



## Federal Health Care Reform — Senate & House Bills Comparison

PROPOSAL	SENATE BILL (H.R. 3590)	HOUSE BILL (H.R. 3962)
<b>Insurance Coverage Expansions &amp; Health Insurance Reform</b>		
Estimated coverage obtained	94% of legal US residents; 92% of all residents	96% of legal US residents; 94% of all residents
Guaranteed issue, renew	Yes; except for grandfathered plans	Yes; all plans in and outside of exchange
Prohibit annual, lifetime benefits	Yes, except for grandfathered plans Beginning 2014	Yes
Insurance Exchange	Yes; states required to establish by 1/1/2014 Must be government or non-profit Must be financially self-sustaining by 2015 National, state and multi-state (with approval from HHS) Individual and small employer group markets; states may allow larger employer groups to buy through Exchange in 2017 Government Accountability Office (GAO) required to study cost and affordability of plans offered in Exchange	Yes; beginning 1/1/2013 National Exchange; states permitted to operate Exchanges if they meet all requirements applicable in national Exchange For uninsured individuals and employers with <11 FTEs; 2014 for employers with <20 FTEs; 2015 phase-in for all other employers
Community rating	Yes, but does not apply to self-insured plans or plans in effect on day of enactment	Yes; rating limited to age, geography and family size

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	(grandfathered plans)  Limits rating to family size, geography, actuarial value, smoking and age	
Allow sale of insurance across state lines	Yes; if state enters "health care compact," which would allow 2 or more states to agree to allow sale of individual plans across state lines beginning in 2016	Yes; through national Exchange and health care compacts beginning in 2015
Public option; national health plan	No Incorporates multi-state qualified health plans (MSQHP) administered by federal government similar to federal employee health benefits program. Must contract with private insurers to offer 2 or more MSQHPs, one of which must be nonprofit, through Exchanges. Provider rates negotiated by MSQHPs. No state opt-out provisions	Yes Available only through Exchange Limited to individuals and small employers for 2 years, then open "Negotiated" rates between Medicare and average rates of plans sold through Exchange
Opt-out from public option health plan for providers	Not applicable	Yes, for hospitals and physicians
Create Consumer Operated and Oriented Plan (CO-OP)	Yes; by 7/1/2013 at least one non-profit, member-run health insurance plan in each state; cannot be an existing health insurer or sponsored by state/local government	Yes; effective 6 months after enactment Non-profit, member-run health insurance co-op to sell insurance through Exchange
Medicare buy-in for 55+	No	No
Individual mandate	Yes; beginning 1/1/2014	Yes; beginning 1/1/2013

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Individual mandate enforcement	<p>Tax penalty:            \$95 in 2014            \$495 in 2015            Greater of 2% of AGI, premium of minimum benefit set, or \$750 in 2016            2016 penalties + cost of living in 2017 and beyond</p> <p>Penalty for children is 50% of individual penalty up to \$2,250 cap</p>	2.5% income tax up to cost of average premium of basic plan sold in the Exchange
Essential benefit set	<p>Yes;            Individual plans in five benefit sets (bronze, silver, gold, platinum and “young invincible” for under 30 year olds)</p> <p>“Metal” benefit sets include preventive, primary care, ER, hospitalization, outpatient, imaging, pediatric, Rx drugs, mental/chemical health;</p> <p>Young invincible is catastrophic plan + 3 primary care visits per year</p> <p>Out-of-pocket limits set at HSA limits; no cost-sharing for preventive services</p>	<p>Yes; developed by public-private Health Benefits Advisory Council</p> <p>Must include preventive, primary care, ER, hospitalization, outpatient, imaging, pediatric, Rx drugs, mental/chemical health</p> <p>No cost-sharing for preventive care            Limit out-of-pocket to \$5,000/individual; \$10,000/family indexed to CPI</p>
Premium subsidies	<p>Yes; costs \$348 billion over 10 years            Available up to 400% of FPL if insurance is bought through Exchange</p>	<p>Yes; “affordability credits”; beginning 1/1/2013            Available up to 400% of FPL</p>
Employer mandate	<p>No; but employers with 50+ employees who don’t offer coverage or offer coverage with premium that exceeds 9.8% of employee’s income and whose employees receive premium subsidies would be assessed \$750/employee            Employers with 50+ employees that offer</p>	<p>Yes; beginning 1/1/2013            Employers must provide coverage and contribute 72.5% of premium for lowest cost, essential benefit plan for single employee and 65% for family or pay 8% payroll tax            Must auto-enroll employees in employer coverage</p>

