

Health Reform Plans	Senate Health Reform Bill ¹	House Health Reform Bill ²
Title and Bill Number	Patient Protection and Affordable Care Act (H.R. 3590)	America's Affordable Health Choices Act (H.R. 3962)
Immediate insurance market reform	<ul style="list-style-type: none"> • Transitional reinsurance program for individual and small group markets in each State. • For 2014, 2015, and 2016, requires States to establish a nonprofit reinsurance entity that collects payments from insurers in the individual and group markets and makes payments to such insurers in the individual market that cover high-risk individuals. • Requires the Secretary to establish Federal standards for the determination of high-risk individuals, a formula for payment amounts, and the contributions required of insurers, which must total \$25 billion over the 3 years. 	<ul style="list-style-type: none"> • Enacts a temporary insurance program with financial assistance for those who have been uninsured for several months or denied a policy because of pre-existing conditions. • The funding for this program is capped at \$5 million and it terminates when those funds are exhausted or when the Health Insurance Exchange is up and running.
National Health Exchange	<ul style="list-style-type: none"> • Requires the Secretary to award grants, available until 2015, to States for planning and establishment of American Health Benefit Exchanges. • By 2014, requires States to establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans and includes a SHOP Exchange for small businesses. • Requires the Secretary to: <ul style="list-style-type: none"> ○ Establish certification criteria for qualified health plans, requiring such plans to meet marketing requirements, ensure a sufficient choice of providers, include essential community providers in their networks, be accredited on quality, implement a quality improvement strategy, use a uniform enrollment form, present plan information in a standard format, and provide 	<ul style="list-style-type: none"> • Creates a new independent entity to facilitate the offering of health insurance choices to individuals and small employers. • The Health Choices Commissioner would establish a process for bids, contracts, and oversight. • The exchange would define coverage; set and enforce standards; facilitate enrollments, monitor complaints; and administer credits. • States may opt to operate the exchange if they follow federal rules. • Health Insurance Exchange Trust Fund to fund the Health Choices Administration

¹ As introduced 11.18.2009

² House Bill as passed on November 7, 2009

Health Reform Plans	Senate Health Reform Bill ¹	House Health Reform Bill ²
	<p>data on quality measures.</p> <ul style="list-style-type: none"> ○ Develop a rating system for qualified health plans and a model template for an Exchange’s Internet portal. ○ Determine an initial and annual open enrollment period, as well as special enrollment periods for certain circumstances. <ul style="list-style-type: none"> • Allows States to require benefits in addition to essential health benefits, but States must defray the cost of such additional benefits. • Requires Exchanges to certify qualified health plans, operate a toll-free hotline and Internet website, rate qualified health plans, present plan options in a standard format, inform individuals of eligibility for Medicaid and CHIP, provide an electronic calculator to calculate plan costs, and grant certifications of exemption from the individual responsibility requirement. • Beginning in 2015, requires Exchanges to be self-sustaining and allows them to charge assessments or user fees. • Allows Exchanges to certify qualified health plans if they meet certification criteria and offering them is in the interests of individuals and employers. • Allows regional or interstate Exchanges if the States agree to, and the Secretary approves, such Exchanges. • Requires Exchanges to award grants to Navigators that educate the public about qualified health plans, distribute information on enrollment and tax credits, facilitate enrollment, and provide referrals on grievances, complaints, or questions. 	
Informed Consumer Choices	<p>HHS Secretary is require to:</p> <ul style="list-style-type: none"> • Requires the Secretary to develop standards for use by health insurers in compiling and providing an accurate 	

Health Reform Plans	Senate Health Reform Bill ¹	House Health Reform Bill ²
	<p>summary of benefits and explanation of coverage.</p> <ul style="list-style-type: none"> The standards must be in a uniform format, using language that is easily understood by the average enrollee, and must include uniform definitions of standard insurance and medical terms. The explanation must also describe any cost-sharing, exceptions, reductions, and limitations on coverage, and examples to illustrate common benefits scenarios. 	
Keep Coverage You Have	Allows any individual enrolled in any form of health insurance to maintain their coverage as it existed on the date of enactment.	Allows the maintenance of current individual health plans as “grandfathered plans” and provides for a five year grace period for current group health plans to meet specified standards (insurance and benefit requirements).
Affordability	<ul style="list-style-type: none"> Refundable credit for coverage under a qualified health plan. The premium assistance credit amount is calculated on sliding scale starting at 2% of income for those at or above 100 percent of poverty and phasing out to 9.8 percent of income for those at 400% of poverty. The reference premium is the second lowest cost silver plan available in the individual market in the rating area in which the taxpayer resides. The premium assistance credits do not take into account benefits mandated by States. Employees offered coverage by an employer under which the plan’s share of the total allowed costs of benefits provided under the plan is less than 60% of such costs or the premium exceeds 9.8% of the employee’s income are eligible for the premium assistance credit. This section also provides for reconciliation of the premium assistance credit amount at the end of the taxable year and for a study on the affordability of health insurance coverage by the Comptroller General. 	<ul style="list-style-type: none"> Sliding scale affordability credits in the exchange for families up to 400% poverty The sliding scale starts at 1.5% of income for those at or below 133% FPL and phasing out at 12% for those at 400% The most recent tax return will serve as income data Cap on annual out-of-pocket spending <p>Small Business Tax Credits</p> <ul style="list-style-type: none"> Provides a tax credit equal to 50% of the amount paid by a small employer for health coverage Phased out in the cases of an employer with 10 to 25 employees and for employers with average wages of \$20,000 and \$40,000 per year An employer may elect to use the credit for a maximum of 2 taxable years

Health Reform Plans	Senate Health Reform Bill ¹	House Health Reform Bill ²
	<p>Employee health insurance expenses of small employers.</p> <ul style="list-style-type: none"> • Provides a sliding scale tax credit to small employers with fewer than 25 employees and average annual wages of less than \$40,000 that purchase health insurance for their employees. • The full credit will be available to employers with 10 or fewer employees and average annual wages of less than \$20,000. • To be eligible for a tax credit, the employer must contribute at least 50% of the total premium cost or 50% of a benchmark premium. In 2011 through 2013, eligible employers can receive a small business tax credit for up to 35% of their contribution toward the employee's health insurance premium. • Tax-exempt small businesses meeting the above requirements are eligible for tax credits of up to 25% of their contribution. In 2014 and beyond, eligible employers who purchase coverage through the State Exchange can receive a tax credit for two years of up to 50% of their contribution. • Tax-exempt small businesses meeting the above requirements are eligible for tax credits of up to 35% percent of their contribution. 	
Public Plan	<p>Federal program to assist establishment and operation of nonprofit, member-run health insurance issuers.</p> <ul style="list-style-type: none"> • Requires the Secretary to award loans for start-up costs and grants to meet solvency requirements, until July 1, 2013, to member-run nonprofits that will offer qualified health plans. • Establishes an Advisory Board with members appointed by the Comptroller General, to terminate by 2016. • Prohibits health insurance issuers that existed on July 16, 2009 or governmental organizations from qualifying for 	<ul style="list-style-type: none"> • Public plan subject to the same market reforms and consumer protections as private plans starting in 2013 • Must offer the same benefits, abide by the same insurance market reforms, follow provider network requirements and other consumer protections • Premiums would be geographically-adjusted and are required to fully cover the cost of coverage as well as administrative costs • Provides \$2 billion to establish the public plan

