ENGELBERG CENTER for
Health Care Reform
at BROOKINGS

LEGISLATIVE REVIEW

Bending the Curve

A Comparative Review of the Senate Finance Committee Reform Proposal

In early September, the Engelberg Center for Health Care Reform released a report, *Bending the Curve: Effective Steps to Address Long-Term Spending Growth,* which was developed by a group of leading experts in health care and economics. The report contains a set of concrete and feasible steps to slow long-term growth in health care spending – a priority also articulated by leaders in Congress. This brief provides a high-level review of the legislation introduced by Senate Finance Committee Chairman Max Baucus, including a side-by-side summary of key provisions of the Bending the Curve report and those in the Baucus proposal.

Overview

The Baucus health care reform proposal offers many promising ideas to improve the overall performance of the U.S. health care system. In addition to steps that would reduce the number of Americans without insurance coverage, the plan includes ways to slow long-term spending growth while building the high-value health care system our nation urgently needs.

We believe there are important opportunities to modify or augment this proposal to further ensure that payment systems, regulations, and institutions are reformed as part of a comprehensive strategy to increase accountability and support for lowering costs and improving quality. In this review, we briefly summarize: 1) aspects of the Baucus proposal that we believe have the greatest potential to slow long-term spending growth; 2) areas not directly included in the proposal that we believe should be addressed; and 3) other aspects of the plan where modifications could increase the effectiveness of the overall reform package.

As emphasized in *Bending the Curve*, the individual reforms described below – and in the report itself – should not be viewed as discrete, incremental steps that alone would slow long-term spending growth. Rather, these are interdependent and reinforcing reforms that should be implemented together to improve and modernize the U.S. health care system.

Key Opportunities for Slowing Long-Term Spending Growth in the Baucus Proposal

The Baucus proposal includes the following provisions that are also included as recommendations in the *Bending the Curve* report:

- Creates an independent entity ("Patient-Centered Outcomes Research Institute") to allocate comparative effectiveness research funding
- Increases payment rates for primary care physicians
- Establishes several steps to increasingly link provider reimbursement to quality and efficiency, including by establishing accountable care organizations (ACOs)
- Expands and streamlines CMS piloting authority and resources to support the rapid testing, evaluation, and expansion or modification of new payment models in Medicare and Medicaid, such as patient-centered medical homes
- Transitions to a Medicare Advantage competitive bidding system
- Establishes an individual insurance requirement, insurance exchanges, rating regulations, and sliding-scale subsidies to: 1) help ensure that insurers compete on price and quality; and 2) help consumers make better health plan decisions, including allowing consumers to save when they select low-cost, high-quality plan options

- Reduces tax expenditures on high-cost health plans by imposing an excise tax on insurers if the value of health coverage exceeds a capped amount

Current Gaps in the Proposal that Should be Addressed to Effectively Bend the Cost Curve

The Baucus proposal does not currently include the following provisions:

- New payment reforms that would, over time, apply significant reimbursement pressure on providers in certain regions experiencing high spending growth – for example, by freezing or slowing market-basket updates for all providers in high-growth regions that choose not to participate in available accountable payment systems such as ACOs, medical homes, or other reforms
- Medical liability reforms that would provide greater liability protections for health care providers and insurers when they follow best practices and/or implement safe, accountable systems identified by evidence
- Accountability incentives for consumers when they take steps to choose high-quality, lower-cost health care providers and health plans, and additional support through shared savings and other incentives when consumers make lifestyle choices that can lead to measurable improvements in health

Additional Areas Where Modifications Could Strengthen the Baucus Proposal

The Baucus proposal also includes provisions that could be improved. For example, modifications to the proposal could:

- Include clear authority for HHS/CMS to expand successful payment and delivery system reform demonstration projects into the broader Medicare program if they prove effective
- Ensure that all payment reforms are on a path to fostering greater accountability for overall cost and quality by making bonuses increasingly linked to performance, including health outcomes and patient experience
- Expand the scope of the new Medicare Commission to: 1) include Medicaid; and 2) permit proposals other than provider reimbursement, including those related to benefit designs, premiums, tax expenditures on employer-based insurance, or other sources of revenue or savings
- Ensure that meaningful, person-level measures of cost and quality are piloted and made available as quickly as possible to inform provider and consumer decisions and to identify whether payment and delivery system reform pilots are actually achieving their purpose
- Specify significant new spending levels on programs to reduce waste, fraud, and abuse and clarify that the funds are mandatory and do not have to be appropriated
- Provide greater institutional support at HHS/CMS to support the increasing data- and other systems-related demands placed on the agency, including those arising from health care reform – for example, the urgent need to provide new payment and delivery system pilots with timely access to data to help pilots improve patient care

The following pages include a more detailed, "side-by-side" examination of specific recommendations in our report and relevant provisions in the Baucus proposal.

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"BENDING THE CURVE" KEY REFORM	SENATE FINANCE COMMITTEE PROPOSAL
PILLAR 1: BUILDING THE NECESSARY FOUNDATION FOR COST CONTAINMENT & VALUE-BASED CARE	
Key Reform 1: Ensure Investments in Health Information Technology (IT) are Effective	
Define "meaningful use" health IT bonuses to ensure effective investments that were included in the American Recovery and Reinvestment Act (ARRA) of 2009	• No provision (bill intends to build on ARRA incentives for effective health IT).
Create interoperability and provider communication standards	• No provision.
Fund technical support programs	• No provision.
Key Reform 2: Make Best Use of Comparative Effectiveness Research (CER)	
Create an entity to allocate CER funding based on the expected value of the evidence to be developed; Emphasize areas of medical uncertainty, public health interventions, and broader provider practice patterns	• Authorizes the establishment of a private, non-profit corporation ("Patient-Centered Outcomes Research Institute") to advance the quality and relevance of clinical evidence through research and evidence synthesis. The entity would focus on disease incidence and prevalence; evidence gaps in terms of clinical outcomes; practice variations; the potential for new evidence to improve health and quality of care; expenditures associated with a health care treatment strategy or health condition; patient needs, outcomes, and preferences, including quality of life; and relevance to assisting patients and clinicians in making informed health decisions. [Page 159-167]
Protect providers and insurers from liability when they follow best practices and implement safe systems identified by evidence	• No provision.
Key Reform 3: Improve the Health Care Workforce	
Create incentives for states to amend scope of practice laws	• No provision.
Align Medicare payments to better support the use of allied health professionals	• Allows physician assistants who do not have a direct or indirect employment relationship with a skilled nursing facility, but who are working in collaboration with a physician, to certify the need for post-hospital extended care services for Medicare payment purposes. [Page 114] • Recognizes attending physician assistants as attending physicians to serve hospice patients for the purposes of a hospice-written plan of care. The provision would continue to exclude physician assistants from the authority to certify an individual as terminally ill. [Page 115] • No further provisions affecting payments to support the use of allied health professionals.