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	coverage and has employee obtain premium subsidies would be assessed \$3,000/subsidized employee or \$750/employee	Sliding scale payroll tax penalty from 2-6% for small employers with annual payroll between \$500,000 and \$750,000  Small employers with annual payroll below \$500,000 are exempt from mandate
Limit enrollment waiting period	Yes; employers with 50 or more employees fined \$600/employee for which a 60+ day waiting period applies	Yes
Medicaid expansion (for lowest income with or without children)	Yes; up to 133% FPL  100% FMAP rate from 2014 until 2016; then 90%  Beginning April 1, 2010, states can cover adults at/below 133% in Medicaid  As of 2014, states must cover foster children up to age 26 who have aged out of foster care	Yes, up to 150% of FPL  100% FMAP for one year (FY2014); then 91%
Require CHIP enrollees to get coverage through Exchange	Yes; CHIP funding ends in FY15, then eligible children covered through Medicaid or Exchange (with DHHS approval) States continue to receive 23% enhanced FMAP for FY16-19 Children of qualifying state/local employees can enroll in CHIP	Yes; CHIP funding ends 12/31/2013, then eligible children covered through Medicaid or Exchange (with DHHS approval)
Medicaid maintenance of effort	Yes; until 12/31/2013	Yes; based on coverage on as of 6/16/2009
Presumptive eligibility	Yes; Allows Medicaid-participating hospitals to make presumptive eligibility determinations beginning 1/1/2014	No

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	States could define benefits available during presumptive eligibility timeframe	
Limit out-of-pocket costs	Yes; Above 400% FPL: \$5,950/individual, \$11,000/family 300-400% FPL: \$4,000/individual, \$7,300/family 200-300% FPL: \$3,000/individual, \$5,500/family Below 200% FPL: \$2,000/individual, \$4,000/family	Yes; Above 350% FPL: \$5,000/individual, \$10,000/family 150-350% FPL: sliding scale Below 150% FPL: \$500/individual, \$1,000/family
Limit prior-authorization and cost sharing for ER services	Yes; prohibits prior authorization and increased cost sharing for emergency services, whether delivered by in- or out-of-network provider	No
Require coverage for during clinical trials	Yes; prohibits from dropping coverage of patient that participates in clinical trial; requires coverage of routine care associated with clinical trial	No
Minimum payout percentage for health plans	Yes; beginning 2014 Applies to grandfathered plans, too Must rebate excess of 85% medical loss ratio in large group or 80% of small group market	Yes; 85% medical loss ratio
Basic Health Program	Available for states to offer to individuals below 200% of FPL who are not eligible for state Medicaid program. Operates outside of the Exchange.	No
High risk pool	Yes; costs \$5 billion over 10 years Within 90 days of enactment individuals previously denied coverage due to pre-existing condition and uninsured for 6 months could enroll in high risk pool until Exchange	Yes; Beginning 1/1/2010 until Exchange Available for anyone with eligible medical condition, retiree with high premium increase, or uninsured for 6 months Premiums set no higher than 125% of prevailing rate in state Deductible no higher than \$1,500/individual Cost sharing limited to \$5,000

