Side-By-Side of Major House Reform Proposals

Issue	H.R. 3962, the Affordable Healthcare for America Act With Manager's Amendment (11/5)	Boehner Substitute, Common Sense Health Care Reform and Affordability Act (11/5)
Public Option	**Public Option.** Creates a new public health insurance option to be offered only through Health Insurance Exchanges. The Secretary will contract with health carriers to provide administrative functions in the same manner as Medicare contractors. This means providing government defined benefits at rates negotiated by HHS. Rates could be at or below Medicare rates. Contractors may not accept insurance risk under the program. **Coverage.** The public option must offer basic, enhanced and premium plans, and may offer premium-plus plans. **Premiums.** Premiums would be set by the Secretary to reflect the cost of benefits and administrative costs, and to provide for a contingency margin of not less than 90 days. Data collection on health status of individuals to determine premiums is required. **Benefits.** The public option is required to provide the same benefit levels, provider networks, consumer protections, and cost-sharing as private plans. **Payment Rates.** Payments for items and services including prescription drugs would be negotiated by the HHS Secretary with aggregate rates no less than Medicare and no more than the average rates paid by other exchange plans. ▪ **Payment Changes.** The Secretary can change the payment rates without a change in law if it improves quality or reduces costs. ▪ **Recourse.** There is no due process (Administrative or Judicial review) of the payment rates or payment methodologies employed by the Secretary. ▪ **Alternate Payments.** The Secretary is authorized to use alternative	**No provision.**

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Issue	H.R. 3962, the Affordable Healthcare for America Act With Manager's Amendment (11/5)	Boehner Substitute, Common Sense Health Care Reform and Affordability Act (11/5)
	payment mechanisms, such as a medical home, accountable care organizations, value based purchasing, differential payments to reflect quality, bundling of services and partial capitation. ▪ Payments can vary geographically. **Participation.** Medicare providers are automatically public option providers unless they opt out. There are no penalties for opting out and providers must have at least a one-year period prior to beginning of the public option to opt out. Members of Congress "may" participate in the public option. **Start Up Costs.** $2 billion is appropriated to the Secretary for start up costs and such sums for initial payment of claims in advance of premiums. Repayment of the start up costs is required over a 10 year period, although it is unclear who would repay the amount.	
Health Insurance Cooperatives	**CO-OPs.** Provides $5 billion in grants or loans over 5 years starting in 2010 to facilitate the establishment of not-for-profit, or member-run health insurance cooperatives. Grants and loans are not available for co-ops existing prior to July 16, 2009. Any profits must be used to reduce premiums or enhance benefits for members. Start-up costs would be paid back by amortizing the loan amount in future premiums. The co-op may not be structured to allow insurance industry "involvement or interference" with the governance of the cooperative, but the cooperative must be licensed to offer insurance in each State in which it offers insurance.	**No provision.**

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Issue	H.R. 3962, the Affordable Healthcare for America Act With Manager's Amendment (11/5)	Boehner Substitute, Common Sense Health Care Reform and Affordability Act (11/5)
High Risk Pools	**Funding.** Provides $5 billion for a temporary national high-risk pool program would be established in 2010, and ending when the insurance exchange is established. The Secretary may run a national pool or contract with states to run the pool. • For states without a high-risk pool program, HHS may work with the state to coordinate other coverage expansions, such as State public-private partnerships (Manager's Amendment). **Eligibility.** Eligible participants include those without coverage for 6 months or more, were denied coverage because of health status, were offered coverage with a preexisting condition exclusion or were offered coverage with a premium rate greater than the premium available in the high risk po The HRP must: ▪ Set premiums no more than 125 percent of the average standard rate; ▪ Provide coverage with a $1,500 deductible and no lifetime or annual caps on benefits; ▪ Maximum cost sharing may be no more than $5,000 for individuals or $10,000 for families. If funding falls short of demand for services, the Secretary shall reduce benefits, increase premiums or establish waiting lists for coverage.	**Funding.** Provides $25 billion for each state to operate a reinsurance program or high risk pool. If a state does not currently operate a HRP, it must establish a reinsurance program. **Eligibility.** Only citizens and nationals would be eligible to participate. Each HRP must: ▪ Offer two coverage options, one of which must be an HSA; ▪ Be self-sustaining; ▪ Eliminate waiting lists and offer coverage to all applicants; ▪ Provide coverage for SSDI eligibles during the 24 month waiting period; ▪ Limit pool premiums to 150 percent of the average standard rate; ▪ Conduct education and outreach; and ▪ Provide coverage for preventive services and disease management for chronic conditions.

