Side-By-Side of Major Health Reform Proposals

Issue	House TriComm Legislation: America's Affordable Health Choices Act of 2009 (Updated 7/24/09)	Senate HELP Committee Legislation: American Health Choices Act (Updated 7/15/09)
Employer Mandate ("Shared Responsibility" for Employers)	Beginning January 1, 2013, an employer must offer qualified health coverage and contribute to that coverage or pay an 8 percent payroll 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: • For an individual, 72.5% of the lowest cost plan that meets the essential benefits package; or • For family coverage, 65% of the lowest cost plan that meets the essential benefits package. • For part-time employees, the contribution requirement is a proportion of the average weekly hours of work by the employee to the minimum weekly hours for full time employment as specified by the Commissioner. An employer may auto-enroll employees and an employee may opt out. An employer may request a hardship exemption from participation requirements for any two-year period. Exemptions will be granted if the employer can reasonably demonstrate that meeting requirements to provide health coverage would result in job losses that would negatively impact the community in which the employer is located (Rep. Hunter amendment, E&L Committee, passed by voice vote). Employers not providing or contributing to health insurance	Beginning in 2011, businesses with 25 or more employees that: • Do not offer health insurance • Do not contribute at least 60% of the monthly premium would be required to pay the government a $750 per worker per year "equity assessment", or $375 for part-time workers. After 2013, these amounts would be adjusted for inflation. Those with fewer than 25 employees would be exempt from the requirement. Individuals with gross incomes not exceeding 150% of FPL would not be considered "qualified individuals". Employers must notify each employee of the existence of the American Health Benefits Gateway, including a description of services provided by the Gateway. Defines "qualified employer" as someone who: • Elects to make all full-time employees eligible for a qualified health plan; • Employers electing to enroll in a qualified plan made available through a Gateway. Individuals eligible for employer-sponsored coverage are considered "qualified individuals" <u>only</u> if that coverage does not meet criteria for minimum qualifying coverage or is not affordable. Unaffordable coverage is defined as when the portion of worker-paid premiums

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	coverage would be required to pay a new tax equal to 8% of average payroll. Exception is provided for employers with less than $250,000 in annual payroll and required contributions gradually increase with payroll expenses. Firms between: • $250,000-$300,000 in payroll would pay 2%; • $300,000-$350,000 would pay 4%; • $350,000-$400,000 would pay 6%; and • $400,000 and above would pay 8%. Changes to ERISA, PHSA and IRC: • Allows states to seek a waiver of ERISA to create a state single-payer option instead of the public option (Rep. Kucinich amendment, E&L Committee, passed 27-19). • 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 (Rep. Courtney amendment, E&L Committee, passed by voice vote). • The proposal allows plans to make an election to be subject to the health participation requirements (pay or play). If an employer makes such election, it will be treated as the establishment and maintenance of a group health plan. Separate elections may be made for separate lines of business and for full time and part time employees.	exceeds 12.5% of the worker's adjusted gross income in 2013 (to be adjusted for inflation). Exempts seasonal workers from being counted in the total number of employees (working less than 120 days per year). Also prevents independent contractors from being treated as employees.

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	• Regular audits will occur to determine noncompliance. Penalties include:
	  • Employers subject to $100/day civil monetary penalty for failure to provide coverage or pay payroll tax.
	  • Total annual penalty against employers is limited to 10 percent incurred or paid for the health plan over the past year or $500,000.
	
	State laws relating to private rights of action with remedies shall apply, expressly overturning ERISA's federal, uniform remedy scheme. We are currently checking with Congressional staff on intent.	

Individual Mandate	The legislative proposal imposes a tax on individuals failing to obtain acceptable coverage by January 1, 2013, which includes: qualified coverage, grandfathered coverage, Medicare, Medicaid, VA, or TRICARE. The tax is equal to 2.5% percent of income and would be capped at the national average premium for self-only basic coverage offered through a health exchange. The tax is also prorated to number of months of non-coverage. Religious and hardship exemptions are allowed. Exemptions are also granted for dependents and those living in states where Gateways are not yet established.	Beginning in 2011, all legal residents would be required to carry health insurance. Penalty for not purchasing qualified coverage to be enforced through a tax penalty—the amount of which is to be determined by the Secretary of the Treasury. Exempt if qualified coverage is not available. Exempt if member of an Indian tribe. Exempt for "financial hardship". Exempt for those with income below 150% FPL. Can purchase qualified or non-qualified plan.