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Reinsurance pool for early retirees	Yes; costs \$5 billion over 10 years Within 90 days of enactment; pay 80% of cost of employer-sponsored insurance for 55-64 year-old-retirees between \$15,000 and \$90,000	Yes; costs \$10 billion over 10 years Within 90 days of enactment; pay 80% of cost of employer-sponsored insurance for 55-64 year-old-retirees between \$15,000 and \$90,000
Dependent coverage extension		Yes; for children up to age 27
Repeal health plan anti-trust exemption		Yes
<b>Payment Cuts &amp; Reforms</b>		
Value Based Purchasing (expansion of CMS demo)	<p>Yes; applies to PPS hospitals</p> <p>Budget neutral</p> <p>Data collection begins in 2012; withholds beginning 2013</p> <p>Based on quality measures for heart failure, heart attack, pneumonia, surgical care activities, and patient satisfaction (does not include readmissions rate as factor in VBP)</p> <p>Efficiency measures (at least 2) to be included in 2014</p> <p>Funded through phased-in 1-2% withholds across all DRGs on low-performing hospitals Includes incentives for attainment or improvement</p> <p>CAHs: 3-year demo projects</p> <p>Pilot programs for VBP for psych, IRFs, LTCHs,</p>	Yes; authorizes CMS to employ VBP but not required

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	<p>cancer hospitals and hospice in 2016; could be expanded in 2018.</p> <p>Physicians: 2% incentive for reporting; 1% penalty for not reporting (spends \$100 million over 10 years)</p>	
Hospital-acquired conditions	<p>Yes; \$1.5 billion over 10 years Begin FY15 1% Medicare cut to bottom quartile of hospitals based on hospital-acquired conditions</p> <p>Extends Medicare nonpayment policy to Medicaid</p>	Yes; extends Medicare nonpayment policy to Medicaid
Readmissions policy	<p>Yes; beginning 2013 \$7 billion over 10 years Applies to PPS hospitals Begin with heart attack, heart failure and pneumonia measures from Hospital Compare; expanded to other yet-to-be-named conditions in 2015 Not limited to preventable/avoidable readmissions Poor performing hospitals will have <i>all</i> Medicare payments reduced by an amount equal to value of payments for excess readmission</p>	<p>Yes; beginning FY12 \$9.3 billion over 10 years Applies to PPS and CAH hospitals 1-5% Medicare cut to poor performing hospitals for all Medicare discharges Based on 30-day readmissions for heart attack, heart failure and pneumonia HHS could expand list of conditions in 2013 Not limited to preventable/avoidable readmissions Readmissions penalties for LTCHs, in-patient rehab, home health and SNFs</p>

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<p>Bundles</p>	<p>Yes Voluntary pilot program to test 8-10 conditions for bundled payment by 2013; DHHS may expand program after 1/1/2016</p> <p>Hospitals, physician groups, SNF and home health agency may apply</p> <p>Requires separate pilot program for continuing care hospital (CCH) model, which provides traditional inpatient rehab facility services, LTCH and SNF under common management. Would include CCH stay + 30 days post discharge</p> <p>Medicaid bundling demo in 8 states from 2012-16</p>	<p>Yes; Instructs CMS to develop a plan (pilot/demo project) for bundles in Medicare</p>
<p>Accountable Care Organizations</p>	<p>Yes; \$4.9 billion over 10 years estimated savings</p> <p>Authorizes DHHS to use other payment methodologies, including ACOs</p> <p>Also referred to as a "shared savings program" and "partial capitation"</p> <p>Includes Part A and Part B services</p> <p>Allows DHHS to give preference to providers participating in ACO model with private payers</p> <p>Allows hospitals to participate in leadership role of ACO</p> <p>Allows state Medicaid programs to run pediatric ACO demos from 2012-17</p>	<p>Permits pilot projects but could be interpreted to exclude hospitals</p>