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Issue	H.R. 3962, the Affordable Healthcare for America Act With Manager's Amendment (11/5)	Boehner Substitute, Common Sense Health Care Reform and Affordability Act (11/5)
State Innovation Programs	**No provision.**	**Funding.** Provides $50 billion to states that adopt reforms that lower health premiums relative to current premiums and to reduce the uninsured. **Premium Reductions.** States must meet targets for premium reductions to receive $35 billion in funds and may not meet targets by subsidizing insurance premiums directly or by expanding Medicaid. **Uninsured Reductions.** $15 billion will also be made to states for reductions in the percentage of the uninsured According to the authors, reforms States may take to reduce costs include pooling mechanisms, regulatory reforms, or insurance policies that offer coverage without benefit mandates.
Gateways/ Exchanges	**Eligibility.** Beginning in 2013, individuals, their dependents and employers (phasing-in employer eligibility starting with the smallest employers) can purchase insurance through the Exchange from private health plans and the public health insurance option. States may set up state-based exchanges subject to approval. Firms with 25 or fewer employees could participate in the Exchange in 2013. Those with 50 or fewer employees could participate in 2014, and those with 100 or fewer could participate in 2015. Access to the Exchange would be restricted to individuals not enrolled in qualified or grandfathered employer or individual coverage, Medicare, Medicaid, TRICARE, VA coverage, or other coverage like a State health benefits risk pool as determined by the Secretary. Individuals eligible for Medicaid will be enrolled in Medicaid rather than the	**Health Plan Finder.** Within 12 months, allows states to contract with a private entity to establish health plan finders to provide information to consumers on benefit plans available within their state. Multi-state finders are also allowed. Finders must provide information on plan benefits, including coverage for specific diseases, costs and quality. Finders would also include information on Medicaid eligibility and how to enroll. **EHRs.** In order to be listed on the Finder, a health plan must maintain electronic health records that are meaningfully used, exchange information, provide health practitioners clinical decision support and can report data on quality.

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Issue	H.R. 3962, the Affordable Healthcare for America Act With Manager's Amendment (11/5)	Boehner Substitute, Common Sense Health Care Reform and Affordability Act (11/5)
	Exchange. **Plan Requirements.** Plans must submit competitive bids to participate in the exchange. Plans participating in the Exchange must be state licensed, report data, meet adequacy standards, provide culturally and linguistically appropriate services, and participate in risk pooling. In order to qualify as an exchange eligible qualified plan, entities must at least offer a basic plan. A plan that offers a basic plan, may offer an enhanced plan. A plan that offers an enhanced plan may offer a premium plan. A plan that offers a premium plan may offer a premium plus plan. **Plan Categories.** Four categories of benefits to be offered. Benefits that must be made available each year would be determined by the Health Choices Commissioner. • Basic plan, which includes the essential benefits package and covers 70% of benefit costs. • Enhanced plan, which includes the essential benefits package and covers 85% percent of benefit costs. • Premium plan, which includes the essential benefits package and covers 95% of the benefit costs. • Premium plus plan, which provides additional benefits such as oral health and vision care and a separate premium for the additional benefits. Cost sharing may vary within each benefit category (mental health, hospital care) by plus or minus 10 percent. State benefit mandates would continue to apply, but States must reimburse the Commissioner for the cost of continuing the mandate. Monthly premiums may not exceed 125% of the prevailing standard rate for	

