pediatric services (including oral and vision) and EPSDT. • Insurers would be required to cover preventative health services with minimal cost sharing. 	<ul style="list-style-type: none"> • Essential Health Benefits must include: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; medical and surgical care; mental health and substance abuse; prescription drugs; rehabilitative, habilitative, and laboratory services; preventative and wellness services; pediatric services (including oral and vision) and EPSDT. • Insurers would be required to cover preventative health services with minimal cost sharing. 	<ul style="list-style-type: none"> • The Essential Benefits Package requires coverage of: hospitalization, outpatient hospitals and outpatient clinic services; professional services of physicians and other health professionals and services incident to such services; prescription drugs, rehabilitative and habilitative services; mental health and substance use disorder services; preventive services; maternity benefits; well baby and well child care including oral, vision, and hearing services. • Amendment: require that all children covered by any exchange plan have access to EPSDT benefits. • No cost-sharing for preventive services; limits cost-sharing for other services; would not permit annual or lifetime limit on coverage; actuarial equivalence requirements for cost-sharing.

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Improving Quality	<ul style="list-style-type: none"> • Simplify health insurance administration by adopting a single set of operating rules for eligibility verification, claims status, claims payment, and the electronic transfer of funds. • Improve care coordination for dual eligibles by creating a new office within the Centers for Medicare and Medicaid services. • Require enhanced collection and reporting of data on race, ethnicity, and primary language. Also require collection of access and treatment data for people with disabilities. 	<ul style="list-style-type: none"> • Develop a national strategy to improve the delivery of health care services, patient health outcomes, and population health that includes publishing an annual national health care quality report card. • Create a Center for Health Outcomes Research and Evaluation within the Agency for Healthcare Research and Quality to conduct and synthesize research on the effectiveness of health care services and procedures to provide providers and patients with information on the most effective therapies for preventing and treating health conditions. • Provide grants for improving health system efficiency, including grants to establish community health teams to support a medical home model; to implement medication management services; to design and implement regional emergency care and trauma systems. • Create a Patient Safety Research Center charged with identifying, 	<ul style="list-style-type: none"> • Strengthen primary care and care coordination by increasing Medicaid payments for primary care providers, providing Medicare bonus payments to primary care practitioners. • Conduct Medicare pilot programs to test payment incentive models for Accountable Care Organizations (ACOs) and bundling of post-acute care payments, and conduct pilot programs in Medicare and Medicaid to assess the feasibility of reimbursing qualified patient-centered medical homes. • Amendment: adopt ACO, bundled payment, and medical home models on a large scale if pilot programs prove successful at reducing costs. • Amendment: conduct ACO pilot programs in Medicaid. • Amendment: establish the Center for Medicare and Medicaid Payment Innovation Center to test payment models that address populations experiencing poor clinical outcomes or avoidable expenditures. • Reduce racial and ethnic disparities

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		<p>evaluating, and disseminating information on best practices for improving health care quality.</p> <ul style="list-style-type: none"> • Develop interoperable standards for using HIT to enroll individuals in public programs and provide grants to states and other governmental entities to adopt and implement enrollment technology. 	<p>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.</p>
Prevention	<ul style="list-style-type: none"> • Provide Medicare beneficiaries access to a comprehensive health risk assessment and creation of a personalized prevention plan. • Eliminate cost-sharing for certain preventive services in Medicare. <i>Cover only proven preventive services in Medicare and Medicaid and provide incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs.</i> • Require Medicaid coverage for tobacco cessation services for pregnant women. • Create a new Medicaid state plan option to permit Medicaid enrollees with at least two 	<ul style="list-style-type: none"> • Develop a national prevention and health promotion strategy that sets specific goals for improving health. • Create a prevention and public health investment fund to expand and sustain funding for prevention and public health programs. • Award competitive grants to state and local governments and community-based organizations to implement and evaluate proven community preventive health activities to reduce chronic disease rates and address health disparities. • Create a temporary Right Choices Program to provide uninsured adults with access to preventive services. 	<ul style="list-style-type: none"> • Develop a national strategy to improve the nation’s health through evidenced-based clinical and community-based prevention and wellness activities. • Improve prevention by covering only proven preventive services in Medicare and Medicaid. • Eliminate any cost-sharing for preventive services in Medicare and increase Medicare payments for certain preventive services to 100% of actual charges or fee schedule rates.