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<p>Global payment demonstration project</p>	<p>Yes; requires 5-state Medicaid demo of global payment system for payment to safety net providers</p>	
<p>Reduce geographic disparities</p>	<p>Not directly Beginning in 2012, CMS provides reports to physicians comparing their resource use with that of other physicians Beginning in 2015 for certain physicians at 2017 for all physicians, budget neutral value-based purchasing program for physicians based on quality of care compared to cost and applying a payment modifier (value index) under the physician fee schedule</p>	<p>Instructs IOM to complete two studies and make recommendations for physician and hospital payments to decrease geographic variations and reward high-value; recommendations implemented unless Congress overrides; HHS can spend \$8 billion over 2 years based on recommendations then budget neutral</p>
<p>Medicare DSH cuts</p>	<p>\$24.4 billion over 10 years  75% cut in FY15 and beyond to eliminate DSH payments above "empirically justified" amounts; amount of cut would be reduced if uninsured rate decreases don't materialize  Portion of 75% cut returned to hospitals depending on amount of uncompensated care they provide</p>	<p>Yes; \$10.3 billion over 10 years; triggered by 8% reduction in national uninsured rates between 2012-14; readjust DSH payments based on 2016 uncompensated care rates</p>

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Medicaid DSH cuts	<p>Yes; \$18.5 billion over 10 years; begin when state's uninsured rate drops 45% from FY09 rate</p> <p>Amount of initial cuts:  25% cut for low-DSH states that spent &lt;99.9% of DSH allotment  17.5% cut for low-DSH states that spent &gt;99.9% of DSH allotment  50% cut for DSH states that spent &lt;99.9% of DSH allotment  35% cut for DSH states that spent &gt;99.9% of DSH allotment</p> <p>Future cuts based on rate of decrease in uninsured population within state</p> <p>No cuts greater than 50% of FY12 DSH allotment amount</p>	<p>Yes; \$10 billion over 10 years</p> <p>\$1.5 billion in FY17  \$2.5 billion in FY18  \$6 billion in FY19</p>
Market basket update cuts	<p>Yes; \$102.7 billion over 10 years; phased-in with larger cuts in out years; 0.2% of cuts in years 2016-19 will not occur if certain drops in rate of uninsured don't result</p> <p>Cuts apply to PPS inpatient; hospital outpatient; inpatient psych. hospitals; inpatient rehab and LTCHs:  2010: market basket - 0.25%  2011: market basket - 0.25% (-0.5% for LTCHs)  2012: market basket - (0.1% + productivity adjustment)  2013: market basket - (0.1% + productivity adjustment)  2014-19: market basket - (0.2% + productivity adjustment)  2020 &amp; beyond: market basket - productivity adjustment</p>	<p>Yes; \$158.4 billion over 10 years  Cuts begin 1/1/2010  Cuts apply to PPS inpatient; hospital outpatient; inpatient psych. hospitals; inpatient rehab and LTCHs:</p>
Wage index reform	<p>Yes; spends \$200 million over 10 years  Requires CMS report and recommendations for comprehensive reform by 2012</p>	<p>No</p>
Extend section 508 reclassifications	<p>Yes; spends \$500 million over 10 years</p>	<p>Yes; spends \$500 million over 10 years</p>

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	Extended through 9/30/2010 DHHS must make up difference in payment for first 1/2 of 2010 by 12/31/2010	Extended through 9/30/2010
Delay or eliminate physicians' sustainable growth rate formula	No (Note: 2-month extension of sustainable growth rate cuts to physician payments passed Senate in other legislation awaiting Presidential signature/veto)	No (Note: 2-month extension of sustainable growth rate cuts to physician payments passed House in other legislation awaiting Presidential signature/veto)
National health board (Super MedPAC, IMAC, IMAB, IPAB)	Yes; Independent Payment Advisory Board; \$23.4 billion over 10 years  Enhanced MedPAC-like role to recommend payment changes to reduce costs; with recommendations implemented unless Congress takes other action; can make non-binding recommendations on system-wide health care cost saving measures  Includes authority over CAHs  Excludes authority over PPS hospitals and others subject to market basket cuts for 10 years	No
Physician rate increases	Yes; 10% bonus for primary care and rural general surgery	Yes; 5% bonus for primary care; 10% bonus for primary care in shortage area
Expand 340B drug program	Yes; includes coverage for inpatient drugs, inpatient and outpatient programs for children's hospitals, cancer hospitals, CAHs and certain sole-community hospitals and rural referral centers	Yes; to include children's, CAHs, Medicare-dependent, sole community, mental health hospitals and rural referral centers Does <i>not</i> include inpatient drugs