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Issue	H.R. 3962, the Affordable Healthcare for America Act With Manager's Amendment (11/5)	Boehner Substitute, Common Sense Health Care Reform and Affordability Act (11/5)
	comparable coverage in the individual market. Qualified plans may subcontract with stand-alone plans to provide dental, vision, mental health or other services. **Financing.** Creates a Health Insurance Exchange Trust Fund that includes new individual and employer taxes, penalties and appropriations, to finance the operation of the exchanges and for affordability credits. **"Price Gouging".** Requires HHS and States to annually review increases in premiums for health insurance coverage. Insurers must submit justification for any premium increase prior to implementation of the increase. Premiums will be continually reviewed and trends in premium increases etc will be provided to the Health Choices Commissioner. States will be required to recommend whether particular insurers should be excluded from participation in the Exchange based on excessive or unjustified premium increases. $1,000,000,000 in grants will be provided between 2010-2015 to assist States with this process (Manager's Amendment).	
Group and Individual Market Reforms	The legislation includes mandates on plans offered in the individual and group markets. The bill requires group plans and individual policies to meet new requirements that include: • Bans coverage exclusions on pre-existing conditions. • Guarantees issue and renewal of policies. • Modified community rating in the group and individual market, with age bands not to exceed 2:1. • Requires dependent coverage to age 26. • Requires adequate provider networks to ensure access to services and requires	The legislation includes mandates on plans offered in the individual and small group markets. The bill requires small group plans and individual policies to meet new requirements that include: • Bans unjust cancellation of insurance coverage. • Guaranteed renewability. • Expands HIPAA group portability to individuals regardless of prior coverage. • Third party review in certain cases before nonrenewal, discontinuation or rescission of policy.

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Issue	H.R. 3962, the Affordable Healthcare for America Act With Manager's Amendment (11/5)	Boehner Substitute, Common Sense Health Care Reform and Affordability Act (11/5)
	transparency in cost sharing differences between in-and out-of-network coverage. • Prohibits discrimination in offering of benefits. • Requires plans to provide at least 90 days notice of any increase or decrease in coverage. • Reduces the look back period from 6 months to 30 days and reduces the pre-existing condition exclusion period (i.e., the waiting period) from 12 months to 3 months for a timely enrollee and 18 months to 9 months for a late enrollee to the plan. **Grandfather Clauses.** Existing plans would be grandfathered only if closed to new enrollees and if they do not vary premiums for individuals by factors other than geography. Collective bargaining agreements ratified before enactment of the legislation would not be affected, until the collective bargaining agreements terminate or three years after enactment of the legislation. Group health plans would have a 5-year grace period to meet new benefit standards and requirements, although the election portion of the bill (where an employer certifies it offers compliant coverage) treats any plan as a new plan, thereby nullifying the grace period.	• Requires dependent coverage through age 24.
Health Benefit Requirements	**Health Board.** Establishes a public-private Health Benefits Advisory Committee to recommend to the Secretary minimum covered benefits and the essential benefits package. The Secretary will determine whether to adopt the recommendations, which would be required to be covered by qualified benefits plans. All qualified health benefits plans must provide: • A minimum set of benefits (essential benefits package), determined by the health	**Health Board.** No provision. • Bans annual or lifetime benefit limits.

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Issue	H.R. 3962, the Affordable Healthcare for America Act With Manager's Amendment (11/5)	Boehner Substitute, Common Sense Health Care Reform and Affordability Act (11/5)
	board • No lifetime or annual coverage limits • Hospitalization, emergency & outpatient services • Physician services • Prescription drugs • Rehabilitative services • Mental health and substance abuse services • Preventive care with no cost sharing (defined as services with A or B rating from USPSTF) • Vaccines consistent with CDC recommendations • Maternity benefits • Well-baby and well-child care including: oral, vision, hearing and related equipment until age 21 Total cost-sharing, in the essential benefits package, including deductible, may not exceed $5,000 for an individual or $10,000 per family per year. This limit would be increased yearly by the increase in CPI-U. Prohibits limits besides cost sharing on coverage unrelated to clinical appropriateness. Copayments and not coinsurance are not to be used to the maximum extent possible. Provide information related to end-of-life planning to individuals and provide option to establish advance directives and physician's order for life sustaining treatment. Prohibits counseling for assisted suicide or euthanasia.	

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<table>
<tr><th>Issue</th><th>H.R. 3962, the Affordable Healthcare for America Act With Manager's Amendment (11/5)</th><th>Boehner Substitute, Common Sense Health Care Reform and Affordability Act (11/5)</th></tr>
<tr><td>Medical Loss Ratio</td><td>Beginning in 2010, insurers in the small and large group market would be required to achieve a medical loss ratio below a level specified by the Secretary (but not less than 85%) so long as it does not destabilize the existing individual market. If plans exceed this limit, rebates to enrollees are required.