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Public Plan Option	Creates a new public health insurance option to be offered through the Health Insurance Exchange beginning in 2013 that must meet the same requirements as private plans regarding benefit levels, provider networks, consumer protections, and cost-sharing. Requires that the cost of coverage and administrative costs of the public plan be financed through revenues from premiums. Premiums would be geographically-adjusted. • $2 billion initial appropriation to establish the public option and provide for administrative costs and initial claims. Sets provider payment rates in the public plan at Medicare rates and allow bonus payments of 5% for the first three years for providers that participate in both Medicare and the public plan and for pediatricians and other providers that don't typically participate in Medicare. • After the first three years, The HHS Secretary would be given the flexibility to set rates. Generally speaking, the overall spending "should" remain consistent with initial levels. HHS Secretary could negotiate prices for services, prescription drugs and medical devices for the public option. Medicare providers could opt out of the public option. Permits the public plan to develop alternative payment mechanisms to improve outcomes, reduce disparities, prevent or manage chronic illness, etc. Alternative payment mechanisms	Creates a new public health option to be offered through the Health Insurance Exchange. Credits provided to individuals and families would be reduced based on income up to 400% of FPL. • The Secretary would negotiate payment rates for health services and products and set premiums to cover expected costs. Reimbursement rates are capped at no greater than the average paid by private plans in the Gateway. • Provides start up loans to qualified carriers to establish a community plan and pay initial claims. Loans must be repaid within 10 years. • Qualified carriers must be not-for-profit. Contracts are made for periods of 5 to 10 years. • Administrative fees would be paid to carriers, and carriers would not assume insurance risk. • Establishes risk corridors for plans to limit premium risk for carriers.

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	include: medical home and other care management payments, value-based purchasing, bundling of services, performance based payments, direct contracting with providers or partial capitation. Physician participation: • Preferred physician: agrees to accept public option's payment rate as payment in full and do not impose charges in excess of the balance billing limitations in Medicare. Providers excluded from other federal health programs would be excluded from participating in the public option.	
Subsidies for Individuals/ Families	In the first two years, affordability credits could only be used to purchase a basic plan. In order to receive credits, individuals must have coverage through an Exchange-participating health benefits plan, not through an employer purchasing coverage through the exchange. Employees offered employer coverage are not eligible in most circumstances for affordability credits. Beginning in year two, employees spending more than 11% of income on their employer-provided plan would be eligible to receive income-based affordability credits in the Exchange. Subsidies would be linked to income levels on a sliding scale. Families and individuals with incomes: • Between 133-150% FPL would be expected to pay 1.5% of their income;	Provides sliding scale premium subsidies for individuals/families up to 400% of FPL. The amount that an individual is required to pay would be ratably reduced to 1 percent of income in the case of an individual with an adjusted gross income that does not exceed 150% of FPL. Premium subsidies would be set as a percentage of a reference premium—the weighted average of the 3 lowest cost qualified health plans available in the region/community—annually adjusted and indexed to the medical care component of the CPI for urban consumers. For those with incomes between 150-200% of FPL, the subsidies would apply to that reference bid for the highest tier plans. For those with incomes between 200-300% of FPL, the subsidies would apply to that reference bid for the middle-tier plans. For those with incomes between 300-400% of FPL, the subsidies would apply to that reference bid for the lowest tier plans.

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	• Between 150-200% FPL would be expected to pay 3%-5% of their income; • Between 200-250% of FPL would be expected to pay 5%-7% of their income; • Between 250-300% FPL would be expected to pay 7%-9% of their income; • Between 300-350% of FPL would be expected to pay 9%-10% of their income; and • At 350-400% FPL would be expected to pay 10%-11% of their income. Subsidies would be capped at the average premium for the three lowest-cost basic plans. Cost-sharing amounts would also be reduced through subsidies, such that individuals with incomes between: • 133-150% of FPL would have a basic plan covering 97 percent of expenses; • 150-200% of FPL: plan would cover 93% of expenses; • 200-250% of FPL: plan would cover 85% of expenses; • 250-300% FPL: plan would cover 78% of expenses; • 300-350% FPL: plan would cover 72% of expenses; and • 350-400% FPL: plan would cover 70% of expenses. Undocumented aliens would not be eligible to obtain affordability credits.	The bill contemplates minimum standard ranges for actuarial values and cost-sharing for individuals/families at varying income levels. • All of the qualified health plans would include annual out-of-pocket limits – with the lowest actuarial plan value's (76% actuarial value) out-of-pocket cap equal to out-of-pocket maximums for high-deductible/HSA plans ($5,800 for self-only coverage and $11,600 for family coverage in 2009). Subsidies would be paid to the state/regional Gateway on behalf of an eligible individual/family. Gateways would be responsible for administering the subsidies including remitting payments from the government to the qualified health plans.
Small Business Credit/ Employer Subsidies	The legislation provides a 50 percent credit towards qualified expenses for employee health coverage. The credit phases out for:	Beginning in 2010, small employers (fewer than 50 employees) would be provided with a health options program credit. To qualify:

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	• Employers whose average and annual employee compensation exceeds $20,000 (indexed to inflation); • The number of employees exceeds 10 ; and • Is not available for coverage of any employee whose aggregate compensation exceeds $125,000. Small business is defined as an employer with 25 or fewer employees. The Commissioner and SBA would establish a program to provide counseling and technical assistance to small employers (Rep. Fudge/Rep. Titus amendment, E&L Committee, passed 28-18). 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.	• Employers must pay an average wage of less than $50,000 • Pay at least 60% of employee health expenses Credit is equal to $1,000 for each employee with single coverage, $2,000 for each employee with family coverage, and $1,500 for each employee receiving insurance coverage for two adults or one adult and one or more children—adjusting for firm size—and number of months of coverage provided. Bonus payments given for each additional 10% of health expenses above 60% paid by employer. The credit would be available indefinitely but firms would be allowed to take the credit in only three out of every four years.
Reinsurance	Creates a temporary reinsurance program for businesses providing retiree health coverage. • $10 billion Reserve Trust Fund at Department of Treasury to help offset costs 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.	• Creates a temporary reinsurance program for employers providing health insurance coverage to retirees ages 55 to 64. Will reimburse employers for 80% of a retiree claim that is between $15,000 and $90,000. 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. • Total funding for the program is capped at $10 billion. • This program will end when the State Gateway structure is established.
COBRA	Would allow workers to keep COBRA coverage until they become eligible for other coverage or the Exchange is in place (Rep. Davis	No provision.

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	amendment, E&L Committee, passed by voice vote).	
Health Insurance Exchange/ Gateways	Creates a nationwide Health Insurance Exchange. Individuals would be eligible to purchase an Exchange plan, as would those whose existing employer coverage is deemed insufficient by the federal government. Acceptable coverage includes enrollment in other qualified coverage and most other federal health programs. Once deemed eligible to enroll in the Exchange, individuals would be permitted to remain in the Exchange until becoming Medicare or Medicaid-eligible. Individuals joining the exchange would remain eligible for Exchange coverage even if their circumstances change which would otherwise exclude them from eligibility. Eligibility would continue until the individual is no longer enrolled with an Exchange-participating health benefits plan. Requires Health Choices Center to set standards in order to avoid "improper steering" of high risk individuals. Employers with 15 or fewer employees would be permitted to join the Exchange in its first year, with employers with 25 or fewer employees permitted to join in its second year (Rep. Titus amendment, E&L Committee, passed 29-19). In the third year and thereafter, the Health Choices Commissioner would be given the authority to expand employer participation "as appropriate". The goal is eventually to allow all employers access to the Exchange. Individuals eligible for Medicaid will be enrolled in Medicaid, rather than the Exchange. Exceptions would be made for childless adults with incomes under 133% of FPL ($14,400 per year per	Provides grants to states—based on population—to establish Gateways, which are analogous to state connectors/exchanges, which would be responsible for: • Facilitating the purchase of health insurance. • Establishing procedures for certifying qualified plans. • Making information on health benefits options available to consumers. • Administering premium subsidies and risk-adjustment payments. • Facilitating enrollment and outreach. • Certify qualified health plans that meet specific criteria. • Assessing surcharges or insurers to pay for administrative and operation expenses of the Gateway. Provides flexibility for states to establish regional or other interstate Gateways. Requires states to adjust payments to health plans based on the actuarial risk of plan enrollees using methods established by the Secretary. Maintains state regulatory and oversight over health insurance coverage and states explicitly that state laws on market conduct or related consumer protections are not preempted. Provides grants for states to establish navigators to facilitate enrollment in qualified plans. Requires plans participating in the Gateway to provide incentives to

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	individual) who had other qualifying coverage within the previous six months. These individuals would be allowed the choice to obtain coverage through Medicaid or the Exchange. • Non-traditional Medicaid beneficiaries would also include children born in the US and not otherwise covered under acceptable coverage. Eligibility would exist from birth until the time the individual is enrolled in other coverage. Benefits that must be made available each year would be determined by the Commissioner. • There would be a requirement that each plan provide one basic plan in each operating area. • Optional for each plan to offer one enhanced and one premium plan. • The difference between basic, enhanced and premium plans would be the levels of cost-sharing required, not the benefits covered. The Commissioner would establish a range of cost-sharing variation not to exceed +/- 10% with each benefit category. • Premium-plus (fourth tier) would be available, and would include extra benefits such as dental or vision. Plans may offer multiple premium-plus plans. Requires that plans: • Be licensed; • Report data; • Implement affordability credits; • Participate in risk pooling; and • Provide culturally and linguistically appropriate services;	providers to better coordinate care, reduce hospital readmissions and implement wellness and health promotion activities; prohibit plans from contracting with hospitals with greater than 50 beds unless those hospitals adopt patient safety and discharge planning programs. Gateways can charge a tax of up to 4% of premiums to cover implementation and administrative costs.

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	• Contract for outpatient services with essential community providers for basic plans. Creates a Health Insurance Exchange trust fund, financed partially by employer payroll taxes. States may offer their own Exchange or join with a group of States to create their own Exchange.	
Health Benefit Requirements	For all qualified health benefits plans: • Requires minimum set of benefits • 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, 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 the Center for Quality Improvement from developing quality-adjusted life year measures or any	Establishes minimum federal requirements for health insurance coverage (for insurers and group plans, including ERISA) through "essential health benefits" that plans must cover for premiums to be eligible for credits/subsidies, including coverage in the following categories: • Ambulatory patient services; • Emergency services; • Hospitalization; • Maternity and newborn care; • Mental health and substance abuse services; • Prescription drugs; • Rehabilitative and laboratory services; • Preventive and wellness services; and • Pediatric services, including oral and vision care. Requires all insurers and self-insured group health plans to develop and implement reimbursement structures that provide incentives for: • the provision of high quality care, case management,