"BENDING THE CURVE" KEY REFORM	SENATE FINANCE COMMITTEE PROPOSAL
Reform graduate medical education payments to promote the teaching of high-value care practices	• Redistributes currently unused residency training slots as a way to encourage increased training, particularly in the areas of primary care and general surgery. [Page 102] • No provisions related to redirecting support for teaching of high-value care practices.
PILLAR 2: REFORMING PROVIDER PAYMENT SYSTEMS TO CREATE ACCOUNTABILITY	
Initial Reforms: Adjust Medicare and Medicaid Fee-for-Service Payment Systems	
Broaden bundled payments, such as hospital and post-acute care, hospital and physician services, high-cost episodes of care	• Creates a Medicaid Bundled Payments Demonstration under which, beginning with up to eight states in 2011, hospital bundled payments would be expanded to include post-acute care provided in acute care hospitals and non-hospital settings, and/or hospital and physician services. [Page 60] • Starting in 2013, requires the Secretary of Health and Human Services to develop, test, and evaluate alternative payment methodologies through a national, voluntary pilot program designed to provide incentives for providers to coordinate patient care across the continuum and to be jointly accountable for the entire episode of care. The Secretary would select up to eight conditions, and the program would include a broad range of providers. If pilots are effective, the Secretary would make implementation recommendations to Congress by FY 2016 regarding whether the pilot should be a permanent part of the Medicare program. These recommendations to Congress would require further legislation to be enacted. [Page 94-96]
Expand the use of pay-for-performance, ideally using health outcome and patient experience measures	• Supports payment reforms such that, starting in FY 2013, hospitals with readmission rates above a certain threshold would receive reduced payments (by 20 percent) for the original hospitalization if a patient with a selected condition is re-hospitalized with a preventable readmission within seven days. If the re-hospitalization is within 15 days, payments would be reduced by 10 percent. [Page 98] • Establishes a Medicare pilot program ("Community Care Transitions Program") under which the Secretary would allocate $500 million over three years to eligible hospitals and community-based organizations to provide care transition services to Medicare beneficiaries at the highest risk of preventable re-hospitalization. Contains no explicit provisions for measuring care or accountability for improved results, but presumably intends to link this program to the readmission payment penalties outlined above. [Page 98] • Extends the Secretary's authority to extend gain-sharing demonstrations (between hospitals and physicians) until September 30, 2011. [Page 100]

"BENDING THE CURVE" KEY REFORM	SENATE FINANCE COMMITTEE PROPOSAL
	• Establishes a Hospital Value-Based Purchasing (VBP) program in Medicare that moves toward paying for hospitals' performance on reported measures, funded through reductions in Medicare payments. [Page 77] • Requires the Secretary, beginning in 2012, to provide reports to physicians that compare their resource use with that of other physicians or groups of physicians. Beginning in 2015, payment would be reduced by 5 percent if an aggregation of the physician's resource use is at or above the 90th percentile of national utilization. After five years, the Secretary would have the authority to convert the 90th percentile threshold for payment reductions to a standard measure of utilization, such as deviations from the national mean. The provision does not specify whether these would be one-time payment reductions (i.e., what happens in year two if physicians are/are not in the top 10th percentile?), nor is it clear to what degree this initiative would offer significant incentives for continued improvement. [Page 79-81] • Directs the Secretary to complete and submit to Congress Medicare VBP implementation plans for home health agencies and skilled nursing facilities by 2011 and 2012, respectively. [Page 83] • No provision explicitly linking payment reforms to measures of outcomes and patient experience
Increase payment rates for primary care, offset by reductions for specialty care	• Establishes a new 10 percent bonus on select evaluation & management codes under the Medicare fee schedule for certain primary care physicians, beginning January 1, 2011 and lasting for five years. In addition, general surgeons providing care in Health Professional Shortage Areas would also be eligible for a 10 percent bonus on major procedure codes beginning January 1, 2011 and lasting for five years. Half of the cost of the bonuses would be offset through an across-the-board reduction on all other codes, except for physicians who primarily provide services in a HPSA. The source of the other half of financing is not specified. [Page 101]
Provide additional payments during this transition period to physicians whose practices serve as "patient-centered medical homes"	• Creates a new Medicaid state plan option under which Medicaid enrollees with chronic conditions could designate a provider as their medical home. An enhanced match of 90 percent FMAP would be extended for two years for medical homes for services rendered for states that take up this option. [Page 74] • Establishes a new "Innovation Center" within CMS (discussed below) to develop and test care delivery model pilots that include broad payment and practice reforms in primary care, including medical home models for high-need beneficiaries, medical homes that address women's unique health care needs, and models that