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Extend temporary FMAP increase	No	Yes; for 6 additional months (Note: also included in House Jobs bill)
<b>Transparency</b>		
Hospital-Acquired Infections	Requires public reporting of HAI based on Medicare claims data used to prevent moving from lower- to higher-paying DRG	Yes; require public reporting through NHSN
Quality transparency	<p>Yes</p> <p>Value-based purchasing and other quality measures would be publicly available</p> <p>IRFs, LTCHs and Hospice: pay-for-reporting with 2% reduction for non-reporting</p> <p>Inpatient psych hospitals and units required to report quality measures in 2014 with 2% reduction for non-reporting</p> <p>Insurers in Exchanges must report on pediatric quality measures</p> <p>Medicaid-specific quality measures created and publicly reported</p>	No
Cost transparency	Yes; require hospitals to report charges for all services and DRGs	No
Health plan transparency	<p>Yes</p> <p>Requires all plans to publicly report payment claims, payment policies, rating practices, clinical services expenses, quality improvement costs,</p>	No

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	<p>non-claims costs and premium revenues</p> <p>Medical reimbursement data centers: Collect reimbursement data from health insurers and make public; develop fee schedules and data-based tools to reflect market rates in geographic areas; can be non-profit or academic</p>	
Comparative effectiveness research	Yes; creates an institute for clinical comparative effectiveness research including at least 1 hospital representative on 21-member board; results cannot be used to mandate coverage or reimbursement decisions; financed partially by fee on health plans through 2019	Yes; Creates Center for Comparative Effectiveness Research within AHRQ; Creates independent Comparative Effectiveness Research Commission with 19 members
Center for Medicare and Medicaid Innovation (CMI)	Yes; by 2011; within CMS; allows for limiting tests of payment and delivery reform within certain geographic areas; instructions to focus on projects expected to reduce costs and improve quality	Yes; by 2011
<b>Provisions Relating to Specific Types Hospitals or Providers</b>		
New requirements for 501(c)(3) hospitals	Yes; complete and publicly report community needs assessment at least every 3 years; adopt and publicize a financial assistance policy; prohibit charging uninsured individuals more than insured rates; additional Form 990 reporting and IRS review similar to SEC oversight of publicly traded companies	No
Extend rural community hospital demonstration program	Yes; for 5 years; base year for hospitals in first 5 years of program set at first cost report beginning on/after first day of 5-year	No

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	extension period	
Urban Medicare-dependent hospitals	Requires study within 9 months of enactment on need for additional payment for urban Medicare-dependent hospitals (do not receive IME or DSH payments, not CAH, rural referral center, sole community hospital, or small rural, and at least 60% of its inpatient days were Medicare) for inpatient services.	No
Low-volume hospitals	Yes; spends \$300 million over 10 years Expands and improves Medicare inpatient PPS adjustment for low-volume hospitals Increases size of low-volume hospital from 1,500 to 1,600 discharges per year	No
Long-Term Care Hospitals	2-year extension of LTCH protections and moratorium in Medicare, Medicaid and SCHIP Extension Act of 2007, but increases the market basket cut to LTCH in FY12	No
Long-term care	FMAP increases available to states that rebalance long-term care services between institutional, home and community-based settings	No
Home health payment rebasing	Yes; in 2014  Calls for study of improving access to home health care for patients with low-income, living in underserved areas, or high-severity illnesses with authority for demo after study	Yes; in 2011  Calls for study of variation in home health margins and performance by June 2011