Beginning in 2014, if the Secretary determines that an MA plan has failed to have a medical loss ratio of at least 85%:

• A rebate must be provided to enrollees;
• New enrollees will be prohibited if plan does not achieve such a ratio for three consecutive years; and
• Plan will be terminated if it does not achieve such a ratio for five consecutive years.</td><td>No provision.</td></tr>
<tr><td>Employer Mandate & Subsidies</td><td>Play or Pay. Requires employers to offer coverage to employees or pay an 8% (of average wages paid by employer) tax to the Health Insurance Exchange Trust Fund. An employer meets the mandate requirement if it offers qualified benefits. Employers must meet a minimum contribution requirement for full-time employees equal to at least 72.5% of the premium cost of single coverage and 65% of the premium cost for family coverage of the lowest cost plan that meets the essential benefits package requirements.

Exemption & Phase-In.

• Annual payroll less than $500,000: exempt;
• Annual payroll between $500,000-$585,000: 2% of payroll;
• Annual payroll between $585,000 and $670,000: 4% of payroll;
• Annual payroll between $670,000 and $750,000: 6% of payroll; and</td><td>Pay or Play. No provision.</td></tr>
</table>

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Issue	H.R. 3962, the Affordable Healthcare for America Act With Manager's Amendment (11/5)	Boehner Substitute, Common Sense Health Care Reform and Affordability Act (11/5)
	• Above $750,000: 8%. **Auto Enrollment.** Requires employers offering coverage to automatically enroll into the employer's lowest cost premium plan any individual not electing coverage under the employer plan or does not opt out of coverage. **COBRA.** Allows workers to keep COBRA coverage until they become eligible for other coverage or the Exchange is in place.	**Auto Enrollment.** Allows employers to auto enroll for health insurance, provided that employees are allowed to decline the coverage.
Individual Mandate & Subsidies	**Mandate.** Requires individuals to have 'acceptable health coverage." Those without coverage pay a penalty of 2.5% of modified adjusted gross income up to the cost of the average national premium for self-only or family coverage under a basic plan in the Health Insurance Exchange. **Exceptions.** Exceptions would be granted for dependents, religious objections and financial hardship. **Affordability Credits.** The bill provides affordability premium credits to eligible individuals and families with incomes up to 400% FPL to purchase insurance through the Exchange. Only verified US Citizens or those lawfully present in the US are eligible for affordability credits (Manager's Amendment). Premium credits would be based on average cost of the three lowest cost basic health plans in the area and will be set on a sliding scale: • 133-150% FPL: 1.5-3% of income • 150-200% FPL: 3-5.5% of income	**Mandate.** No provision.

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Issue	H.R. 3962, the Affordable Healthcare for America Act With Manager's Amendment (11/5)	Boehner Substitute, Common Sense Health Care Reform and Affordability Act (11/5)
	• 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 After 2013, the income-based caps would be indexed so that the share of premiums that enrollees in each income band paid would be maintained over time. As a result, the income-based caps would gradually become higher over time, ranging from 1.6% to 12.8% in 2016.	
Access Expansions	**Purchase Across State Lines.** Effective January 1, 2015, States may form Health Care Choice Compacts to facilitate the purchase of individual insurance across state lines. Insurers in compact states would still have to comply with most state requirements, including consumer protection laws (benefit mandates) that drive up costs. **Small Employer Credit.** The legislation provides a 50 percent credit towards qualified expenses for employee health coverage. The credit would be available for 2 years and phases out for: • Employers whose average and annual employee compensation is between $20,000-$40,000/year; • The number of employees is between 10-25. For employers with more than 10 employees, the tax credit is reduced by an amount which bears the same ratio to the amount of the credit as the excess of the number of employees over 10:15. The credit is not permitted for employees earning more than $80,000/year.	**Purchase Across State Lines.** Allows purchasing of insurance across state lines. Insurance policies would be subject to laws in a company's home state but exempt from many consumer protection laws, rating rules and benefit mandates in other states where the coverage is sold. **AHPs.** Provides small businesses power to pool together and form association health plans, to offer health benefits at lower prices. Contribution rates must be nondiscriminatory, and would be set by the plans. Benefit options would also be set by the plans. Small employers are defined as 50 or less employees.