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	other measures that can be used to deny benefits against a beneficiary's wishes (Rep. Gingrey amendment, E&C Committee, passed by voice vote). Prohibits limits besides cost sharing on coverage unrelated to clinical appropriateness. Cost sharing must equal the actuarial value of the benefits at: • 70% for basic • 85% for enhanced • 95% for premium • 95% plus coverage of services beyond the essential benefits package for premium plus plan. Requires copayments and not coinsurance to be used to the maximum extent possible. Group health plans would have a 5-year grace period to meet new benefit standards and requirements.	• care coordination and chronic care management, • reduction in preventable hospital readmissions through discharge planning, • improvements in patient safety and reduction in medical errors through the appropriate use of best clinical practices, evidenced based medicine and health information technology, • wellness and health promotion activities, • child health measures, as defined under the Social Security Act, • Culturally and linguistically appropriate care, as defined by the Secretary of HHS.
	Establishes a public-private Health Benefits Advisory Committee to recommend covered benefits and an essential benefits package. The committee would include: • US Surgeon General (Chair) • 9 members appointed by the President (not federal employees) • 9 members appointed by GAO • An even number (not to exceed 8) of Federal employees, appointed by the President.	"Medical Advisory Council" – council run through the Institute of Medicine (IOM) at the National Academies of Science. • The Council would be required to ensure that the "actuarial gross value" of the essential benefits package is equal to the benefits provided under a "typical employer plan." Provides reports to Congress on "essential health care benefits" for establishing minimum qualifying coverage and income contingent subsidies.

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Health Board/ Council	Members must include providers, consumers, employers, labor, health insurers, and experts in health financing, delivery, disparities, children's health and at least one practicing physician. The Committee would recommend benefit standards to the HHS Secretary. • Committee must take innovation into account and their recommendations must not lead to rationing of care. Initial recommendations are due one year after enactment. The legislation also creates the Health Choices Administration as an independent, executive Branch agency, headed by a health Choices Commissioner appointed by the President and confirmed by the Senate. The Commissioner would: • Establish and enforce standards for qualified benefits plans • Establish and operate a Health Insurance Exchange • Administer individual health affordability credits • Collect data to promote quality and value and address health disparities • Impose sanctions	
Individual and Group Market Reforms	The legislation includes mandates on plans offered in the individual and group markets. 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. Creates an exception for consumer for consumer directed health plans and arrangements and treats these plans as qualified	Establishes comprehensive insurance market regulations in the group (both inside and outside Gateway) and individual market, including: • Guaranteed available and renewability of coverage. • Modified community rating, with age bands not to exceed 2:1. • Prohibits pre-existing condition exclusions. • Prohibits annual or lifetime limits.

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	coverage (Rep. Petri Amendment, E&L Committee, passed by unanimous consent). Group health plans would be allowed 5 years to become compliant with the new mandates established by the bill, which 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. • Premiums charged may not vary except by age (2:1). • Prohibits discrimination in offering of benefits. • Requires adequate provider networks to ensure adequate access to services and requires transparency in cost sharing differences between in-and out-of-network coverage. It is unclear if a plan sponsor certifies they are in compliance, whether there would be a grace period, because the bill treats the plan as new.	• Requires health insurance issuers offering group or individual coverage to disclose total premium revenue spending on: (1) reimbursement for clinical services; (2) activities to improve quality; and (3) all other non-claims costs. Prohibits discrimination against individuals based on health-status, including establishing eligibility rules based on: (1) health status; (2) medical condition; (3) claims experience; (4) receipt of health care; (5) medical history; (6) genetic information; (7) evidence of insurability; and (8) disability. Insurance issuers would be required to cover preventive services (with an A or B rating from USPSTF, immunizations and services recommended for infants, children and adolescents) and cover dependents up to age 26. Requires a group health plan and health insurance issuer offering group or individual coverage to develop a reimbursement structure for making payments to health care providers that provides incentives for high quality care that reflects the payment policy of the Medicare program. Collective bargaining agreements (CBA) ratified before enactment of the legislation would not be affected, until the collective bargaining agreements terminate. Group health plans and health insurance issuers may not impose any preexisting condition exclusions. Enrollment may be restricted as it relates to open or special enrollment periods. Group health plans and insurers may not establish lifetime or annual

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		limits on the dollar value of benefits for any participant or beneficiary.

Medical Loss Ratio	• Medicaid: Requires qualified plans to have a minimum medical loss ratio of not less than 85%, with the methodology to be determined by the Health Choices Commissioner. Provision would take effect on or after July 1, 2010.
	
	• MA: 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.
	
	• QHBPs: Beginning in 2011, qualified plans are required to achieve a medical loss ratio of a percentage to be determined by the Health Choices Commissioner. Plans exceeding that limit are required to issue rebates to enrollees.
		Insurers are required to provide an "annual rebate" for administrative costs that exceed certain thresholds.