Health Reform Plans	Senate Health Reform Bill ¹	House Health Reform Bill ²
	<p>the program.</p> <ul style="list-style-type: none"> • Allows participants to form a private purchasing council to enter into collective purchasing arrangements for items and services, but which may not set provider payment rates. • Prohibits government representatives from serving on the board of directors of participants or the council. • Appropriates \$6 billion for the CO-OP program, and exempts participants from taxation. <p>Community health insurance option</p> <ul style="list-style-type: none"> • Requires the Secretary to offer a Community Health Insurance Option as a qualified health plan through Exchanges. • Allows States to enact a law to opt out of offering the option. • Requires the option to cover only essential health benefits; States may require additional benefits, but must defray their cost. • Requires the Secretary to set geographically adjusted premium rates that cover expected costs. • Requires the Secretary to negotiate provider reimbursement rates, but they must not be higher than average rates paid by private qualified health plans. • Subjects the option to State and Federal solvency standards and to State consumer protection laws. • Establishes a start-up fund to provide loans for initial operations, to be repaid with interest within 10 years. • Authorizes the Secretary to contract with nonprofits for the administration of the option. <ul style="list-style-type: none"> • Requires qualified health plans offered under the CO-OP program, as a Community Health Insurance Option, or as 	<ul style="list-style-type: none"> • Secretary shall negotiate payment for health care providers and items and services, including prescription drugs. • Providers would have the option to opt out • Secretary shall evaluate the progress of payment and delivery system reforms and apply them to the public option • Secretary would have the authority to develop conditions of participation • Enrollment is voluntary

Health Reform Plans	Senate Health Reform Bill ¹	House Health Reform Bill ²
	<p>a nationwide plan, to be subject to all Federal and State laws that apply to private health insurers.</p>	
<p>State Flexibility to Establish Alternative Programs</p>	<p>State flexibility to establish basic health programs for low-income individuals not eligible for Medicaid.</p> <ul style="list-style-type: none"> • Allows States to contract, through a competitive process that includes negotiation of premiums, cost-sharing, and benefits, with standard health plans for individuals who are not eligible for Medicaid or other affordable coverage and have income below 200 percent of the FPL. • Requires the Secretary to certify that participating individuals do not have to pay more in premiums and cost-sharing than they would have paid under qualified health plans, and that the plans cover essential health benefits. • Requires the Secretary to transfer to participating States 85% of the tax credits and cost-sharing reductions that would have been provided to individuals enrolled in standard health plans if they were enrolled in qualified health plans. <p>Waiver for State innovation.</p> <ul style="list-style-type: none"> • Beginning in 2017, allows States to apply for a waiver for up to 5 years of requirements relating to qualified health plans, Exchanges, cost-sharing reductions, tax credits, the individual responsibility requirement, and shared responsibility for employers. • Requires States to enact a law and to comply with regulations that ensure transparency. • Requires the Secretary to provide to a State the aggregate amount of tax credits and cost-sharing reductions that would have been paid to residents of the State in the absence of a waiver. • Requires the Secretary to determine that the State plan 	<ul style="list-style-type: none"> • States may opt to operate the exchange if they follow federal rules.

Health Reform Plans	Senate Health Reform Bill ¹	House Health Reform Bill ²
	<p>for a waiver will provide coverage that is at least as comprehensive and affordable, to at least a comparable number of residents, as this title would provide; and that it will not increase the Federal deficit.</p>	
<p>Provisions relating to offering of plans in more than one State.</p>	<ul style="list-style-type: none"> • By July 1, 2013, requires the Secretary, in consultation with NAIC, to issue regulations for interstate health care choice compacts, which can be entered into beginning in 2016. • Under such compacts, qualified health plans could be offered in all participating States, but insurers would still be subject to the consumer protection laws of the purchaser's State. • Requires insurers to be licensed in all participating States, and to clearly notify consumers that a policy may not be subject to all the laws and regulations of the purchaser's State. • Requires States to enact a law to enter into compacts and Secretarial approval, but only if the Secretary determines that the compact will provide coverage that is at least as comprehensive and affordable, to at least a comparable number of residents, as this title would provide; and that it will not increase the Federal deficit or weaken enforcement of State consumer protection laws. • Allows insurers in the individual and small group markets to offer a qualified health plan nationwide, which is subject to only the State benefit mandate laws of the State in which the plans are issued; but requires such plans to provide the essential benefits package. • Allows States to enact a law to opt out of allowing the offering of nationwide plans. • Requires insurers to file plan forms with each State in which they will offer nationwide plans for review. 	
<p>Role of Public Programs</p>	<p>Medicaid</p>	<p>Medicaid</p>

Health Reform Plans	Senate Health Reform Bill ¹	House Health Reform Bill ²
	<ul style="list-style-type: none"> • Creates a new State option to provide Medicaid coverage through a State plan amendment beginning on January 1, 2011. • Eligible individuals include: all non-elderly, non-pregnant individuals who are not entitled to Medicare. • Creates a new mandatory Medicaid eligibility category for all such “newly-eligible” individuals with income at or below 133% FPL beginning January 1, 2014. • Also, as of January 1, 2014, the mandatory Medicaid income eligibility level for children ages six to 19 changes from 100% FPL to 133% FPL. States have the option to provide Medicaid coverage to all non-elderly individuals above 133% FPL through a State plan amendment. • From 2014 through 2016, the Federal government will pay 100% of the cost of covering newly-eligible individuals. • In 2017 and 2018, States that initially covered less of the newly-eligible population would receive more assistance than those States that covered at least some non-elderly, non-pregnant individuals. • Other States would receive a FMAP increase for services provided to newly-eligible individuals of 34.3 and 33.3 percentage points in 2017 and 2018, respectively. • Expansion States would receive 30.3 and 31.3 percentage points in 2017 and 2018, respectively. Beginning in 2019 and thereafter, all States would receive an FMAP increase of 32.3 percentage points for such services. • Requires states to maintain the same income eligibility levels through December 31, 2013 for all adults. • This maintenance of effort requirement would be extended through September 30, 2019 for all children currently covered in Medicaid or CHIP. • Between January 1, 2011 and January 1, 2014, a State 	<ul style="list-style-type: none"> • Expands Medicaid to individuals and families with incomes below 150% FPL • Federal government would pay 100% of the costs of Medicaid coverage for this population in 2013 and 2014, then 91% in 2015 and beyond • Reduce Medicaid DSH by \$10B (\$1.5B in FY 2017, \$2.5B in FY 2018, and \$6B in FY 2019) • Will increase federal funding to increase primary care reimbursement rates at no less than 80% of Medicare rates in 2010, 90% in 2011, and 100% in 2012. The federal government would pay 100% of the incremental costs attributable to this requirement through 2014, then 90% in 2015 and beyond. • Require Medicaid coverage of preventive services • Allow states to cover family planning services • Medical home pilot • Tobacco cessation • Optional coverage of nurse home visitation • Optional coverage for free-standing birth centers • ACO pilot program <p>CHIP</p> <ul style="list-style-type: none"> • CHIP maintenance of effort requirement

Health Reform Plans	Senate Health Reform Bill ¹	House Health Reform Bill ²
	<p>would be exempt from the MOE requirement for optional, non-pregnant, non-disabled, adult populations whose family income is above 133% FPL if the State certifies to the Secretary that the State is currently experiencing a budget deficit or projects to have a budget deficit in the following State fiscal year.</p> <ul style="list-style-type: none"> • Tobacco cessation • Improve preventive services • School-based health centers <p>CHIP</p> <ul style="list-style-type: none"> • Additional Federal financial participation for CHIP. • Upon enactment, States would be required to maintain income eligibility levels for CHIP through September 30, 2019. From fiscal year 2014 to 2019, States would receive a 23 percentage point increase in the CHIP match rate, subject to a cap of 100%. • CHIP-eligible children who cannot enroll in CHIP due to Federal allotment caps would be eligible for tax credits in the State Exchange. • Makes technical corrections to selected provisions in the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and the ARRA. <p>Enrollment Simplification and coordination with State Health Insurance Exchanges.</p> <ul style="list-style-type: none"> • Allows individuals to apply for and enroll in Medicaid, CHIP or the Exchange through a State-run website. • Requires State Medicaid and CHIP programs and the Exchange to coordinate enrollment procedures to provide seamless enrollment for all programs. <p>Streamlining of procedures for enrollment through an</p>	