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Issue	H.R. 3962, the Affordable Healthcare for America Act With Manager's Amendment (11/5)	Boehner Substitute, Common Sense Health Care Reform and Affordability Act (11/5)
	Retiree Health. Creates a temporary reinsurance program for businesses providing retiree health coverage. • $10 billion Reserve Trust Fund at Department of Treasury to help offset costs (80%) of a health claim that is between $15,000 and $90,000 for employers providing retirees age 55-64 with retiree health care. • Reimbursement is on a claim-by-claim basis and not for aggregate costs. • Amounts paid are used to reduce premiums and cost sharing for plan participants and cannot be used to reduce the costs of an employer. **Follow On Biologics.** Requires a new legal pathway for follow on biologics with 12 year exclusivity.	**HSAs.** HSA funds may be used for premiums for high deductible health plans. Expands "savers" credit for low income individuals and families to qualified contributions to an HSA. Allows HSA funds to be used for medical expenses prior to establishing a HDHP if incurred within 60 days. **Follow On Biologics.** Requires a new legal pathway for follow on biologics with 12 year exclusivity.
Medicaid	Expands Medicaid to all non-disabled, childless adults under age 65 who are ineligible for Medicare and with incomes up to 150% FPL ($16,200/year for individuals). The Federal government will pay 100% of Medicaid costs for his population in 2013 & 2014, then 91% of costs in 2015 and beyond. ▪ Newly eligible, non-traditional 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. ▪ Provides Medicaid for all newborns lacking coverage for first 60 days who do not otherwise have coverage. After 60 days, the newborn will become a traditional Medicaid eligible individual unless covered by acceptable coverage.	**No Provisions.**

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Issue	H.R. 3962, the Affordable Healthcare for America Act With Manager's Amendment (11/5)	Boehner Substitute, Common Sense Health Care Reform and Affordability Act (11/5)
	▪ Provides optional Medicaid coverage to low-income HIV infected individuals and for family planning services for low-income women. ▪ Requires Medicaid coverage of Clinical Prevention Services Task Force recommendations of preventive services with grades of A or B and vaccinations recommended by the CDC. Eliminates any cost sharing associated with these benefits. Extends 1-year transitional medical assistance (TMA) through December 21, 2012. Primary care doctors participating in Medicaid will receive an increase in their rates, up to Medicare levels. Increases the Medicaid drug rebate percentage from 15.1% to 22.1% of AMP and extend the prescription drug rebate to Medicaid managed care plans. Sense of Congress that States should be allowed to elect under their Medicaid State plans a Community First Choice Option that would provide coverage of community-based attendant services and supports furnished in homes and communities to those individuals who would otherwise qualify for Medicaid institutional coverage (Manager's Amendment). Increases Medicaid/CHIP spending by $425 billion over 10 years.	
Medicare	**Part A.** Modifies market basket updates to account for productivity improvements for inpatient hospital, home health, skilled nursing facility and other Medicare providers. Incorporates productivity improvements into market basket updates that do not already incorporate such improvements.	**No provisions.**

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Issue	H.R. 3962, the Affordable Healthcare for America Act With Manager's Amendment (11/5)	Boehner Substitute, Common Sense Health Care Reform and Affordability Act (11/5)
	• CBO estimates these provisions would save approximately $131 billion over ten years. **Part B**. Incorporates productivity improvements into market basket updates that do not already incorporate such improvements. • CBO estimates these provisions would save approximately $42 billion over ten years. **Parts A & B.** Reduces payments for preventable hospital readmissions. • CBO estimates this provision would save approximately $9.3 billion over ten years. **Part C/Medicare Advantage.** Limits cost-sharing in MA plans to no more than cost-sharing in traditional Medicare. Provides bonus payments to high-quality plans. Restructures payments to MA plans, phasing to 100% of fee-for-service payments and adjusts for coding intensity. • CBO estimates that phasing to 100% of fee-for-service payments would save $170 billion over ten years. **Part D.** Increases the assets test limits in 2012. Provides for a 50% discount on brand name drugs in the Part D donut hole. Shrinks the size of the donut hole by $500 in 2010, and continues to narrow the hole until it is fully eliminated in 2019. Requires drug manufacturers to provide drug rebates for dual eligibles enrolled in Part D plans. • CBO estimates that eliminating the coverage gap and providing discounts for drugs originally in the coverage gap would save $42 billion over ten	