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	chronic conditions or one condition and risk of developing another to designate a provider as a health home.		
Work Force	<ul style="list-style-type: none"> • Establish a multi-stakeholder Workforce Advisory Committee to develop a national workforce strategy for recruiting, training, and retaining a health care workforce that meets current and projected health care needs. • Increase the number of Graduate Medical Education (GME) training positions by redistributing currently unused slots, with priorities given to primary care, general surgery and to states with the lowest resident physician-to-population ratios. • Increase flexibility in laws and regulations that govern GME funding to promote training in outpatient settings, and ensure the availability of residency programs in rural and underserved areas. • Establish Teaching Health Centers, defined as community- 	<ul style="list-style-type: none"> • Authorizes \$300 million in 2010, increasing to \$1.2 billion on 2016 to the National Health Service Corps (NHSC). • Establish a National Health Care Workforce Commission to make recommendations and disseminate information on health workforce priorities, goals, and policies including education and training, workforce supply and demand, and retention practices. • Reform Graduate Medical Education to increase the supply, education, and training of doctors, nurses, and other health care workers, especially in pediatric, geriatric, and primary care. 	<ul style="list-style-type: none"> • Authorizes \$796 million through 2019, and \$3.17 billion through 2019 to the National Health Service Corps (NHSC). • Amendment: Energy and Commerce committee authorizes NHSC through 2014 only. • Allows for part-time service to satisfy loan or scholarship obligations, provided commitment time is increased, or award is reduced. • Reform Graduate Medical Education to increase training of primary care providers by redistributing residency positions and promote training in outpatient settings and support the development of primary care training programs. • Support training of health professionals, including advanced education nurses, who will practice in underserved areas; establish a public health workforce corps; and

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	based, ambulatory patient care centers, including federally qualified health centers and other federally funded health centers.		<p>promote training of a diverse workforce and provide cultural competence training for health care professionals.</p> <ul style="list-style-type: none"> • Provide grants to each state health department to address core public health infrastructure needs. • Amendment: support the development of interdisciplinary mental and behavioral health training programs. • Amendment: establish a training program for oral health professionals.
Financing	<ul style="list-style-type: none"> • CBO estimates the cost of the coverage components of the plan to be \$774 billion over ten years. These costs are financed through a combination of savings from Medicare and Medicaid and new taxes and fees. • The largest source of new revenue will come from an excise tax on high cost insurance plans that exceed \$8,000 for single coverage and \$21,000 for family coverage—which CBO estimates will raise \$215 billion over ten 	<ul style="list-style-type: none"> • CBO estimates this proposal will cost \$615 billion over 10 years. Because the Senate HELP Committee does not have jurisdiction over the Medicare and Medicaid programs or revenue raising authority, mechanisms for financing the proposal will be developed in conjunction with the Senate Finance Committee. 	<ul style="list-style-type: none"> • CBO estimates the net cost of the proposal (less payments from employers and uninsured individuals) to be \$1.042 trillion over ten years. Approximately half of the cost of the plan is financed through savings from Medicare and Medicaid. • Remaining costs financed through a surcharge imposed on families with incomes above \$350,000 and individuals with incomes above \$280,000.

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	<p>years. • Amendment: The modified Chairman’s Mark of the America’s Healthy Future Act of 2009, released on September 22, 2009, will use \$28 billion of the existing \$49 billion surplus to offset the costs of the changes.</p>		