Health Reform Plans	Senate Health Reform Bill ¹	House Health Reform Bill ²
	<p>Exchange and State Medicaid, CHIP, and health subsidy programs.</p> <ul style="list-style-type: none"> • Requires the Secretary to establish a system for the residents of each State to apply for enrollment in, receive a determination of eligibility for participation in, and continue participation in, applicable State health subsidy programs. • The system will ensure that if any individual applying to an Exchange is found to be eligible for Medicaid or a State children’s health insurance program (CHIP), the individual is enrolled for assistance under such plan or program. 	
Community Services	<p>Would establish the Community First Choice Option to provide community based attendant services for those are Medicaid eligible and require and institutional level of care</p>	
Standard Benefits Package	<ul style="list-style-type: none"> • Requires qualified health plans to be certified by Exchanges, provide the essential health benefits package, and be offered by licensed insurers that offer at least one qualified health plan at the silver and gold levels. • Creates four benefit categories for the reformed individual and small group health insurance markets: <ul style="list-style-type: none"> ○ Bronze: actuarial value of 60% with an out-of-pocket limit the HSA current law limit ○ Silver: actuarial value of 70% ○ Gold: actuarial value of 80% ○ Platinum: actuarial value of 90% • In the individual market, a catastrophic plan may be offered to individuals who are under the age of 30 or who are exempt from the individual responsibility requirement because coverage is unaffordable to them or they have a hardship. • A catastrophic plan must cover essential health benefits and at least 3 primary care visits, but must require cost-sharing up to the HSA out-of-pocket limits. 	<ul style="list-style-type: none"> • Essential Benefits Package • Requires plans to meet the benefit standards recommended by the Benefits Advisory Committee • Benefits Advisory Committee, a public-private committee with providers and health care experts, chaired by the Surgeon General would recommend a benefits package based on standards set in law • The package would be the minimal quality standard for employer plans • Actuarially equivalent to 70% of the package if there is no cost-sharing imposed

Health Reform Plans	Senate Health Reform Bill ¹	House Health Reform Bill ²
	<ul style="list-style-type: none"> If an insurer offers a qualified health plan, it must offer a child-only plan at the same level of coverage. 	
Market Reforms	<p>Individual and Small Group Market Reforms Effective 2014</p> <ul style="list-style-type: none"> No lifetime or annual limits Prohibition on rescissions Coverage of preventive health services Extension of dependent coverage Guaranteed availability of coverage Guaranteed renewal Prohibition of preexisting condition exclusions or other discrimination based on health status. Prohibit discrimination based on health status Prohibitions on excessive waiting periods Limited variation in premium rates would be permitted for tobacco use, age, geography, and family composition. Rating based on: <ul style="list-style-type: none"> Tobacco use – 1.5:1 Age – 3:1 Family composition <p>Small Group Purchasing Through SHOP Exchanges</p> <ul style="list-style-type: none"> Small businesses would have access to state-based Small Business Health Options Program (SHOP) exchanges 	<ul style="list-style-type: none"> Prohibits pre-existing condition exclusions Guaranteed issue and renewal Prohibits the use of rescissions except in instances of fraud Rating based on: <ul style="list-style-type: none"> Age (no more than 2:1) Geography Family size Parity in mental health and substance abuse disorder benefits Must have adequate provider networks Plans must meet a medical loss ratio of not less than 85%, effective for plan years beginning in January 1, 2010 Transparency and plan disclosure Timely internal grievance and appeals mechanisms and external review by independent board Establishes an annual review process for increases in health insurance premiums by the Secretary of HHS in conjunction with the States that requires insurers to submit a justification for any premium increases prior to implementation. Effective for plan years beginning January 1, 2010. Requires health insurers to allow individuals through age 26, not otherwise covered, to remain on their parents' health insurance at their parents' choice for plan years beginning January 1, 2010. Prohibits insurers from limiting or denying coverage based on acts stemming from domestic violence for plan years beginning January 1, 2010. Prohibits health insurers from utilizing lifetime limits

Health Reform Plans	Senate Health Reform Bill ¹	House Health Reform Bill ²
Administrative Simplification	<ul style="list-style-type: none"> • Accelerates HHS adoption of uniform standards and operating rules for the electronic transactions that occur between providers and health plans that are governed under the HIP AA (such as benefit eligibility verification, prior authorization and electronic funds transfer payments). • Establishes a process to regularly update the standards and operating rules for electronic transactions and requires health plans to certify compliance or face financial penalties collected by the Treasury Secretary. 	<p>on benefits for plan years beginning January 1, 2010.</p> <ul style="list-style-type: none"> • Establish standardized rules for coordination and subrogation of benefits • Establish standardized language and forms
Health Choices Administration		<ul style="list-style-type: none"> • Establishes a Health Choices Administration to be headed by a Health Choices Commissioner • Responsible for carrying out: <ul style="list-style-type: none"> ○ Qualified plan standards ○ Health insurance exchange ○ Individual affordability credits ○ A study and report describing the differences between insured and self-insured plans ○ Providing recommendations to ensure that the law does not create incentives for small and mid-size businesses to self insure or create adverse selection in the risk pools of insured plans ○ Define marketing standards that qualified plans are required to meet • Includes a Health Insurance Ombudsman
Individual Mandate	<p>Yes</p> <ul style="list-style-type: none"> • Requires individuals to maintain minimum essential coverage beginning in 2014. • Failure to maintain coverage will result in a penalty of \$95 in 2014, \$350 in 2015, \$750 in 2016 and indexed thereafter. 	<p>Yes</p> <ul style="list-style-type: none"> • Economic hardship exemption • Penalty based on 2.5% of modified adjusted gross income above a specific level for those who do not obtain coverage

Health Reform Plans	Senate Health Reform Bill ¹	House Health Reform Bill ²
	<ul style="list-style-type: none"> • For those under the age of 18, the applicable penalty will be one-half of the amounts listed above. • Exceptions to the individual responsibility requirement to maintain minimum essential coverage are made for religious objectors, individuals not lawfully present, and incarcerated individuals. • Exemptions from the penalty will be made for those who cannot afford coverage, taxpayers with income under 100% of poverty, members of Indian tribes, those who have received a hardship waiver and those who were not covered for a period of less than three months during the year. 	
Employer Mandate	<ul style="list-style-type: none"> • Requires employers with more than 200 employees to automatically enroll new full-time employees in coverage with adequate notice and the opportunity for an employee to opt out of any coverage the individual or employee was automatically enrolled in. • Requires an employer with more than 50 full-time employees that does not offer coverage and has at least one full-time employee receiving the premium assistance tax credit to make a payment of \$750 per full-time employee. • An employer with more than 50 full-time employees that requires a waiting period before an employee can enroll in health care coverage will pay \$400 for any full-time employee in a 30-60 day waiting period and \$600 for any full-time employee in a 60-90 day waiting period. • An employer with more than 50 employees that does offer coverage but has at least one full-time employee receiving the premium assistance tax credit will pay the lesser of \$3,000 for each of those employees receiving a tax credit or \$750 for each of their full-time employees total. 	<ul style="list-style-type: none"> • Employers have the option to provide health insurance for their workers or contribute funds on their behalf. • Minimum contribution is 72.5% of the premium for individual coverage and 65% of the premium for family coverage. • The fee is based on 8% of the payroll. • Employers that offer coverage must meet minimum benefit and contribution requirements. • Small business exemption for those employers with an annual payroll that does not exceed \$500,000. • Phases in the 8% payroll tax between an annual payroll of \$500,000 and \$750,000 at which point employers are subject to the full 8%. • Authorizes the creation of rules that would prohibit employers from engaging in practices that steer employees away from employer-offered coverage into coverage in the exchange. • Secretary is required to study on the impact of the employer requirement.