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Issue	H.R. 3962, the Affordable Healthcare for America Act With Manager's Amendment (11/5)	Boehner Substitute, Common Sense Health Care Reform and Affordability Act (11/5)
	years. **Accountable Care Organization and Medical Home Pilot Programs.** Provides for additional expansion and testing of these pilot programs. **Cost Sharing.** Allows 100 percent coverage for cost sharing, including deductible, for physician office and hospital outpatient preventive services.	
Program Integrity	**Waste, Fraud & Abuse.** Requires providers and suppliers to adopt programs to reduce waste, fraud and abuse. Mandates state use of national correct coding initiative. Screening for new providers or suppliers.	**Waste, Fraud and Abuse.** Increases to $300 million funding for the Health Care Fraud and Abuse Control Account. Requires screening of new providers of services or suppliers applying for the first time for a Medicare provider number and billing privileges. Establishes comprehensive provider database tracking providers, services, suppliers and related entities participating in Medicare and/or Medicaid.
Quality/Prevention / Wellness	**Comparative Effectiveness Research.** Establishes a Center or Comparative Effectiveness Research within AHRQ 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. Funded by a tax on all insurance policies. **Primary Care.** Provides bonus payments to primary care providers. **CMS Payment Demos.** Establishes the Center for Quality Improvement to identify, develop, evaluate, disseminate, and implement best practices in the delivery of health care services, such as Accountable Care Organizations, Medical Home, etc.	**Comparative Effectiveness Research.** Repeals the Federal Coordinating Council for Comparative Effectiveness Research.

Issue	H.R. 3962, the Affordable Healthcare for America Act With Manager's Amendment (11/5)	Boehner Substitute, Common Sense Health Care Reform and Affordability Act (11/5)
	Physician Sunshine. Requires 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.	
	Administrative Simplification. Requires standards within two years for electronic transactions. Requires all Medicare payments to be made by Electronic Funds Transfer by January 1, 2015.	**Administrative Simplification.** Requires standards within two years for electronic transactions. Requires all Medicare payments to be made by Electronic Funds Transfer by January 1, 2014.
	Prevention. Establishes prevention and wellness trust of $15.4 billion over the next 5 years. ▪ Develop a national strategy to improve health through evidence-based clinical and community-based prevention and wellness activities. ▪ Eliminates any cost-sharing for preventive services in Medicare and increase Medicare payments for certain preventive services to 100% of actual charges of fee schedule rates. ▪ Implementation of medication management services for treatment of chronic diseases. ▪ Establishment of diabetes screening collaboration and outreach program (Manager's Amendment).	**Prevention/Wellness.** Group health plan or issuer may provide premium discounts and cost sharing reductions by up to 50 percent of the value of the benefits based on participation in a standards-based wellness program. Current law caps the deduction at 20 percent.
	Wellness. Creates a new $33 billion fund to promote evidence based clinical and community prevention and wellness initiatives, including core public health infrastructure activities. The activities include specific national prevention and wellness goals and national priorities.	

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Issue	H.R. 3962, the Affordable Healthcare for America Act With Manager's Amendment (11/5)	Boehner Substitute, Common Sense Health Care Reform and Affordability Act (11/5)
	Creates a $30 million employer-sponsored wellness grant.	
Lawsuits	The legislation shall not modify or impair state law governing legal standards or procedures used in malpractice cases, including authority of a State to make or implement such law (Manager's Amendment). States would receive incentive payments if they enact and implement a medical liability reform law that prevents and promptly resolves disputes, encourages the disclosure of medical errors, and maintains access to affordable liability insurance. Such laws may contain certificates of merit or early offers as an alternative to litigation. Grants will be used by states to "improve health care". • Laws must not limit attorneys' fees or impose caps on damages.	Limits on costs related to medical malpractice including capping noneconomic and punitive damages and making changes in the allocation of liability. • Lawsuits must be filed with 3 years after the injury or 1 year after discovery of the injury. • Compensation unlimited for actual economic losses. • Noneconomic damages capped at $250,000 • Limits attorney's fees • Punitive damages capped at $250,000 or two times the amount of economic damages, whichever is greater. CBO expects that those limits would reduce health care costs directly by reducing premiums for medical liability insurance and associated costs and indirectly by slightly reducing the utilizing of health care services. Over a ten year period, CBO estimates those changes would reduce spending on mandatory programs by about $41 billion and increase revenues by $13 billion as an indirect effect of reducing the costs of private health insurance plans.
Long-Term Care	Establishes a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program), to provide individuals with functional limitations a cash benefit to purchase non-medical services and supports necessary to maintain community residence. Program would be financed through voluntary payroll deductions. CBO estimates the program is fundamentally actuarially unsound (premiums do	**No provision.**