Medicare Provisions	**Part A Reforms**: **SNFs:** MB freeze for second, third and fourth quarters of FY 2010. • Codifies recalibration factor included in FY 2010 SNF-PPS proposed rule. • Provides budget neutral adjustment within payment	None

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	system to improve payment accuracy for non-therapy ancillary services and therapy services. **IRFs:** MB freeze for the second, third and fourth quarters of FY 2010. **Productivity Improvements**: Adds a productivity adjustment to the MB update for inpatient hospitals, SNFs, inpatient rehabilitation hospitals, psychiatric hospitals and hospice beginning in 2010. • Sets a floor for inpatient hospital MB update so that the combination of the productivity adjustment and any adjustments for quality reporting or meaningful use of electronic health records cannot cause the MB update to dip below zero. *The same adjustment would also be incorporated into the HOPPS and home health market basket updates beginning in 2010.* **DSH:** Report due to Congress by January 1, 2016 on Medicare DSH payments. If there is a "significant decrease" in the national rate of insurance, the HHS Secretary would have the authority to adjust Medicare DSH payments starting in 2017 to the empirically justified level plus an adjustment reflecting uncompensated care costs. **Part B Reforms:** **SGR:** Requires that the update to the single conversion factor for 2010 be the percentage increase for the MEI for that year.	

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	Rebases the SGR using 2009 for future update adjustments, beginning in 2011. Places limitations on physician services included in the target growth rate computation. **Misvalued PFS Codes:** Requires the Secretary of HHS to periodically identify codes used under the physician fee schedule as being misvalued and to make appropriate adjustments to the relative values associated with those codes. The Secretary is required to identify misvalued codes by identifying codes that have the fastest growth, that have substantial changes in practice expense, codes for new technologies, multiple codes that a frequently billed for a single services, codes with low relative values, and any other codes determined by the Secretary. Requires the Secretary of HHS to establish a process to validate relative units under the physician fee schedule. Appropriates $20,000,000 for FY 2010 and each subsequent year for implementation. **Payments for Efficient Areas:** Provides incentive payments for physicians practicing in areas identified as the most cost-efficient areas of the country. The payment would be available from January 1, 2011-January 1, 2013 and would be equal to the regular payment plus 5%. **Physician Quality Reporting Initiative**: Extends PQRI payments through 2012. Before 1012, the HHS Secretary is responsible for developing a plan to integrate clinical reporting on quality measures with reporting requirements relating to meaningful use of EHRs.	

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	Part B Premium Adjustment: Allows capital gains from sale of a primary residence to count as a life-changing event to utilize a more recent tax year for determination of the Part B income-related premium. **Part D Reforms:** **Rebates:** Effective 2011, Medicaid rebates would be applied to Part D drugs dispensed to full-benefit dual eligibles. **Coverage Gap**: Beginning in 2011, the Secretary shall progressively increase the initial coverage limit and decrease the annual out-of-pocket thresholds to eventually eliminate the Part D coverage gap. There is no date certain by which the gap would close, although the legislative summary prepared by House Democratic staff states that the coverage gap would close completely in 2023. • Includes requirement that manufacturers provide discounts of 50% for brand-name drugs utilized by Part D enrollees in the Part D coverage gap. **LTC Pharmacies**: Repeals existing law requirement that requires long-term care pharmacies to have not less than 30 days (but not more than 90 days) to submit claims to the sponsor for reimbursement under the plan. **Mid-Year Enrollment Changes**: Establishes a special enrollment period for beneficiaries enrolled in a Part D plan that materially changes their formulary mid-year that reduces the coverage or	

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	increases the cost-sharing of a drug that has been prescribed to the beneficiary. **MISC.:** **ASCs:** Required to submit cost reports. Also requires the Secretary to require reporting of additional data relating to the quality of services furnished at an ambulatory surgical center beginning in 2012. **Reducing Hospital Admissions:** Makes adjustments to hospital payments for excessive readmissions beginning October 1, 2010. Payments to hospitals that would be reduced if they have excessive readmissions to an amount equal to the base operating DRG payment amount for the discharge and the adjustment amount that is equal to 1 minus the ratio of aggregate payments for excess readmissions or the floor adjustment factor which will be .99 in FY 2012; .98 in FY 2013; .97 in FY 2014; or .95 in the following FYs. **Home Health MB Update:** Provides for a 0 percent market basket update in 2010. **Payment Adjustments for Home Health Care:** Provides adjustments in case mixes beginning in 2010. Rebases Home Health prospective payment amount for 2011 to be determined by the Secretary of HHS. If for some reason the Secretary is unable to calculate a new base payment amount for	

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	2011, the Secretary is required to substitute 95 percent of the amount for the calculation. **Post Acute Care Services Payment Reform**: Requires HHS Secretary to submit a report to Congress within 3 years of enactment on how to implement post-acute bundled payments. **Self-Referrals**: Prohibits physician ownership in hospitals that are new as of January 1, 2009. Grandfathers ownership structures of hospitals existing prior to January 1, 2009. **SNPs**: Extends the SNP program through 2012 and extends Fully Integrated Dual Eligible Special Needs Plans (FIDESNP) through 2015. **MA Reforms** Starting in 2011, phases in the calculation of MA county rates based upon fee-for-service costs over three years • In 2011, the MA benchmark equals 2/3 of the current law benchmark plus 1/3 local FFS costs • In 2012, the MA benchmark equals 1/3 of the current law benchmark plus 2/3 local FFS costs • In 2013 and thereafter, amount to be specified by the Secretary. **Quality Bonus for MA Plans**: Beginning in 2011, MA plans identified as high quality plans, will receive additional payments equal to 1% in 2011, 2% in 2012, and 3% in 2013 and thereafter. MA plans	