Health Reform Plans	Senate Health Reform Bill ¹	House Health Reform Bill ²
	<ul style="list-style-type: none"> • The Secretary of Labor shall conduct a study to determine whether employees' wages are reduced by reason of the application of the assessable payments. 	
SNF Payments and provisions	<ul style="list-style-type: none"> • Productivity adjustment • Medicare Skilled Nursing Facility Value-Based Purchasing (VBP): Direct the Secretary to submit a plan to Congress by 2011 related to home health providers and 2012 related to SNFs outlining how to effectively move these providers into a VBP payment system. • Requires disclosure of ownership • Requires SNFs and nursing homes to develop and implement compliance and ethics programs to be followed by their employees and agents • Additional information on Nursing Home Compare • Requires the reporting of expenditures on wage and benefits • Standardized complaint form • National Independent Monitor Pilot Program • Regular reporting of staff data • Notification of facility closure • Demos on culture change and IT • Nursing home background checks 	<ul style="list-style-type: none"> • FY 2010 rates at FY 2009 levels • Productivity adjustment • Case mix adjustment • Revises payment for nontherapy ancillary services and therapy services • Require the disclosure of ownership • Compliance and ethics programs • Quality assurance and performance improvement program • Requires more information on Nursing Home Compare • Reporting of direct care expenditures • Standardized complaint form • Ensure staffing accountability • National Independent Monitor Pilot Program • CMPs for deficiencies
IRF Payments and provisions	<ul style="list-style-type: none"> • Productivity adjustment • Establishes quality reporting program 	<ul style="list-style-type: none"> • Market basket frozen for FY 2010 • Productivity adjustment
Inpatient Hospital Payments	<ul style="list-style-type: none"> • Reduces the market basket update, including adjustments to reflect gains in productivity <ul style="list-style-type: none"> ○ Market basket minus 0.25 percentage point reduction in 2010 and 2011 ○ 0.2 percentage point market basket reduction from 2012-2019 in addition to the productivity adjustments • Requires the Secretary to implement quality measure reporting programs 	<ul style="list-style-type: none"> • Productivity adjustment • Sets a floor for inpatient hospital market basket update • Adjustment to hospital payments for excess readmissions • Provides assistance for transitional care activities

Health Reform Plans	Senate Health Reform Bill ¹	House Health Reform Bill ²
	<ul style="list-style-type: none"> Providers who do not successfully participate in the program would be subject to a reduction in their annual market basket update 	
Post-Acute Care Payment Reform	<p>National Pilot Program on Payment Bundling</p> <ul style="list-style-type: none"> Directs the Secretary to develop a national, voluntary pilot program encouraging hospitals, doctors and post-acute care providers to achieve savings for the Medicare program through increased collaboration and improved coordination of patient care by allowing the providers to share in such savings. Medicaid bundled payment demo 	<ul style="list-style-type: none"> Directs Secretary to submit to Congress a detailed plan on how to implement post-acute bundled payments Converts the Acute Care Episode demonstration project to a pilot program and expand the program
DSH Payments	<ul style="list-style-type: none"> Requires the Secretary to update hospital payments to better account for hospitals' uncompensated care costs. Starting in 2015, hospitals' Medicare DSH payments would be reduced to reflect lower uncompensated care costs relative to increases in the number of insured. Reduces States' Medicaid DSH allotments by 50% once the rate of uninsurance in a State decreases by 45% (low DSH States would receive a 25% reduction). As the rate of uninsurance continues to decline, the States' DSH allotments would be reduced by a corresponding amount. At no time could a State's DSH allotment be reduced by more than 65% compared to its FY2012 allotment. 	<ul style="list-style-type: none"> Reduces Medicaid DSH by \$10B (\$1.5 billion in FY 2017, \$2.5 billion in FY 2018, and \$6.0 billion in FY 2019) Medicare DSH Report
Ambulatory Surgical Centers	<ul style="list-style-type: none"> Productivity adjustment 	<ul style="list-style-type: none"> Required to submit cost data and other data Productivity adjustment Requires ASCs to report information on healthcare-associated infections
Outpatient Hospital Payment	<ul style="list-style-type: none"> Productivity adjustment 	<ul style="list-style-type: none"> Productivity adjustment
Physician Payments	<p>SGR</p> <ul style="list-style-type: none"> Replaces the scheduled 21% payment reduction to the Medicare physician fee schedule for 2010 with a 0.5 percent positive update. 	<ul style="list-style-type: none"> Extends a floor on geographic adjustments to the work portion of the fee schedule through 2011 Accountable Care Organization Pilot Program Increases the Medicare payment rate by 5% for

Health Reform Plans	Senate Health Reform Bill ¹	House Health Reform Bill ²
	<p>Value-Based Modifier for Physician Payment Formula</p> <ul style="list-style-type: none"> • Directs the Secretary of HHS to develop and implement a budget-neutral payment system that will adjust Medicare physician payments based on the quality and cost of the care they deliver. • Quality and cost measures will be risk-adjusted and geographically standardized. • The Secretary will phase-in the new payment system over a 2-year period beginning in 2015. <p>Misvalued RVUs</p> <ul style="list-style-type: none"> • Requires the Secretary to periodically identify physician services as being potentially misvalued, and make appropriate adjustments to the relative values of such services under the Medicare physician fee schedule. <p>Primary Care Bonus</p> <ul style="list-style-type: none"> • Establishes a new 10% bonus on select E&M codes under the Medicare fee schedule for five years, beginning January 1, 2011. • Half of the cost of the bonuses would be offset through an across-the-board reduction in all other services. <p>Physician Value-Based Purchasing</p> <ul style="list-style-type: none"> • Strengthens and expands the Physician Quality Reporting Initiative program, including requiring all eligible health professionals to participate by 2011. • Improves the Medicare physician feedback program and penalize physicians who utilize significantly more resources than their peers. <p>Improvements to the physician feedback program.</p>	<p>primary care services of physicians specializing in primary care.</p> <ul style="list-style-type: none"> • Reevaluate codes and RVUs • Modifications to PQRI • Physician payment sunshine provisions • Updates the method used to determine the localities used for Medicare’s geographic adjustment factor in CA

Health Reform Plans	Senate Health Reform Bill ¹	House Health Reform Bill ²
	<ul style="list-style-type: none"> • Expands Medicare’s physician resource use feedback program to provide for development of individualized reports by 2012. • Reports will compare the per capita utilization of physicians (or groups of physicians) to other physicians who see similar patients. • Reports will be risk-adjusted and standardized to take into account local health care costs. <p>Physician Payment Sunshine</p> <ul style="list-style-type: none"> • Covers drug, device, biological, or medical supplier that makes a payment to a physician, practice, or hospital with a residency training program 	
LTCH Payments and Provisions	<ul style="list-style-type: none"> • Productivity adjustment • Extends the Medicare, Medicaid and SCHIP Extension Act of 2007, Section 114(c) and (d) by one years. • Requires the Secretary to implement quality measure reporting programs • Providers who do not successfully participate in the program would be subject to a reduction in their annual market basket update 	<ul style="list-style-type: none"> • Productivity adjustment
Dialysis Payments and provisions		<ul style="list-style-type: none"> • Extends coverage of immunosuppressive drugs for kidney transplant • Applies quality measures • Provide OIG access to ownership or compensation agreements between renal dialysis facilities and physicians
Medicare Graduate Medical Education (GME)	<ul style="list-style-type: none"> • Increases GME training positions through a slot re-distribution program for currently unused training slots and priority would be given to increasing training in primary care and general surgery. • Encourages additional training in outpatient settings and ensure communities retain vital training slots if a hospital 	<ul style="list-style-type: none"> • Redistributes of unused residency positions • Increases training in non-provider settings • Preserves resident cap positions from closed hospitals • Increases accountability for approved medical residency training