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Skilled nursing facilities	One-year delay of SNF payment changes to 10/1/2011	Freezes FY10 market basket update for SNFs at FY09 rates
<b>Employer provisions</b>		
Small business tax credits for employee health insurance	Yes; beginning in 2010; full credit available to firms with average wages up to \$25,000; smaller credit available for firms with avg wages up to \$50,000	Yes; 2-year credit up to 50% of employer costs for coverage if employer has less than 25 employees and average wages less than \$40,000
Wellness program incentives	Yes; beginning 2011 \$200 million in grants over 5 years for businesses with less than 100 employees and don't have wellness program as of enactment Employer-sponsored plans could offer premium discounts or other incentives for employee participation in wellness programs DHHS demo program for individual market incentives in 2014	Yes; beginning 7/1/2010 Grants to small employers for wellness programs Available for 3 years Grants capped at lesser of \$50,000 or \$150/employee
Mandatory vouchers for Exchange	Yes; employers that offer coverage must provide a "free choice premium voucher" equal to employer's premium contribution for employees to buy insurance through Exchange if the cost of employer-sponsored insurance is between 8-9.8% of employee's income	No
<b>Workforce Provisions</b>		
Redistribute unused GME slots	Yes; redistributes 65% of unused residency training positions with focus on primary care and general surgery; qualified hospitals could request up to 75 new slots	Yes; redistributes 90% of unused residency positions with focus on primary care; qualified hospitals could request up to 20 new slots
Increase scholarship and loan	No	Yes

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repayments		
<b>Other Provisions</b>		
Administrative simplification	Yes; require DHHS to consider transaction standards and operating rules if there could be greater uniformity and reduced costs; evaluation must begin 1/1/2012 and conducted every 3 years	Yes; offers implementation assistance for providers in rural and underserved areas
RAC expansion	Yes; to Medicaid and Parts C and D	Yes
Physician self referral/physician-owned hospitals	Yes; eliminates Stark exception for physician-owned hospitals other than those under development as of 8/1/2010	Yes, eliminates Stark exception but grandfathers in hospitals with Medicare agreement as of 1/1/2009
Tort reform	Authorizes DHHS to award demo grants to states for development, implementation and evaluation of tort litigation alternatives	Allows states to test certificate of merit alternatives to medical liability system
<b>Revenue provisions</b>		
Surcharge on high income earners	No	Yes; beginning 1/1/2011 5.4% tax on individuals with \$500,000 AGI, families with \$1 million AGI
Medical device manufacturer fee	Yes; \$20 billion over 10 years; fee on manufacturer (not an excise/point-of-sale tax)	Yes; \$20 billion over 10 years; sales tax mechanism that could be easily passed on to providers
Health insurance fee	Yes; \$80 billion phased in over 10 years; exemption for non-profit insurers with 90% loss ratio	No
High-premium plans tax	Yes; \$149 billion over 10 years Beginning 2013	No

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	40% excise tax on high-premium insurance plans (\$8,500/individual, \$23,000/family)	
Hospital insurance tax for high-wage workers	Yes; 0.9% for single with \$200,000+ and couples with \$250,000+	No
Tanning services	Yes; 10% beginning 7/1/2010	No
Limit HSA, medical flex account, pre-tax expenditures to prescription medications (not over-the-counter drugs)	Yes; 1/1/2011	Yes; 1/1/2011
Limit medical flex account contribution to \$2,500	Yes; 1/1/2011	Yes; 1/1/2013
<b>Estimated total cost by CBO over 10 years</b>	<b><i>\$855 billion</i></b>	<b><i>\$1.052 trillion</i></b>