

House and Senate Health Reform Draft Legislation Comparison

The chart below serves to highlight the major components of the leading health reform proposals that have been put forward thus far by Congress. It is based upon materials that have been made available to the public, and is subject to change as the process moves forward. The information below is up to date as of November 9, 2009.

	House Tri-Committee H.R. 3962	Senate HELP Committee S. 1679	Senate Finance Committee S. 1796
	<p>* <u>Energy & Commerce</u> marked up and passed their portion of the bill on July 31 by a 31-28 vote</p> <p>* <u>Ways & Means</u> marked up and passed their portion of the bill on July 17 by a 23-18 vote</p> <p>* <u>Education & Labor</u> also completed marking up and pass their portion of the bill on July 17 by a 26-22 vote.</p> <p>*The various committee drafts were merged into H.R. 3200, which has since been reintroduced as H.R. 3962, the Affordable Health Care for America Act, which passed the House by a vote of 220-215 on November 7, 2009.</p>	<p>* HELP Committee completed mark up of their bill and passed it July 15 by a party line vote of 13-11.</p> <p>*On September 17, 2009, new HELP Committee Chairman Senator Tom Harkin (D-IA) formally introduced The Affordable Health Choices Act (S. 1679), which is the final legislative text of the language passed by HELP in July.</p>	<p>* Senate Finance Committee completed marking up its draft on October 2, 2009. A vote on this mark was postponed until receiving a cost analysis from CBO. The Finance Committee passed their draft by a vote of 14-9 (1 Republican, Senator Olympia Snowe of Maine joining with the Democrats) on October 13, 2009.</p>
Medicare	<p>-Reduces the period for Medicare claims submission to no later than 12 months.</p> <p>-Requires the Institute of Medicine to</p>	<p>-Does not included SGR Reform</p> <p>-Does not include PQRI provisions</p>	<p>-Reduces the period for Medicare claims submission to no later than 12 months.</p> <p>-Establishes Medicare</p>

	<p>conduct a study on geographic variation in health care spending across all providers and recommend changes to Medicare payments that promote high-value care; require the Secretary to develop an implementation plan and issue regulations to implement the Medicare payment changes unless Congress acts to stop implementation.</p> <p>-Establishes of Center for Medicare and Medicaid Innovation within CMS. Establishes within the Centers for Medicaid and Medicaid Services a Center for Medicare & Medicaid Innovation. The purpose of the Center will be to research, develop, test, and expand innovative payment and delivery arrangements to improve the quality and reduce the cost of care provided to patients in each program. Dedicated funding is provided to allow for testing of models that require benefits not currently covered by Medicare. Successful models can be expanded within both programs.</p> <p>-Conduct Medicare and Medicaid pilot program to test payment incentive models for accountable care organizations and to assess the</p>	<p>-Establishes a Health Care Program Integrity Coordinating Council and department positions at HHS and DOJ to deal with fraud, waste, and abuse in both public and private coverage</p> <p><u>GME</u></p> <p>-Reforms GME to increase the supply, education and training of doctors, nurses, and “other” health care workers, especially in pediatric, geriatric and primary care – by awarding grants</p>	<p>Commission to submit proposals for reducing excess cost growth. These proposals will be submitted to Congress and without legislative action, will go into effect automatically. Prohibits proposals that would ration care, change benefits or eligibility.</p> <p>- Create an Innovation Center within the Centers for Medicare and Medicaid Services to test, evaluate, and expand in Medicare, Medicaid, and CHIP different payment structures and methodologies to “foster patient-centered care, improve quality, and slow Medicare costs growth.”</p> <p>- Requires CMS to develop a comprehensive “One PI” Integrated Data Repository – in addition to including all claims and payment data for Medicare/Medicaid it would include new data sources such as quality of care under fee for service, patient neglect/abuse, site visits and penalties/settlements.</p> <p>- Establish a hospital value-based purchasing program in Medicare</p>
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	<p>feasibility of reimbursing qualified patient-centered medical homes.</p> <p>- Seeks to reduce waste, fraud, and abuse in public programs by allowing provider screening, enhanced oversight periods, and enrollment moratoria in areas identified as being at elevated risk of fraud in all public programs, and by requiring Medicare and Medicaid program providers and suppliers to establish compliance programs.</p> <p><u>SGR Reform</u></p> <p>-Does not include SGR Reform – long term fix was separated from H.R. 3962 and is now a stand-alone bill, H.R. 3961.</p> <p><u>PQRI Modifications</u></p> <p>-Extends through 2012 payments under the PQRI program, which provide incentives to physicians who report quality data to Medicare.</p> <p><u>GME</u></p> <p>- Provides incentives for the training of primary care physicians and</p>		<p>to pay hospitals based on performance on quality measures</p> <p><u>SGR Reform</u></p> <p>-Does not include a permanent SGR fix, but would prevent the physician fee cut in 2010 and replace with a .5% increase.</p> <p><u>PQRI Modifications</u></p> <p>-Extends past 2010 payments under PQRI.</p> <p><u>GME</u></p> <p>- Increase the number of Graduate Medical Education (GME) training positions by redistributing currently unused slots, with priorities given to primary care and general surgery and to rural states.</p>
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	encourages medical residency training in non-hospital settings		
Medicaid	-Expand Medicaid to all individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 150% FPL.	-Original drafted included an expansion Medicaid to <u>all</u> individuals with incomes up to 150% FPL, but this language was removed in the committee amended draft.	- Expand Medicaid to all individuals with incomes up to 133% of the federal poverty level.
Quality	<p><u>Comparative Effectiveness</u></p> <p>- Establishes a Center for Comparative Effectiveness Research within the Agency for Healthcare Research and Quality to conduct, support, and synthesize research on outcomes, effectiveness, and appropriateness of health care services and procedures.</p> <p>-Independent CER Commission will oversee the activities of the Center.</p> <p>- Provides that comparative effectiveness research findings may not be construed as mandates for payment, coverage, or treatment or used to deny or ration care. Establish the Comparative Effectiveness Research Trust Fund.</p> <p><u>Quality Measure</u></p>	<p><u>Comparative Effectiveness</u></p> <p>-HHS “shall establish a national strategy to improve the delivery of health care services, patient health outcomes, and population health”</p> <p>-Creates a Patient Safety Research Center, with the duties to “identify, evaluate and disseminate” information on best practices for improving health care quality.</p> <p>-Provides within 5 years of enactment for implementation of a system for reporting quality measures that protect patient privacy and makes such performance measures publicly available via a website.</p> <p>-Establishes the Center for</p>	<p><u>Comparative Effectiveness</u></p> <p>- Establish a non-profit Patient-Centered Outcomes Research Institute to identify research priorities and conduct research that compares the clinical effectiveness of medical treatments. The Institute will be overseen by an appointed multi-stakeholder Board of Governors and will be assisted by expert advisory panels. Includes language that “the Institute would not mandate coverage, reimbursement, or other policies for any public or private payer. None of the reports or research findings would be construed as mandates, guidelines, or policy recommendations.”</p> <p><u>Quality Measures</u></p>