Health Reform Plans	Senate Health Reform Bill ¹	House Health Reform Bill ²
	closes.	<ul style="list-style-type: none"> • Clarifies that State Medicaid programs may receive federal matching payments for the costs of graduate medical education.
Community Health Centers		Authorizes an additional \$12 billion for use over the next five years (FY 2011 – FY 2015)
Emergency Care Programs	<ul style="list-style-type: none"> • Provides funding to the Assistant Secretary for Preparedness and Response to support pilot projects that design, implement, and evaluate innovative models of regionalized, comprehensive, and accountable emergency care and trauma systems. • Requires the HHS Secretary to support emergency medicine research, including pediatric emergency medical research. 	<ul style="list-style-type: none"> • Establishes a new program to strengthen the nation’s emergency room and trauma center capacity. Authorizes \$100 million for FY 2011 and such sums as may be necessary for each of FY 2012 through FY 2015 to carry out this program. • Creates an Emergency Care Coordination Center within the HHS Office of the Assistant Secretary for Preparedness and Response. Authorizes such sums as may be necessary for each of FY 2011 through FY 2015 to carry out the various activities of the Center.
Workforce Issues	<ul style="list-style-type: none"> • Creates a National Health Care Workforce Commission • Establishes state health care workforce development grants • Health care workforce assessment • Federally supported student loan funds • Increases nurse faculty • Demo to integrate quality improvement and patient safety training in clinical education of health professionals 	<ul style="list-style-type: none"> • Public health investment fund • Increases to the National Health Services Corp loan repayment benefits • Expands the primary care, nursing and public health workforces • Increases funding for scholarships and loan forgiveness to promote primary care and nursing care • Center for workforce analysis
Health IT	<ul style="list-style-type: none"> • Requires the development of standards and protocols to promote the interoperability of systems for enrollment of individuals in Federal and State health and human services programs. • These standards shall allow for electronic data matching, and electronic documentation. • The Secretary may require State or other entities to incorporate such standards as a condition of receiving Federal HIT funds. 	

Health Reform Plans	Senate Health Reform Bill ¹	House Health Reform Bill ²
Prevention and Wellness	<ul style="list-style-type: none"> • Creates a National Prevention, Health Promotion and Public Health Council with members appointed by the President • Establishes a prevention and public health fund • Creates an independent Prevention Services Task Force • CDC Director shall convene an Independent Community Preventive Services Task Force • Education and outreach campaign on preventive benefits • Secretary shall award grants to States to establish Right Choices Programs through Medicaid provide preventive services • Establishes community transformation grants to implement evidence-based community preventive health activities 	<ul style="list-style-type: none"> • Establishes a Prevention and Wellness Trust with \$15.4B over 5 years • Requires the Secretary to submit a national strategy designed to improve the nation’s health through evidence-based clinical and community-based prevention and wellness activities within one year of enactment and at least every two years thereafter • Task Force on Clinical Preventive Services • Task Force on Community Preventive Services • Data collection improvements (HIT) • Prevention and Wellness research • Implementation of best practices
Payment Reforms	<p>Hospital Value-Based Purchasing (VBP)</p> <ul style="list-style-type: none"> • Establishes a VBP program for hospitals starting in 2013. • A percentage of hospital payment would be tied to hospital performance on quality measures related to common and high-cost conditions, such as cardiac, surgical and pneumonia care. • Quality measures included in the program will be developed and chosen in cooperation with external stakeholders. <p>Medicare Home Health Agency and Skilled Nursing Facility VBP</p> <ul style="list-style-type: none"> • Directs the Secretary to submit a plan to Congress by 2012 related to home health providers and SNFs outlining how to effectively move these providers into a VBP payment system. <p>Quality Reporting for Other Providers</p> <ul style="list-style-type: none"> • Requires the Secretary to implement quality measure 	<ul style="list-style-type: none"> • Post acute payment reform

Health Reform Plans	Senate Health Reform Bill ¹	House Health Reform Bill ²
	<p>reporting programs for long-term care hospitals, inpatient rehabilitation facilities, PPS-exempt cancer hospitals and hospice providers</p> <ul style="list-style-type: none"> • Providers who do not successfully participate in the program would be subject to a reduction in their annual market basket update. 	
Physician Owned Hospitals	<ul style="list-style-type: none"> • Prohibits physician-owned hospitals that do not have a provider agreement prior to February 1, 2010, to participate in Medicare. • Such hospitals that have a provider agreement prior to February 1, 2010, could continue to participate in Medicare under certain requirements addressing conflict of interest, bona fide investments, and patient safety issues, and expansion limitations. 	<ul style="list-style-type: none"> • Prohibits physician ownership in hospitals that are new as of January 1, 2009 • Grandfathers the ownership structures of all physician-owned hospitals with Medicare provider numbers prior January 1, 2009. • Allows for growth of existing physician-owned hospitals within certain parameters
Geographic inequities adjustment factors under Medicare	<ul style="list-style-type: none"> • Directs the Secretary to adjust the practice expense GPCI for 2010 to reflect ¾ of the difference between relative costs of employee wages and rents in different fee schedule areas 	<ul style="list-style-type: none"> • IOM will report to CMS on the validity and effects of the geographic adjusters and recommend improvements • CMS is instructed to address geographic inequities and may spend up to \$4B per year for 2 years
Medicare Part D Reforms	<ul style="list-style-type: none"> • Medicare beneficiaries who enroll in the Medicare Part D prescription drug program will receive significant help purchasing prescription drugs when they hit the coverage gap portion starting in 2010 • Instead of paying 100% of their drug costs in the gap, Part D beneficiaries with low to moderate incomes will receive a 50% discount on the price of brand-name drugs covered by their plan. • Reduces the premium subsidy under Part D for beneficiaries with incomes at or above the Part B income thresholds. • Elimination of cost sharing for certain dual-eligible individuals • Improved complaint system 	<ul style="list-style-type: none"> • Eliminates Part D coverage gap beginning with at \$500 reduction in 2010 and a complete phase out by 2019 paid for by requiring drug manufacturers to pay Medicaid rebates for dual eligibles • Incorporates voluntary PhRMA agreement to provide discounts of 50% for brand-name drugs in the coverage gap • Prevents plans from making formulary changes that increase cost-sharing or otherwise reducing coverage once the plan marketing period begins