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	identified as an improved quality MA plan shall receive additional payments equal to 0.33 percent in 2011, 0.66 percent in 2012, and 1% in 2013 and thereafter. **Enrollment Periods**: Starting 2011, the Annual Coordinated Election Period which currently occurs from November 15 – December 31 is changed to November 1 – December 15 of each year. **Employer Group Plans**: Starting 2011, the Secretary may provide waivers of other MA requirements to employer group plans only if 90 percent of the MA eligible individuals enrolled in such plan reside in a county in which the MA organization offers an MA local plan. **MA Regional Plan Stabilization Fund**: Eliminated. **Rural Access** **Telehealth**: Expands and enhances beneficiary access to telehealth services. Establishes new advisory committee on telehealth to expand coverage and recommend reimbursement changes. Expands telehealth services to rural renal dialysis facilities. **Extenders**: Holds rural hospitals harmless from implementation of the outpatient prospective payment system (PPS) through 2011. Also extends through 2011: • Disregard of hospital reclassifications for purposes of	

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	determining the applicable hospital wage index; • The floor for calculating the work geographic index in the physician payment formula; • Existing payment provisions for the technical component of physician pathology services; and • Rural add-on for payment of ambulance services and improvements to air ambulance services. **Beneficiary Improvements** • Increases assets tests for MSP and low-income subsidy to $17,000/individual and $34,000/couples. • Removes MA rebates from calculation of low-income subsidy benchmark. **Reducing Health Disparities**: Requires the Secretary to conduct a study that examines the extent to which Medicare service providers utilize, offer, or make available language services for beneficiaries of limited English proficiency and ways that Medicare can pay for language services. The study must include the extent to which plans utilize or offer language services. **GME**: Provides for the re-distribution of unused GME training slots, beginning in 2011, to hospitals, provided that no hospital shall receive more than 20 additional positions, and that all re-distributed residency positions be directed towards primary care. Increases reimbursement for training in non-provider settings. Establishes a demonstration project for approved teaching health centers. Establishes new rule for counting resident time for didactic and scholarly activities.	

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Expansion of Public Programs/ Medicaid	Beginning in 2013, expands Medicaid to all non-disabled, childless individuals with incomes below 133-1/3 percent of FPL ($14,400 per individual). Provides 100 % federal FMAP match.
	
	Requires State Medicaid programs to provide coverage for newborns up to the first 60 days of life who do not otherwise have acceptable coverage, beginning in 2013. Federal government would pay 100% of federal FMAP match.
	
	Beginning in 2013, requires State Medicaid programs to cover parents and individuals with disabilities under age 65 with incomes at or below 133% of FPL ($29,300/year for a family of 4). Federal government would pay 100% of federal FMAP match.
	
	Requires HHS Secretary to reduce Medicaid DSH payments to States by a total of $10 billion:
	
	• Reduce by $1.5 billion in FY 2017;
	• Reduce by $2.5 billion in FY 2018; and
	• Reduce by $6.0 billion in 2019.
	
	Establishes 5 year medical home pilot program, including children and high risk pregnant women. Federal government would match costs of community care workers at:
	
	• 90% for first two years
	• 75% for next three years, up to a total of $1.235 billion.
	
	States must accept individuals into Medicaid programs determined
		Assumes expansion of Medicaid to 150% of FPL for all individuals. Individuals eligible for Medicaid would be covered through state Medicaid programs and not eligible for credits to purchase coverage through Gateways.
		
		Grants individuals eligible for CHIP the option of enrolling for CHIP or a qualified plan through a gateway.
		
		Funding for Federally Qualified Health Centers:
		
		• FY 2010: $2,988,821,592
		• FY 2011: $3,862,107,440
		• FY 2012: $4,990,553,440
		• FY 2013: $6,448,713,307
		• FY 2014: $ 7,332,924,155
		• FY 2015: $ 8,332,924,155
		• FY 2016 and beyond: amount to be adjusted by:
		
		  • One plus average percentage increase in costs incurred per patient
		
		  • One plus the average percentage increase in total number of patients.