"BENDING THE CURVE" KEY REFORM	SENATE FINANCE COMMITTEE PROPOSAL
	transition primary care practices toward alternatives to fee-for-service reimbursement. [Page 91] • Makes Medicare Advantage plans eligible for new bonus payments for care coordination and management activities, including through medical homes. [Page 136]
Ensure Medicare payments support the use of allied health professionals	• No provision.
Reduce payments for care of low-value relative to cost	• No provision.
Increase spending on programs to reduce waste, fraud, and abuse	• Requires that the Secretary screen all providers and suppliers before granting Medicare billing privileges and imposes new disclosure requirements on providers and suppliers enrolling in Medicare. States would be authorized to impose similar screening procedures in Medicaid. [Page 185] • Requires CMS to complete development of the comprehensive Integrated Data Repository to expand existing program integrity data sources and expand data sharing and data matching across Federal health care claims and payment data. [Page 186] • Expands and consolidates provider databases with a national patient abuse/neglect registry into a centralized sanctions data system, including information on providers in Medicare and all state Medicaid programs. [Page 189] • Extends the Recovery Audit Contractors program to Medicare Parts C and D and Medicaid. [Page 193] • Increases funding for the Health Care Fraud and Abuse Control (HCFAC) program by $10 million each year for ten years. [Page 194] • While HCFAC program funding increases are specified (above), the total additional funding allotted to all waste, fraud, and abuse activities is unspecified. Moreover, it is not clear to what extent funds for each of these programs would be mandatory or would need to be appropriated.
Enable Medicare Prescription Drug Plans (PDPs) to share in overall cost savings created by more effective use of prescription drugs	• No provision.
Establish a regulatory pathway for follow-on biologics	• No provision.

"BENDING THE CURVE" KEY REFORM	SENATE FINANCE COMMITTEE PROPOSAL
Key Reform 1: Build New Payment Systems for Provider Accountability	
Pilot Accountable Care Organizations (ACOs)	• Establishes a voluntary ACO program beginning in 2012 for practitioners in group practice arrangements; networks of practices; partnerships or joint-venture arrangements between hospitals and practitioners; hospitals employing practitioners; and other groups of providers of services and suppliers. There are no time limits placed on ACOs; presumably, successful ACOs would be permitted to continue indefinitely. Further, there are no limits on the number of ACO pilots that could be established by the Secretary under this program. The ACO provision neither explicitly permits nor prohibits the development of alternative payment models for ACOs in addition to "one-sided" shared savings (e.g., partial capitation) on a voluntary basis.
Pilot "enhanced episode-based payment" systems and other promising payment systems	• The CMS Innovation Center provision outlined below could potentially include enhanced episode-based payment system pilots. • Establishes a Medicaid Global Payments demonstration project available in up to five states from 2010 to 2012, under which a large, safety net hospital system participating in Medicaid would be permitted to alter its provider payment system from a fee-for-service (FFS) structure to a capitated, global payment structure. [Modification to original Chairman's Mark; Modification of Kerry Amendment #C3]
Tiered copayments to encourage use of more efficient providers	• No provision.
Key Reform 2: Apply Pressure to "Non-Accountable" Medicare Payments	
Establish "Virtual ACO" incentives several years	• No provision for a virtual ACO that would apply to all providers not participating in accountable payment systems in regions with excessive per beneficiary costs. • Applies a new payment modification to the FFS physician payment formula that would pay physicians based upon the relative quality of care they achieve for Medicare beneficiaries relative to cost. Consistent with other provisions in the Chairman's Mark, the Secretary would provide information to physicians about the value of care they provide. The Secretary would later implement payment consequences beginning in 2015 based on the value of care delivered during the performance period. By 2017, all physician payments would be subject to this payment reform. [Modification of original Chairman's Mark; Cantwell Amendment #D1]
Eventually freeze market-basket updates for two years for providers not participating in accountable payment systems	• No provision for adjustments linked to provider participation in accountability payment systems (with the exception of reductions for high-spending physicians noted above).