Health Reform Plans	Senate Health Reform Bill ¹	House Health Reform Bill ²
	<ul style="list-style-type: none"> • Immediate reduction in coverage gap for 2010. Increases the initial coverage limit in the standard Part D benefit by \$500 for 2010. 	
Medicare Rural Access Protections	<ul style="list-style-type: none"> • Extends the existing outpatient hold harmless provision through the end of FY2010 and would allow Sole Community Hospitals with more than 100 beds to also be eligible to receive this adjustment through the end of FY2010. • Reinstates reasonable cost reimbursement, thus improving access to laboratory services for those in rural communities. • Extends the Extend Rural Community Hospital Demonstration Program for one year and expands eligible sites to additional rural states. • Extends the Medicare Dependent Hospital Program for an additional year. • Temporarily increase payment for certain low-volume hospitals, ensuring that rural hospitals are adequately reimbursed for serving their communities. • Expands the Community Health Integration Models in Certain Rural Counties demonstration project to more eligible counties, and will also allow physicians to participate in the demonstration project. 	<ul style="list-style-type: none"> • Telehealth expansion • Extension of geographic floor for work
Low-Income Beneficiary Provisions		<ul style="list-style-type: none"> • Improves assets test for Medicare Savings Program and LIS program • Eliminates Part D cost-sharing for certain non-institutionalized full benefit dual eligibles • Reduces barriers to enrollment • Intelligent assignment in enrollment
Therapy Caps	Extends the exceptions process for therapy caps through December 31, 2010.	Extends therapy cap exception through December 31, 2011.
Therapeutic Classes of Part D Drugs	Codifies the current six classes of clinical concern, removes the criteria specified in section 176 of MIPPA that would have	

Health Reform Plans	Senate Health Reform Bill ¹	House Health Reform Bill ²
	<p>been 30 used by HHS to identify protected classes of drugs and gives the Secretary authority to identify classes of clinical concern through rulemaking.</p>	
<p>Improving Coordination and Collaboration</p>	<p>Payment for Accountable Care</p> <ul style="list-style-type: none"> • Rewards Accountable Care Organizations (ACOs) that take responsibility for the costs and quality of care received by their patient panel over time. • ACOs can include groups of health care providers (including physician groups, hospitals, nurse practitioners and physician assistants, and others). • ACOs that meet quality-of-care targets and reduce the costs of their patients relative to a spending benchmark are rewarded with a share of the savings they achieve for the Medicare program. • Allow for a pediatric ACO demo project <p>Medicaid global payment system demonstration project.</p> <ul style="list-style-type: none"> • Establishes a demonstration project, in coordination with the CMS Innovation Center, in up to five States that would allow participating States to adjust their current payment structure for safety net hospitals from a fee-for-service model to a global capitated payment structure. 	<ul style="list-style-type: none"> • Rewards for efficient providers <ul style="list-style-type: none"> ○ Accountable care organization pilot ○ Payment bundling ○ Medical home pilot • Increases primary care payments by 5% • Increases rates for certified nurse-midwives • Waives Medicare cost-sharing for preventive services
<p>Reducing Medical Errors and HAI</p>	<ul style="list-style-type: none"> • Beginning in FY2012, this provision would adjust payments for hospitals paid under the inpatient prospective payment system based on the dollar value of each hospital's percentage of potentially preventable Medicare readmissions for the three conditions with risk adjusted readmission measures that are currently endorsed by the National Quality Forum. • Provides the Secretary authority to expand the policy to additional conditions in future years and directs the Secretary to calculate and make publicly available information on all patient hospital readmission rates for 	<p>Requires hospitals and ASCs to report public health information on healthcare-associated infections to the Centers for Disease Control and Prevention.</p>

Health Reform Plans	Senate Health Reform Bill ¹	House Health Reform Bill ²
	<p>certain conditions.</p> <ul style="list-style-type: none"> • Starting in FY2015, hospitals in the top 25th percentile of rates of HAI for certain high-cost and common conditions would be subject to a payment penalty under Medicare. • Requires the Secretary to submit a report to Congress by January 1, 2012 on the appropriateness of establishing a healthcare acquired condition policy related to other providers participating in Medicare, including nursing homes, IRFs, LTCHs, outpatient hospital departments, ASCs, and health clinics. 	
Quality Infrastructure	<ul style="list-style-type: none"> • Requires the Secretary to establish and update annually a national strategy to improve the delivery of health care services, patient health outcomes, and population health. Establishes, not later than January 1, 2011, a Federal health care quality internet website. • Requires the President to convene an Interagency Working Group on Health Care Quality comprised of Federal agencies to collaborate on the development and dissemination of quality initiatives consistent with the national strategy. • Authorizes \$75 million over 5 years for the development of quality measures at AHRQ and the CMS. Quality measures developed under this section will be consistent with the national strategy. • Provides \$20 million to support the endorsement and use of endorsed measures by the HHS Secretary for use in Medicare, reporting performance information to the public, and in health care programs. • Requires the Secretary to collect and aggregate consistent data on quality and resource use measures from information systems used to support health care delivery to implement the public reporting of performance information. 	<p>Quality Measures</p> <ul style="list-style-type: none"> • Establishes national priorities and performance measures for quality improvement • Creates an incentive system to increase payments to high-quality plans in low-cost areas • Extends CMS authority to adjust risk scores in Medicare Advantage for observed differences in coding patterns relative to fee-for-service. • Eliminates stabilization fund • Extends of reasonable cost contracts • Requires a study on effectiveness of MA risk adjustment system • Limits cost sharing • Application of quality measures

Health Reform Plans	Senate Health Reform Bill ¹	House Health Reform Bill ²
Employer-Sponsored Wellness Programs	<ul style="list-style-type: none"> • A group health plan may offer incentives to individual who voluntarily participates in wellness programs • Technical assistance for these programs • National worksite health policies and programs study • Requires the CDC to study and evaluate best employer-based wellness practices and provide an educational campaign and technical assistance to promote the benefits of worksite health promotion to employers. 	
Medicare Advantage Reforms and Part D	<ul style="list-style-type: none"> • Sets MA payment based on the average of the bids from MA plans in each market. • Creates performance bonus payments based on a plan's level of care coordination and care management and achievement on quality rankings. • Provides a four-year transition to new benchmarks beginning in 2011. • Provides a longer transition of the amount of extra benefits available from plans to beneficiaries in certain areas where the level of extra benefits available is highest relative to other areas. • Prohibits MA plans from charging beneficiaries cost sharing for covered services that is greater than what is charged under the traditional fee-for-service program. • Requires plans that provide extra benefits to give priority to cost sharing reductions, wellness and preventive care, and then benefits not covered under Medicare. • Extends HHS authority to adjust risk scores in MA for observed differences in coding patterns relative to traditional fee-for-service. • Simplifies of annual beneficiary election periods. • Extends the period of time for which cost plans may operate in areas that have other health plan options. • Authorizes the HHS Secretary to deny bids submitted by MA and prescription plans, beginning in 2011, that 	<ul style="list-style-type: none"> • Phase-in of payment based on fee-for-service cost over 3 years • Quality-based payment adjustment • Improves risk adjustment system • Simplifies of annual beneficiary election periods • Eliminates MA regional plan stabilization fund • Enrollment reforms

Health Reform Plans	Senate Health Reform Bill ¹	House Health Reform Bill ²
	propose to significantly increase beneficiary cost sharing or decrease benefits offered under the plan.	
Special Needs Plans	<ul style="list-style-type: none"> • Extends the SNP program through 2013 and requires SNPs to be NCQA approved. • Allows HHS to apply a frailty payment adjustment to fully-integrated, dual-eligible SNPs that enroll frail populations. • Requires HHS to transition beneficiaries enrolled in SNPs that do not meet statutory target definitions and requires dual-eligible SNPs to contract with State Medicaid programs beginning 2013. • Requires an evaluation of Medicare Advantage risk adjustment for chronically ill populations. 	<ul style="list-style-type: none"> • Limits SNP enrollment to open enrollment period • Extends SNPs through 2012 and certain fully integrated dual eligible SNPs through 2015 • Extends the moratorium on service area expansions for dual eligible SNPs that do not meet certain requirements. • Extends SNPs that serve residents in continuing care retirement communities.
Public Program Integrity	<ul style="list-style-type: none"> • Requires the Secretary to conduct provider screening • Imposes new disclosure requirements on providers and suppliers enrolling in Medicare • Requires CMS to complete development of the comprehensive Integrated Data Repository (IDR). • Consolidates and expands existing provider databases • Provider compliance and penalties • Expands the Recovery Audit Contractor (RAC) Program to Medicare Parts C and D and Medicaid • States would be required to contract with one or more RAC • Program integrity funding and reporting requirements • Expands the number of areas in DME competitive bidding 	
Long-Term Care Services and Supports	<ul style="list-style-type: none"> • Establishes national voluntary insurance program for purchasing community living assistance services and support (CLASS program). • Establishes a new, voluntary, self-funded public long-term care insurance program, to be known as the CLASS Independence Benefit Plan, for the purchase of community living assistance services and supports by individuals with functional limitations. 	<ul style="list-style-type: none"> • Establishes national voluntary insurance program for purchasing community living assistance services and support (CLASS program). • Establishes a new, voluntary, public long-term care insurance program, to be known as the CLASS Independence Benefit Plan, for the purchase of community living assistance services and supports by individuals with functional limitations.