	<p>- Establish the Center for Quality Improvement to identify, develop, evaluate, disseminate, and implement best practices in the delivery of health care services. Develop national priorities for performance improvement and quality measures for the delivery of health care services.</p>	<p>Health Outcomes Research and Evaluation to “ to collect, conduct, support, and synthesize research with respect to comparing health outcomes, effectiveness, and appropriateness of health care services and procedures in order to identify the manner in which diseases, disorders, and other health conditions can most effectively and appropriately be prevented, diagnosed, treated, and managed clinically.”-Includes language that “Center reports and recommendations shall not be construed as mandates for payment, coverage, or treatment.”</p>	<p>- “Develop a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health.”</p>
<p>Public Health/Workforce Development</p>	<p>- Establish a multi-stakeholder Advisory Committee on Health Workforce Evaluation and Assessment to develop and implement a national health workforce strategy.</p> <p>-Establishes a Public Health Workforce Corps to address public health workforce shortages. The</p>	<p>- HHS to award grants to states, public health departments, federally qualified health centers, and other nonprofits to promote positive health behaviors for populations in medically underserved areas through the use of community</p>	<p>- Establish a multi-stakeholder Workforce Advisory Committee to develop a national workforce strategy for recruiting, training, and retaining a health care workforce that meets current and projected health care needs.</p>