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Key Reform 3: Improve Payment/Coverage Flexibility and Rapid Learning to Achieve Lower Costs and Better Quality	
Expand and streamline CMS's piloting authority and resources to support the rapid testing, evaluation, and expansion or elimination of new payment models in Medicare and Medicaid	• Establishes an Innovation Center within CMS (with appropriations of $10 billion over ten years) that would be authorized to test, evaluate, and expand a wide range of different payment structures and methodologies that aim to foster patient-centered care, improve quality, and slow the rate of Medicare cost growth. The Center would target dual-eligible beneficiaries, those with chronic conditions or other needs. This language does not seem to permit broader population-level interventions that include but are not limited to dual-eligible populations or those with chronic conditions. The Center would be given the authority to terminate or modify the design of models at any time during a testing period. However, this provision does not specify how or if successful Innovation Center pilots could be expanded and implemented more broadly in the Medicare program. [Page 90-91] The Innovation Center would include the Medicaid and CHIP programs. [Modification of Chairman's original Mark; Kerry Amendment #D5] • Makes permanent the authority granted to the Secretary under Section 646 of the Medicare Modernization Act (section 1866C of the Social Security Act) to authorize additional shared-savings, quality improvement programs with providers and other organizations. [Page 91]
Support public-private regional collaborations with Medicare, Medicaid, and private payers using consistent quality and cost measures for payment	• No provision, though presumably public-private regional collaborations could be linked to activities of Innovation Center pilots and Medicare ACOs.
Empower an entity to improve the value and ensure the long-term sustainability of Medicare and Medicaid by proposing policy changes that are subject to fast-track, up-or down votes in Congress	• Establishes an independent Medicare Commission that would submit proposals to Congress aimed at extending the solvency of Medicare, slowing Medicare cost growth, and improving the quality of care delivered to Medicare beneficiaries. Specific proposals would be required if a spending trigger is set based on excess cost growth. Congress could make budget-neutral amendments to the proposals, and fast-track legislative procedures would be used to consider the proposals. As written, proposed reforms would be limited to provider payments and could not include benefit designs, premiums, or other sources of revenue increases. [Page 157] • No provision for similar authority related to the Medicaid program.
Reform medical liability to increase support for providers and insurers to make decisions based on high-value, evidence-based practices.	• Encourages but does not require states to develop and test alternatives to the current civil litigation system as a way of improving patient safety, reducing medical errors, encouraging the efficient resolution of disputes, increasing the availability of prompt and fair resolution of disputes, and improving access to liability insurance.

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	Encourages but does not require Congress to consider establishing a state demonstration program to evaluate alternatives to the current civil litigation system. [Page 174] • No provision related to protections for providers based on high-value, evidence-based practices.
Reform anti-trust laws and create processes for expedited waivers from anti-gainsharing and Stark laws	• No separate provision, but waivers presumably would be incorporated in Medicare pilot and ACO authorities described above for shared savings and other payment reforms.
PILLAR 3: IMPROVING HEALTH INSURANCE MARKETS	
Key Reform 1: Restructure Non-Group and Small-Group Markets around an Exchange Model	
Include requirements for guaranteed issue without limited pre-existing condition exclusions; limited health rating (i.e., age and behaviors only); and full risk-adjustment of premiums	• Individual market: Establishes guaranteed issue/renewability, prohibitions on excluding coverage for pre-existing conditions and rescinding coverage; all consistent risk adjustment systems. Ensures that premiums could only vary by tobacco use, age, and family composition. This provision would have a bigger effect if other behavioral steps that could be included elsewhere to improve health could also affect premiums). [Pages 1-2; 8] • "Flat", sliding-scale exchange subsidies: The value of refundable tax credit subsidies would be linked to the actuarial value of the "bronze" plan in the insurance exchange, which would provide stronger incentives to lower costs as consumers must pay more out of pocket for selecting more generous insurance policies. [Page 20-21] • Small-group market: Establishes the same rules as those affecting the individual market, but phased in over a period of up to five years starting in 2013. [Pages 3-4; 8]
Implement an enforced mandate that individuals maintain continuous, creditable basic coverage	• Requires all U.S. citizens and legal residents, beginning in 2013, to purchase coverage through: 1) the individual market, a public program, an employer in the small group market (meeting at least the requirements of a "bronze" plan, or 2) in the large group market. [Page 28]
Establish health insurance exchanges; tie plan participation in exchanges to administrative standardization/simplification and to public reporting of consistent performance measures	• Exchanges: Establishes state exchanges by 2010. [Pages 14-16] • Benefit categories in exchanges: Would establish four benefit categories (i.e., bronze, silver, gold, and platinum), each with specific actuarial standards that participating plans must meet to participate in the exchanges. [Page 17] • Administrative standardization: Requires standard enrollment and marketing requirements and procedures [Pages 14-15] • Public reporting of performance measures: Plans could be rated on their relative quality and price compared to other plans offering products in the same benefit level. The state exchange would