Health Reform Plans	Senate Health Reform Bill ¹	House Health Reform Bill ²
	<ul style="list-style-type: none"> • Requires the Secretary to develop an actuarially sound benefit plan that ensures solvency for 75 years; allows for a five-year vesting period for eligibility of benefits; creates benefit triggers that allow for the determination of functional limitation; and provides cash benefit that is not less than an average of \$50 per day. • No taxpayer funds will be used to pay benefits under this provision. 	<ul style="list-style-type: none"> • Requires the Secretary to develop an actuarially sound benefit plan that ensures solvency for 75 years; allows for a five-year vesting period for eligibility of benefits; creates benefit triggers that allow for the determination of functional limitation; and provides cash benefit that is not less than an average of \$50 per day. • Requires States to comply with primary and secondary payor rules established by the Secretary with respect to the CLASS program under section 2581. • Requires States to designate or create fiscal agents for personal care attendant workers serving CLASS program beneficiaries.
Health Disparities	Requires federal health programs to collect uniform data on race, ethnicity, gender and disability to help program administrators and researchers work to end disparities among these groups.	<ul style="list-style-type: none"> • Requires HHS to study use of language services • Promotes access to services for those with limited English proficiency • IOM Report on impact of language services
Reducing Fraud and Abuse	<ul style="list-style-type: none"> • Increases Health Care Fraud and Abuse Control (HCFAC) funding would by \$10 million each year for fiscal years 2011 through 2020. The provision would also permanently apply the CPI-U adjustment to HCFAC and Medicare Integrity Program (MIP) funding. • Requires the Secretary to maintain a national health care fraud and abuse data collection program for reporting certain adverse actions taken against health care providers, suppliers, and practitioners, and submit information on the actions to the National Practitioner Data Bank (NPDB). The Secretary would also be required to establish a process to terminate the Healthcare Integrity and Protection Databank (HIPDB) and ensure that the information formerly collected in the HIPDB is transferred to the NPDB. 	<ul style="list-style-type: none"> • Increase funding for Health Care Fraud and Abuse Control Account (\$100 million annually) • Allows expanded use of funds by the CMS Medicare Integrity Program • Increases penalties for false statements on provider or supplier enrollment applications • Increases penalties for false Medicare, Medicaid, or CHIP data • Increases penalties for delaying inspector general investigations • Increases penalties for MA and Part marketing violations • Requires providers and suppliers to adopt programs to reduce waste, fraud, and abuse • Requires physicians to provide documentation on

Health Reform Plans	Senate Health Reform Bill ¹	House Health Reform Bill ²
	<ul style="list-style-type: none"> • Requires States and Medicaid managed care entities to submit data elements from MMIS as determined necessary by the Secretary for program integrity, program oversight, and administration. 	<p>referrals to programs at high risk of waste and abuse</p> <ul style="list-style-type: none"> • Requires repayments of Medicare and Medicaid overpayments • OIG access to certain information on renal dialysis facilities
Repeal Trigger		Repeal MMA Trigger
Follow on biologics	<ul style="list-style-type: none"> • Establishes a process under which the Secretary is required to license a biological product that is shown to be biosimilar to or interchangeable with a licensed biological product, commonly referred to as a reference product. • Prohibits the approval of an application as either biosimilar or interchangeable until 12 years from the date on which the reference product is first approved. • If FDA approves a biological product on the grounds that it is interchangeable to a reference product, HHS is prohibited from making a determination that a second or subsequent biological product is interchangeable to that same reference product until 1 year after the first commercial marketing of the first interchangeable product. • Authorizes HHS to issue guidance with respect to the licensure of biological products under this new pathway, and it includes provisions governing patent infringement concerns such as the exchange of information, good faith negotiations, and initiation infringement actions. • Applies certain provisions of the Food, Drug, and Cosmetic Act to this subtitle with respect to pediatric studies of biological products. • Requires HHS to develop recommendations for Congress with respect to the goals for the process for the review of biosimilar biological product applications for the first five fiscal years after FY 2012. 	<ul style="list-style-type: none"> • Establishes a process under which the Secretary is required to approve applications for biological products that have been shown to be biosimilar or interchangeable to an already licensed biological product (the reference product). • Requires notification to the Federal Trade Commission and the Assistant Attorney General of certain types of agreements regarding biosimilar or reference products. • Allows for the collection of user fees for the approval of biosimilar or interchangeable biological products. • Establishes that a biological product applicant's submission of a statement regarding patents identified by the patent holder constitutes an act of infringement of the patents that claim the biological product.

Health Reform Plans	Senate Health Reform Bill ¹	House Health Reform Bill ²
340 B Program	<ul style="list-style-type: none"> • Extends the 340B discounts to inpatient drugs and also extends participation to certain children’s hospitals, cancer hospitals, critical access and sole community hospitals, and rural referral centers. • Improves program integrity • Requires GAO study to make recommendations on improvements 	<ul style="list-style-type: none"> • Extends the section 340B discounts to certain critical access hospitals, children’s hospitals, cancer hospitals, and other entities. • Establishes new auditing, reporting, and other compliance requirements for the Secretary, and for pharmaceutical manufacturers and 340B covered entities.
Comparative Effectiveness Research (CER)	<p>Patient-Centered Outcomes Research</p> <ul style="list-style-type: none"> • Establishes a private, nonprofit entity (the Patient-Centered Outcomes Research Institute) governed by a public-private sector board appointed by the Comptroller General to identify priorities for and provide for the conduct of comparative outcomes research. • Requires the Institute to ensure that subpopulations are appropriately accounted for in research designs. • Prohibits any findings to be construed as mandates on practice guidelines or coverage decisions and contains patient safeguards to protect against discriminatory coverage decisions by HHS based on age, disability, terminal illness, or an individual’s quality of life preference. • Provides funding for the Institute and authorizes and provides funding for the AHRQ to disseminate research findings of the Institute, as well as other government-funded research, to train researchers in comparative research methods and to build data capacity for CER. • Federal coordinating council for comparative effectiveness research. Upon date of enactment, this provision would sunset the Federal Coordinating Council created in the American Recovery and Reinvestment Act of 2010 (P.L. 111-5). 	<ul style="list-style-type: none"> • Creates a new Center at the AHRQ , supported by a combination of public and private funding that will conduct, support and synthesize CER. • Establishes an independent stakeholder commission which recommends to the Center research priorities, study methods, and ways to disseminate research. • A majority of the Commission members would be required to be physicians, other health care practitioners, consumers or patients. • Contains protections to ensure that subpopulations are appropriately accounted for in research study design and dissemination; protections to prevent the Center and Commission from mandating payment, coverage or reimbursement policies.; protections to ensure that research findings are not construed to mandate coverage, reimbursement or other policies to any public or private payer, and clarify that federal officers and employees will not interfere in the practice of medicine. • Establishes the trust fund for the CER program with dedicated amounts going to both the Center for Comparative Effectiveness Research and the Comparative Effectiveness Research Commission. • Establishes a fee that is assessed on private insurance on the basis of the number of insured individuals to fund the research program, provides for transfers