	<p>program provides scholarship and loan repayment support for public health professionals serving in areas of need.</p> <ul style="list-style-type: none"> - Provides funding to support training programs for general, pediatric, and public health dentists and dental hygienists, including faculty loan repayment benefits. 	<p>health workers.</p> <ul style="list-style-type: none"> - Establishes National Health Care Workforce Commission, with purpose of advising Congress with on the health care workforce and projected workforce needs <p><u>Loan Repayment Program</u></p> <ul style="list-style-type: none"> -Creates Public Health Workforce Loan Repayment Program – to be eligible health professional must be a US citizen; have employment with a Federal, State, local, or tribal public health agency to commence upon graduation and serve for at least 3 years. Loan payment can be up to \$35,000 annually. “Health professional” definition includes dentists <p><u>Dental Training Program</u></p> <ul style="list-style-type: none"> -HHS grants available for hospitals, dental schools or non-profit for development or operation of “approved 	
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		<p>professional training program” in the field of general dentistry, pediatric dentistry, or public health dentistry. Also provides financial assistance to those participating in training programs, and loan repayment programs for faculty.</p> <p><u>“Alternative Dental Health Care Providers”</u></p> <p>-HHS award grants to 15 eligible entities to establish a demonstration program to develop training programs to train, or employ, “alternative dental health care providers” in order to increase access to dental health care services in rural and other underserved communities. “Alternative dental health care providers” defined to include community dental health coordinators, advance practice dental hygienists, independent dental hygienists, supervised dental hygienists, primary care</p>	
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		physicians, and dental therapists.	
<p style="text-align: center;">Shared Responsibility</p>	<p><u>Individual Mandate</u></p> <ul style="list-style-type: none"> - Require all individuals to have “acceptable health coverage” (hardship exemptions made). Those without coverage pay a penalty of 2.5% of their adjusted income above the filing threshold up to the cost of the average national premium for self-only or family coverage under a basic plan in the Health Insurance Exchange. <p><u>Employer Mandate</u></p> <ul style="list-style-type: none"> - Require employers to offer coverage to their employees and contribute at least 72.5% of the premium cost for single coverage and 65% of the premium cost for family coverage of the lowest cost plan that meets the essential benefits package requirements or pay 8% of payroll into the Health Insurance Exchange Trust Fund. - Annual payroll less than \$500,000 are exempt from the mandate. Those between \$500,000-\$750,000 receive 	<p><u>Individual Mandate</u></p> <ul style="list-style-type: none"> -All individuals will be required to have health coverage (hardship exemptions made) – enforced through a tax penalty to be determined by the Secretary of the Treasury. <p><u>Employer Mandate</u></p> <ul style="list-style-type: none"> - Language includes that an employer (exempt if 25 or fewer employees) must either offer qualified health coverage to all full and part employees or shall pay to the Secretary of HHS \$750 for full time employee and \$375 per part time employee. 	<p><u>Individual Mandate</u></p> <ul style="list-style-type: none"> - All U.S. citizens and legal residents will be required to have ‘qualifying’ health coverage. (hardship exemptions made) Those that do not comply will face a tax penalty of \$750 per adult per year (phased in by 2017). <p><u>Employer Responsibility</u></p> <ul style="list-style-type: none"> - Does not include a comprehensive employer mandate. - Assess employers with more than 50 employees and do not offer employees health coverage a fee for each employee who receives a tax credit for health insurance through an exchange. (The penalty is the lesser of a flat dollar amount equal to the average national tax credit for each full-time employee receiving a tax credit or \$400 times the total number of full-time employees in

	reduced “pay or play” penalties.		<p>the firm.)</p> <ul style="list-style-type: none"> • Require employers with 200 or more employees to automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of coverage if they have coverage from another source.
<p>Health Insurance Exchange or Gateway</p>	<p>-Create a National Health Insurance Exchange, through which individuals and employers (phasing-in eligibility for employers starting with smallest employers) can purchase qualified insurance, including from private health plans and the public health insurance option.</p> <p>-Premium and cost-sharing credits available to individuals/families with incomes up to 400% of the federal poverty level (or \$73,240 for a family of three in 2009)</p> <p>-Create four benefit categories of plans to be offered through the Exchange:</p> <p>*Basic plan includes essential benefits</p>	<p>-Creates state-based American Health Benefit Gateways, through which individuals and small employers can purchase qualified coverage</p> <p>-Low income Americans who enroll in plans through the Gateways will be eligible for premium credits, provided on sliding scale, available to individuals/families with incomes up to 400% of the FPL</p> <p>-Gateway shall establish procedures for the certification, recertification, and decertification, consistent with guidelines developed by HHS</p>	<p>- Create state-based exchanges for the individual market and small business health options program (SHOP) exchanges for the small group market.</p> <p>- Allow small businesses with up to 100 employees to purchase coverage through the SHOP exchanges beginning in 2015 and permit states to allow businesses with more than 100 employees to purchase coverage in the SHOP exchange beginning in 2017.</p> <p>- Creates the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of non-profit, member-run health insurance companies in all 50 states and District of Columbia.</p>