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	to be a non-traditional Medicaid eligible individual. Beginning in 2013, states may not use eligibility standards or procedures under CHIP that are more restrictive than those in effect on June 16, 2009. CHIP enrollees are required to obtain coverage through the health insurance exchange. Services that qualify for optional Medicaid coverage: • Nurse home visitation services for families with a first-time pregnant woman or child under age 2. • Family planning services. • Services provided at freestanding birth centers that are not part of a hospital. Mandates that Medicaid pays for primary care services at a rate not less than: • 80% of applicable Medicare payment rate for services furnished in 2010; • 90% for services furnished in 2011 • 100 % for services furnished in 2012 and after. Extends translation services. Creates optional eligibility category for low-income individuals	

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	infected with HIV. Directs non-payment for hospital services to treat conditions (identified under Medicare) that could reasonably have been prevented, effective January 1, 2011. Extends TMA through December 31, 2012. Extends Medicaid payments to pharmacists for multiple source drugs through the end of 2010. Beginning in 2011, limits Medicaid payments to 130% of AMP. Increases minimum manufacturer rebate for brand-name drugs purchased by State Medicaid programs from $15.1% of AMP to 22.1% of AMP, effective in 2010. Effective July 1, 2010, Manufacturers would be required to pay rebates to State Medicaid programs for drugs dispensed to program beneficiaries enrolled in Medicaid managed care organizations. Prohibits federal matching payments for the cost of healthcare acquired conditions that are determined to be non-covered services for Medicare purposes.	
Health IT	Requires integration of clinical reporting using quality measures and health information technology beginning in 2012. Develop interoperable standards for using HIT to enroll individuals in public programs and provide grants to states and	HHS to develop interoperable and secure standards and protocols to enroll individuals in public programs. Provides grants to states and other governmental entities to adopt and

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	other governmental entities to adopt and implement enrollment technology. Expedited standards approval process.	implement enrollment technology and to replace legacy systems. Expedited standards approval process.
FOBs	None.	Includes provision for 12 years of data exclusivity, plus additional exclusivity in certain situations.
CER	Establishes a Center for Comparative Effectiveness Research within AHRQ, to "conduct, support and synthesize research with respect to outcomes, effectiveness and appropriateness of health care services and procedures. An independent Comparative Effectiveness Research Commission will be established to oversee and evaluate the activities carried out by the Center. The Commission would consist of: • Director of AHRQ • Chief Medical Officer of CMS • 15 additional members representing "broad constituencies of stakeholders." Would establish a "Health Care Comparative Effectiveness Research Trust Fund". Transfers to the fund include: • FY 2010: 90,000,000 • FY 2011: $100,000,00 • FY 2012: $110,000,000 The fund would be financed by a premium tax on all insurance policies capped at $375 million.	Establishes within AHRQ a center to 'collect, support, and synthesize research with respect to comparing health outcomes, effectiveness, and appropriateness of health care services and procedures." Within one year, the center will develop methodological standards to be used when conducting studies of comparative health outcomes and value. The center will assist users in HIT in promoting timely incorporation of research findings into clinical practice. The Center's reports and recommendations shall not be construed as mandates for payment, coverage or treatment.

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Long Term Care/ Community Living Assistance	Establishes a national voluntary insurance program, the CLASS Independence Benefit Plan, for community living assistance services and supports (Rep. Pallone Amendment, E&C Committee, passed by voice vote).	Community Living & Assistance Services & Supports (CLASS): establishes a voluntary national insurance program for purchasing community living assistance services and support (CLASS Program) to provide care for 10 million Americans with severe disabilities. The program will provide individuals with functional limitations a cash benefit to purchase non-medical services and supports necessary to maintain community residence. The program is financed through voluntary payroll deductions: all working adults will be automatically enrolled in the program, unless they choose to opt-out.
Improving Quality/Health System Performance	**Physician Payments Sunshine Provision**: The bill creates new reporting requirements on drug and device manufacturers and distributors regarding their financial relationships with physicians and other health care providers. Specifically, manufacturers and distributors would be required to disclose the details behind any "transfer of value directly, indirectly, or through an agent," with some limited exceptions. A "transfer of value" includes any drug sample, gift, travel, honoraria, educational funding or consulting fees, stocks, or other ownership interest. Monetary penalties for non-reporting are included. Strengthen **primary care** and care coordination by increasing Medicaid payments (by 5%) for primary care providers, providing Medicare bonus payments to primary care practitioners serving in health professional shortage area (an additional 5%), and conducting pilot programs in Medicare and Medicaid to assess the feasibility of reimbursing qualified patient-centered medical homes. Improve coordination of care for dual eligibles by creating a new office within the Centers for Medicare and Medicaid Services and	Develop a national strategy to improve the delivery of health care services, patient health outcomes, and population health that includes publishing an annual national health care quality report card. Develop, through a multi-stakeholder process, quality measures that allow assessments of health outcomes; continuity and coordination of care; safety, effectiveness and timeliness of care; health disparities; and appropriate use of health care resources. Require public reporting on quality measures through a user-friendly website. Create a Patient Safety Research Center charged with identifying, evaluating, and disseminating information on best practices for improving health care quality. Provides grants to establish community health teams to support a medical home model. Provides grants to implement medication management services in treatment of chronic disease to improve quality of care and reduce overall cost. MTM services would be targeted at those who take 4 or