"BENDING THE CURVE" KEY REFORM	SENATE FINANCE COMMITTEE PROPOSAL
	include an indication of the plans' rating on the Web site. [Modification to original Chairman's Mark; Modification of Kerry Amendment #C8]
Key Reform 2: Reduce Inefficient Subsidies for Employer-Provided Health Insurance	
Cap the existing income tax exclusion for employer-provided insurance	• No provision to directly cap the income tax exclusion on employer-based insurance. • Imposes an excise tax on insurers if the aggregate value of employer-sponsored health coverage for an employee exceeds a threshold amount. The tax would be equal to 40 percent of the aggregate value that exceeds $8,000 for individual coverage and $21,000 for family coverage for 2013. The threshold amounts would be indexed to the CPI-U plus one percent beginning in 2014. CBO projects savings of over $200 billion as a result. [Page 199; as modified by Amendment # F1] • A related noteworthy provision would require employers to disclose the value of the benefit provided by the employer for each employee's health insurance coverage on the employee's annual Form W-2 to promote greater transparency in health care costs. [Page 202]
Adjust the cap based on plan demographics and location; phase out geographic adjustments	• N/A
Key Reform 3: Promote Competitive Bidding in Medicare Advantage	
Set local benchmarks at the average of bids, with plans bidding below the benchmark keeping the full difference and plans above the benchmark collecting the difference in additional premiums	• Transitions the calculation of MA benchmarks on actual plan costs as reflected in plan bids rather than statutorily set rates. MA plans would continue to receive 75 percent of the difference between their bids and the benchmark rates as a rebate payment until 2013. Beginning in 2014, MA plans that bid below the new benchmark rates would receive a rebate amount equal to 100 percent of the difference between their bids and the new benchmarks. MA plans that bid equal to or above the new benchmark rates would continue to be paid the benchmark amount and would be required to charge an enrollee premium equal to the difference between their bids and the benchmarks. [Page 134]
Establish a significant quality bonus for attaining measured quality standards, with the full bonus returned to enrollees in enhanced benefits	• Creates a new bonus payment for care coordination and management activities that are conducted by MA plans. Creates a second bonus for prior year achievement or improvement in plan quality performance. When added together, the two bonus payments would equal a maximum of 5 percent of national per beneficiary Medicare costs. [Page 135] • Creates an additional efficiency bonus for MA plans that bid significantly below per capita FFS costs. Specifically, MA plans that