	<p>package and covers 70% of the benefit costs of the plan;</p> <p>* Enhanced plan includes essential benefits package, reduced cost-sharing compared to the basic plan and covers 85% of benefit costs of the plan;</p> <p>*Premium plan includes essential benefits package with reduced cost-sharing compared to the enhanced plan and covers 95% of the benefit costs of the plan;</p> <p>* Premium plus plan is a premium plan that provides additional benefits, such as oral health and vision care.</p> <p>*Create a Consumer Operated and Oriented Program (CO-OP) to facilitate the establishment of non-profit, member-run health insurance cooperatives to provide insurance through the Exchange.</p> <p>-Restrict access to coverage through the Exchange to individuals who are not enrolled in qualified or grandfathered employer or individual</p>	<p>of health plans as qualified health plans.</p> <p>- Eligible small employers (employers who elect to make all full-time employees eligible for a qualified health plan via Gateway and have 50 or fewer full time employees) can receive tax credits based on the number of full time employees, proportion of employees provided health insurance and employee wages.</p> <p>--Gateway access restricted to those not enrolled in qualified or grandfathered coverage, Medicare, Medicaid, TRICARE or VA.</p> <p>-CHIP enrollees <u>have option</u> to use Exchange for coverage.</p>	<p>- Create four benefit categories of plans plus a separate “young invincible plan” to be offered through the exchange, and in the individual and small group markets.</p> <p>- Provide refundable and advanceable premium credits to individuals and families with incomes between 133-400% FPL to purchase insurance through the health insurance exchanges.</p>
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	coverage, Medicare, Medicaid, TRICARE, or VA coverage.		
Public Option	<p>-Exchange includes a public option, required to negotiate rates with providers so that the rates are not lower than Medicare rates and not higher than the average rates paid by other qualified health benefit plan offering entities. Health care providers participating in Medicare are considered participating providers in the public plan unless they opt out.</p> <p>- Public option must meet the same requirements as private plans regarding benefit levels, provider networks, consumer protections, and cost-sharing. Require the public plan to offer basic, enhanced, and premium plans, and permit it to offer premium plus plans. Finance the costs of the public plan through revenues from premiums.</p>	<p>- Provides that a public option, now referred to as a “community” option will be included in the Gateway.</p> <p>-Community option would not require provider participation or impose a penalty for non-participation. Also, no requirement for an individual to participate in the public option or be penalized for non-participation.</p> <p>-Unless state offers/assumes cost for addition benefits, community option would only include essential benefits defined by the Secretary of HHS</p> <p>-Community plan shall be self-sustaining via premiums, but will require a start-up fund.</p> <p>-Secretary of HHS will negotiate reimbursement rates</p>	<p>- Does not include a public option.</p>

		<p>with providers for community plan. Rate must “not be higher, in aggregate, than the average reimbursement rates paid by health insurance issuers offering qualified health plans through the Gateway.”</p>	
<p>Insurance/ Essential Benefits</p>	<p>-Private insurance must guarantee issue/renewability may not be based on gender. Prohibits exclusion for pre-existing conditions.</p> <p>- Minimum benefits definition: preventive and primary care, emergency services, hospitalization, physician services, outpatient services, day surgery and related anesthesia, diagnostic imaging and screenings (including x-rays), maternity and newborn care, pediatric services (including dental and vision), medical/surgical care, prescription drugs, radiation and chemotherapy, and mental health and substance abuse services that at least meet minimum standards set by Federal and state laws.</p> <p>- Includes provision allowing a qualified health benefits plan to</p>	<p>-Prohibits pre-existing condition exclusions</p> <p>-Issue/renewability can not be based on gender</p> <p>-Require insurers to provide coverage for “preventative care measures” without cost sharing.</p> <p>-All plans in the individual and group markets are required to provide coverage for children up to age 26</p> <p>-Essential benefits definition, includes the following minimums and shall be outlined by the Secretary of HHS</p> <ul style="list-style-type: none"> -Ambulatory patient services. -Emergency services. - Hospitalization. 	<p>-Private insurance must guarantee issue/renewability may not be based on gender. Prohibits exclusion for pre-existing conditions.</p> <p>- Minimum benefits definition: preventive and primary care, emergency services, hospitalization, physician services, outpatient services, day surgery and related anesthesia, diagnostic imaging and screenings (including x-rays), maternity and newborn care, pediatric services (including dental and vision), medical/surgical care, prescription drugs, radiation and chemotherapy, and mental health and substance abuse services that at least meet minimum standards set by Federal and state laws.</p>