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	allow certain Medicare Advantage plans to serve as fully integrated dual eligible special needs plans. Develop national priorities for performance improvement and quality measures for the delivery of health care services. Reduce racial and ethnic disparities by conducting a study on the feasibility of developing Medicare payment systems for language services and provide Medicare demonstration grants to reimburse culturally and linguistically appropriate services. **Nursing Home Transparency**: Requires SNFs and NFs to disclose ownership information; Develop standards for the collection of data on race, ethnicity, and primary language. Directs HHS Secretary to establish national priorities for performance improvement. Requires hospitals and ASCs to publicly report information on healthcare-associated infections to the Centers for Disease Control and Prevention.	more medications, take any "high-risk" medicines (not defined), or have 2 or more chronic conditions. HHS Secretary would be required to submit an evaluation of the program that assesses, in part, "the impact of patient cost sharing requirements on medication adherence and recommendations for modifications." Requires hospitals to confidentially report on hospital re-admission rates. Provide grants to improve the availability of trauma centers and services.
Preventing Fraud and Abuse	Provides an additional $100 million annually for the Health Care Fraud and Abuse Control Fund. Enhanced penalties for providers who knowingly make or cause to make false statements on provider or supplier enrollment applications.	Establishes new HHS and DOJ Health Care Fraud Senior Level Positions to advise the HHS Secretary and AG on policy and program development with respect to fraud and issues and coordinate efforts within DOJ, OIG, HHS and other agencies on fraud and abuse prevention, detection, investigation and prosecution for both public and private health insurance coverage.

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	Enhanced penalties for submission of false claims data, individuals who delay inspections, audits, or evaluations, and providers who have been excluded from a public program and yet knowingly prescribe an item or service covered under that program. New safeguards to assure quality care in hospices. Enhanced penalties for Medicare Advantage and Part D plans for specified marketing violations and providing false data. Enhanced penalties for obstruction of program audits. Authorizes the Secretary to conduct enhanced screening and oversight if s/he determines that there is significant risk of fraudulent activity with respect to a category of provider or supplier in the Medicare, Medicaid and CHIP programs. The Secretary may impose a moratorium on the enrollment of providers or suppliers during these periods. Enhanced disclosure rules requiring new suppliers or providers of services to disclose affiliations in the past 10 years with any provider or supplier that has outstanding debt or has been excluded from federal health programs. Establishes a payment modifier when service results in the ordering of additional services, prescription drugs, or durable medical equipment. Requires all providers and suppliers, excepting physicians, to adopt compliance programs. Reduces the period for submission of Medicare claims to 12	Establishes new coordinating council to coordinate strategic planning among federal agencies involved in health care integrity and oversight. Enhanced criminal penalties and oversight for multiple employer welfare arrangements. Requests that the National Association of Insurance Commissioners (NAIC) develops a uniform reporting model for health insurance issuers to refer suspected cases of fraud and abuse to state insurance departments or other responsible state agencies.

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	months. Requires that physicians who order durable medical equipment or home health services billable to Medicare be Medicare-enrolled physicians. Requires physicians who order DME or home health services to maintain written documentation of these claims available to the Secretary. Requires physicians to have a face-to-face encounter (including telehealth) prior to certifying eligibility for home health services. Allows the Secretary to subpoena documents or testimony for purposes relating to an exclusion investigation. Requires that overpayments be reported and returned within 60 days. Requires billing agents, clearinghouses, or other alternate payees to be registered under Medicare and Medicaid in a manner to be specified by the Secretary. Grants the Department of Justice, in consultation with OIG and CMS, access to Medicare and Medicaid claims and payment databases in a manner that complies with HIPAA and privacy laws. Eliminates duplication between the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank and phases out the HIPDB. Makes information in the National Practitioner Data Bank available	

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	to the VA.	
"Cost Containment"	Simplify health insurance administration by standardizing health care claims forms, operating rules for using and processing health care transactions, and quality reporting requirements and increasing electronic exchange of administrative and clinical data. Reduce spending on public programs by: • Refusing Medicaid payments for health care-acquired conditions; • Allowing provider screening, enhanced oversight periods, and enrollment moratoria in areas identified as being at elevated risk of fraud in all public programs; • Requiring Medicare and Medicaid program providers and suppliers to establish compliance programs; and • Requiring evaluations and reports under Medicare and Medicaid integrity programs.	• Establish a Health Care Program Integrity Coordinating Council and two new federal department positions to oversee policy, program development, and oversight of health care fraud, waste, and abuse in public and private coverage. • Develop a national prevention and health promotion strategy that sets specific goals for improving health. Create a prevention and public health investment fund to expand and sustain funding for prevention and public health programs. • Provide grants for improving health system efficiency, including grants to establish community health teams to support a medical home model; to implement medication management services; to design and implement regional emergency care and trauma systems.
Financing	• Income surtax on taxpayers with incomes greater than $350,000/year. The tax would be impose at a progressive rate: o Married households with income between $350,000-$500,000 would be subject to a 1% surtax; o Married households with incomes between $500,000-$1,000,000 would be subject to a 1.5% tax; and o Income in excess of $1,000,000 would be subject to a tax of 5.4%.	Nothing specific

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	The 1% and 1.5% tax would be elevated to 2% and 3% respectively, if health cost savings are not achieved.	

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