"BENDING THE CURVE" KEY REFORM	SENATE FINANCE COMMITTEE PROPOSAL
	bid more than 85 percent below the average per capita FFS Medicare cost in each payment area would be able to retain 10% of the difference between their bids and 85 percent of the average FFS amount. [Page 137] • Requires MA plans to use 100 percent of bonus payment amounts (including efficiency bonuses) to cover the costs of additional benefits offered to their enrollees. [Page 137]
Consider a transition to including Medicare fee-for-service in the bidding system	• No provision.
PILLAR 4: SUPPORTING BETTER INDIVIDUAL CHOICES	
Key Reform 1: Reform Medicare Benefit Design to Promote Value and Beneficiary Savings	
Restructure Medicare Parts A and B with a global deductible and catastrophic out-of-pocket maximum	• No provision.
Establish tiered copays consistent with the principles of value-based insurance design	• Encourages Medicare beneficiaries to receive preventive screenings by removing cost-sharing for services covered by Medicare and recommended (rated "A" and "B") by the U.S. Preventive Services Task Force. [Page 70] • No provisions related to the broader use of value-based insurance design beyond a limited number of preventive services (as outlined above).
Reform Medicare supplemental plans (Medigap and retiree) to eliminate first-dollar coverage, restrict to 50 percent the coverage of Medicare's copays, and require that coverage maintain tiered copays based on value	• No provision on elimination of first-dollar coverage, restriction to 50 percent of Medicare copays, or maintenance of tiered copays based on value. • Requests that the National Association of Insurance Commissioners create new model plans to include nominal cost sharing to encourage the use of appropriate Part B physician services based on evidence either published or from integrated delivery systems, of how cost sharing affects utilization of appropriate physician care. [Page 144]
Enhance and publicize provider quality and cost information	• Establishes a Hospital Value-Based Purchasing (VBP) program in Medicare that includes public reporting on a range of specific quality measures, on each condition or procedure, and on total performance. [Page 77] • Beginning in 2010, health plans would be required to report the proportion of premium dollars spent on items other than medical care (the definition of "medical care" is not specified). Also in 2010, hospitals would be required to list standard charges for all services and Medicare diagnosis related groups. [Page 39]
Increase flexibility to alter benefits over time to reflect best available value-based standards	• No provision.

"BENDING THE CURVE" KEY REFORM	SENATE FINANCE COMMITTEE PROPOSAL
through greater Medicare flexibility and liability safe-harbors for private plans adopting similar measures	
Key Reform 2: Promote Prevention and Wellness that Reduces Costs	
Target obesity reduction through price incentives (e.g., sugar-sweetened beverage taxes), and through aggressive piloting and evaluation of other reforms that are designed to improve the evidence base of reforms that demonstrably reduce obesity	• Appropriates an additional $25 million for the Secretary to carry out the Childhood Obesity Demonstration Project beyond 2013. [Page 74] • No provision for sugar-sweetened beverage taxes.
Allow premium rebates for measurable health and risk-factor improvements, provided that all beneficiaries have an opportunity to save money	• No provision for the allowance of premium rebates. • Provides Medicare beneficiaries with access (beginning in 2011) to a comprehensive health risk assessment (HRA) to identify chronic diseases, modifiable risk factors, and emergency or urgent health needs. Based on the HRA, Medicare payment would be authorized for a visit to a PCP to create a personalized prevention plan. [Page 69] • Allows all beneficiaries to be eligible for the wellness visit once every year with no co-payment or deductible. [Page 70] • As noted above, encourages Medicare to receive preventive screenings by removing cost-sharing for services covered by Medicare and recommended (rated "A" and "B") by the U.S. Preventive Services Task Force (USPSTF). [Page 70] • Directs the Secretary to establish by 2011 an initiative to provide incentives to Medicare beneficiaries who complete certain healthy lifestyle programs targeting high blood pressure, high cholesterol; tobacco use, overweight or obesity, diabetes, and falls; $100 million over five years would be appropriated for this purpose. [Page 72] • Requires states to cover tobacco cessation services for pregnant women without cost-sharing for such services. [Page 73] • Entitles states opting to provide Medicaid coverage for all USPSTF recommended services and immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) as well as removes cost-sharing for those services to receive a one percent point increase in the FMAP for those services, and for the required comprehensive tobacco cessation services for pregnant women. [Page 73]
Establish public health outcome-based accountability for locally-dominant providers, enforced through bonuses/penalties in Medicare and Medicaid payment rates	▪ No provision.

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Key Reform 3: Support Patient Preferences for Palliative Care	
Provide an opportunity for Medicare beneficiaries to file and regularly update advanced directives that truly reflect their personal preferences for care, and make these directives available to providers	• No provision.
Create a liability safe-harbor for providers adhering to advanced directives	• No provision.