	<p>subcontract with stand-alone health insurance issuers or insurers for the provision of dental, vision, mental health, and other benefits and services,</p>	<ul style="list-style-type: none"> -Maternity and newborn care. -Mental health and substance abuse services. - Prescription drugs. - Rehabilitative devices, and laboratory services. -Preventive and wellness services. -Pediatric services, including oral and vision care as determined appropriate by the Council. 	<p>- Stand-alone dental plans would be permitted to offer pediatric dental benefits directly and to offer coverage through the exchange. These plans must comply with all consumer protection requirements in order to participate in the exchange.</p>
<p>Misc.</p>	<p><u><i>Flexible Spending Accounts(FSA) & Health Savings Accounts (HSA)</i></u></p> <ul style="list-style-type: none"> - Limit the amount of contributions to a FSA for medical expenses to \$2,500 per year. - Increase the tax on distributions from a HSA that are not used for qualified medical expenses to 20% (from 10%) of the disbursed amount. <p><u><i>Medical Device Tax</i></u></p> <ul style="list-style-type: none"> -Includes a 2.5% annual tax on medical device to be assessed at point of sale. Does not exempt any category 	<p><u><i>Oral Health Prevention Services</i></u></p> <ul style="list-style-type: none"> - A 5-year national public education campaign will be established focusing on oral healthcare prevention and education including prevention of oral disease and oral cancer. This campaign will begin no later than 2 years after enactment. -Grants will be awarded to community-based providers of dental services (FQHCs, 	<p><u><i>Flexible Spending Accounts(FSA) & Health Savings Accounts (HSA)</i></u></p> <ul style="list-style-type: none"> - Limit the amount of contributions to a FSA for medical expenses to \$2,500 per year. - Increase the tax on distributions from a HSA that are not used for qualified medical expenses to 20% (from 10%) of the disbursed amount.

	<p>of medical supplies so the tax would be applicable to FDA Class I - III medical devices.</p> <p><u>Liability Reform</u></p> <p>-Establishes an incentive program for States to adopt and implement alternatives to traditional medical malpractice litigation. Such alternatives may not include provisions that limit attorneys' fees or impose caps on damages.</p> <p><u>Oral Health Provisions</u></p> <p>-HHS will make grants to, or enter into contracts with, eligible entities to plan, develop, operate, or participate in an accredited professional training program for oral health professionals. Will also provide financial assistance to oral health professionals who are participants in any such program, and plan to work in general, pediatric, or public health dentistry, or dental hygiene.</p> <p><u>CARES Act</u></p> <p>-Includes the text of H.R. 1339, the CARES Act, which would require</p>	<p>hospital clinics, etc.) as well as private providers to “demonstrate the effectiveness of research-based dental caries disease management activities.” Essentially, those receiving grants will collect data to submit to Health and Human Services for planning and implementing the public education campaign.</p> <p>-The CDC and HHS will enter in cooperative agreements with states to establish oral health program guidance, data collection, and interpretive services and work to develop a “multi-dimensional delivery system for oral health and implement science-based programs.” Specially referenced are the promotion of dental sealants and water fluoridation.</p> <p>-States will be mandated to report to HHS oral health care measurements (yet to be determined) for the Pregnancy</p>	
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	<p>insurance companies, to cover corrective procedures to address congenital craniofacial anomalies for children age 21 and under. This language would also clarify the purpose of these procedures as reconstructive, rather than cosmetic.</p> <p><u>Antitrust Reform</u></p> <p>-Repeals the antitrust exemption that was established in the 1945 McCarran-Ferguson Act for health insurance companies.</p>	<p>Risk Assessment Monitoring System.</p> <p>-HHS will develop oral health care components that shall include “tooth-level surveillance” for inclusion in the National Health and Nutrition Examination Survey.</p>	
<p>Financing</p>	<p>-CBO cost - \$894 billion over ten years.</p> <p>-Partially financed through savings from Medicare and Medicaid are estimated to be \$426 billion over ten years and the primary sources of these savings include incorporating productivity improvements into Medicare market basket updates, reducing payments to Medicare Advantage plans, changing the Medicaid drug rebate provisions, and cutting Medicaid and Medicare DSH payments.</p> <p>-Primarily funded by The largest source of new revenue will come</p>	<p>-CBO Cost - \$645 billion over 10 years (note – does not have jurisdiction over Medicare, Medicaid or revenue raising)</p>	<p>-CBO Cost - \$829 billion over 10 years</p> <p>-Primarily financed through reducing payments to Medicare Advantage plans, expected savings via newly created Medicare Commission, changing Medicaid drug rebate provisions and cutting Medicaid and Medicare DSH payments.</p> <p>-New revenue is an excise tax on high cost insurance.</p>

	from a 5.4% surcharge imposed on families with incomes above \$1,000,000 and individuals with incomes above \$500,000.		
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