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Issue	H.R. 3962, the Affordable Healthcare for America Act With Manager's Amendment (11/5)	Boehner Substitute, Common Sense Health Care Reform and Affordability Act (11/5)
	not finance benefits over the long term). CBO scores the program as saving $72 billion over 10 years.	
CBO Estimates/Financing	**Cost.** Over 10 years: • Gross total of $1,055 billion in subsidies provided through the exchanges, increased net outlays for Medicaid and CHIP, and tax credits for small employers. • Net Cost of $894 billion for proposed expansions in insurance coverage. • $605 billion in federal subsidies would be provided to purchase coverage through the exchanges and related spending. • Does not include $210 billion in new Medicare physician payments. • Projected to reduce federal deficit by $9 billion in 2019 and $129 billion over ten years. **Taxes.** Revenue (over ten years): • Imposes a tax on individuals without acceptable health coverage of 2.5% of modified adjusted gross income, which CBO estimates would raise $33 billion. • Imposes a 5.4% tax on individuals earning in excess of $1 million (joint) or $500,000 (individual), which CBO estimates would increase federal revenues by $460 billion. • New payroll taxes on non-electing employers up to 8 percent of payroll, which CBO estimates would raise $135 billion. • Imposes a 2.5% tax on medical devices beginning in 2013, which CBO	**Cost.** Over ten years: • Gross total of $61 billion in coverage expansions. • Net cost of $8 billion for coverage expansion. • Projected to reduce federal deficit by $13 billion in 2019 and by $76 billion over the ten years. **Taxes.** Revenue (over ten years): • Raises $27 billion by making employer sponsored care less expensive, thereby increasing income subject to taxation. • Cuts $5 billion in taxes by making HSAs more attractive.

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Issue	H.R. 3962, the Affordable Healthcare for America Act With Manager's Amendment (11/5)	Boehner Substitute, Common Sense Health Care Reform and Affordability Act (11/5)
	estimates would increase revenues by $20 billion. • Biofeuls credit raises $24 billion. • Limits on HSAs and FSAs raise $20 billion. **Spending Reductions.** Direct spending in Medicare & Medicaid would be reduced by approximately $396 billion over ten years. **Effects on Coverage.** • Number of nonelderly people who are insured would be reduced by 36 million, leaving about 18 million non-elderly residents uninsured. • 21 million people would purchase their own coverage through the exchanges. • 15 million more enrollees in Medicaid than the total number projected for Medicaid and CHIP combined under current law. • 6 million fewer individuals would purchase coverage in the individual and small group markets. **Effect on Premiums.** Not scored by CBO, but outside estimates put premium increases in the hundreds or thousands. For those eligible for premium subsidies, costs would be paid by taxpayers. Unsubsidized individuals would see cost increases. **Subsidy.** Average subsidy rises from $5,500 in 2015 to $6,800 in 2019.	**Spending Reductions.** Direct spending in federal health programs as a result of tort reform, administrative simplification and follow on biologics reduce spending by $49 billion. **Effects on Coverage.** • Reduces the number of uninsured by about 3 million, leaving about 52 million non-elderly residents uninsured. • Increases employer-sponsored insurance by 2 million. **Effects on Premiums.** CBO estimates substantial reduction in premiums, primarily in the individual and small group markets. • Average premiums in the small group market would decline by 7 to 10 percent. • Individual market premiums would be reduced, on average, by 5 to 8 percent. • Large group premiums would be reduced by zero to 3 percent.