Health Reform Plans	Senate Health Reform Bill ¹	House Health Reform Bill ²
		from the Medicare trust funds to the CERTF in addition to the fee.
Vaccines	<ul style="list-style-type: none"> • Improving access to preventive services for eligible adults in Medicaid. The current Medicaid State option to provide other diagnostic, screening, preventive, and rehabilitation services would be expanded to include: (1) any clinical preventive service recommended with a grade of A or B by the U.S. Preventive Services Task Force and (2) with respect to adults, immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) and their administration. States that elect to cover these additional services and vaccines, and also prohibit cost-sharing for such services and vaccines, would receive an increased FMAP of one percentage point for these services. • Authorizes States to purchase adult vaccines under CDC contracts. • Authorizes a demonstration program to improve immunization coverage. States may use funds to implement interventions that are recommended by the Community Preventive Services Task Force, such as reminders or recalls for patients or providers, or home visits. Reauthorizes the Immunization Program in Section 317 of the Public Health Service Act. • Requires GAO study and report to Congress on coverage of vaccines under Medicare Part D and the impact on access to those vaccines. 	<ul style="list-style-type: none"> • Transfers coverage from Medicare Part D to Medicare Part B for all Medicare-covered vaccines. • Vaccines but for influenza will be paid for according to the average sales price methodology. • Allows children who do not have insurance coverage for immunizations to receive vaccines through the VFC program at a public health clinic.
National Medical Device Registry		<ul style="list-style-type: none"> • Establishes a national directory for class III medical devices and class II devices that are permanently implantable, life-supporting, or life-sustaining. • Device information in the registry would be linked with patient safety and outcomes data from various public and private databases to facilitate analyses of

Health Reform Plans	Senate Health Reform Bill ¹	House Health Reform Bill ²
Independent Medicare Advisory Board	<ul style="list-style-type: none"> Creates an independent, 15-member Medicare Advisory Board tasked with presenting Congress with comprehensive proposals to reduce excess cost growth and improve quality of care for Medicare beneficiaries. In years when Medicare costs are projected to be unsustainable, the Board's proposals will take effect unless Congress passes an alternative measure that achieves the same level of savings. Congress would be allowed to consider an alternative provision on a fast-track basis. The Board would be prohibited from making proposals that ration care, raise taxes or Part B premiums, or change Medicare benefit, eligibility, or cost-sharing standards. 	post-market device safety and effectiveness.
Medicaid and CHIP Payment and Access Commission (MACPAC)	<ul style="list-style-type: none"> Clarifies the topics to be reviewed by the MACPAC including Federal Medicaid and CHIP regulations, additional reports of State-specific data, and an assessment of adult services in Medicaid. The provision would also authorize \$11 million to fund MACPAC for FY2010. 	
MedPAC	<ul style="list-style-type: none"> MedPAC shall report aggregate Medicaid and commercial trends in spending, utilization, and financial performance for providers where a significant portion of revenue is associated with Medicaid 	
Medical Malpractice	<ul style="list-style-type: none"> Expresses the sense of the Senate that health reform presents an opportunity to address issues related to medical malpractice and medical liability insurance, states should be encouraged to develop and test alternative models to the existing civil litigation system, and Congress should consider state demonstration projects to evaluate such alternatives. 	<ul style="list-style-type: none"> Establishes an incentive program for States to adopt and implement alternatives (certificate of merit or "early offer") as alternatives to traditional medical malpractice litigation. Such alternatives may not include provisions that limit attorneys' fees or impose caps on damages. Authorizes such sums as may be necessary to carry out this program.

Health Reform Plans	Senate Health Reform Bill ¹	House Health Reform Bill ²
High Cost Insurance Excise Tax	<ul style="list-style-type: none"> • Levies an excise tax of 40 percent on insurance companies and plan administrators for any health coverage plan that is above the threshold of \$8,500 for single coverage and \$23,000 for family coverage. • The tax would apply to self-insured plans and plans sold in the group market, but not to plans sold in the individual market (except for coverage eligible for the deduction for self-employed individuals). • Applies to the amount of the premium in excess of the threshold. The threshold would be indexed at CPI-U plus one percentage point, and a transition rule would increase the threshold for the 17 highest cost States for the first 3 years. • An additional threshold amount of \$1,350 for singles and \$3,000 for families is available for retired individuals age 55 and older and for plans that cover employees engaged in high risk professions. 	
Employer W-2 Reporting of Value of Health Benefits	<ul style="list-style-type: none"> • Requires employers to disclose the value of the benefit provided by the employer for each employee's health insurance coverage on the employee's annual Form W-2. 	
Limit Health FSA Contributions	<ul style="list-style-type: none"> • Provides that nontaxable reimbursements from health flexible spending accounts, health reimbursement arrangements, and health savings accounts do not include a medicine or drug unless the medicine or drug is prescribed or is insulin. • Limits the amount of contributions to health Flexible Spending Accounts (FSAs) to \$2,500 per year, beginning after December 31, 2010. 	<ul style="list-style-type: none"> • Provides that nontaxable reimbursements from health FSAs, health reimbursement arrangements, and health savings accounts do not include a medicine or drug unless the medicine or drug is prescribed or is insulin. • Limits salary reduction contributions to health flexible spending arrangements to \$2,500 (indexed to the consumer price index).
Eliminate Deduction for Employer Part D Subsidy	<ul style="list-style-type: none"> • Eliminates the deduction for the subsidy for employers who maintain prescription drug plans for their Medicare Part D eligible retirees. • This would be effective beginning in 2011. 	
Standardize the Definition	<ul style="list-style-type: none"> • Conforms the definition of qualified medical expenses for 	

Health Reform Plans	Senate Health Reform Bill ¹	House Health Reform Bill ²
of Qualified Medical Expenses	<p>health savings accounts, health FSAs, and HRAs to the definition used for the itemized deduction.</p> <ul style="list-style-type: none"> An exception to this rule would allow amounts paid for over-the-counter medicine with a prescription to still qualify as medical expenses. 	
Penalty for Use of HSA Funds for Non-qualified Medical Expenses	<ul style="list-style-type: none"> Increases the additional tax for HSA withdrawals prior to age 65 that are not used for qualified medical expenses from 10% to 20%, beginning in 2011. 	<ul style="list-style-type: none"> Increases the 10% penalty on distributions from health savings accounts that are not used to pay for health related expenditures to 20%.
Corporate Information Reporting	<ul style="list-style-type: none"> Requires businesses that pay any amount greater than \$600 during the year to corporate providers of property and services to file an information report with each provider and with the IRS. Information reporting already is required on payments for services to non-corporate providers. This applies to payments made after December 31, 2011. 	<ul style="list-style-type: none"> Requires information reporting with respect to payments made in the course of a trade or business to a corporation.
Non-profit Hospitals	<ul style="list-style-type: none"> Establishes new requirements applicable to nonprofit hospitals. The requirements would include a periodic community needs assessment. 	
Pharmaceutical Manufacturers Fee	<ul style="list-style-type: none"> Imposes an annual flat fee of \$2.3 billion on the pharmaceutical manufacturing sector, beginning in 2010. This nondeductible fee would be allocated across the industry according to market share and would not apply to companies with sales of branded pharmaceuticals of \$5 million or less. 	
Medical Device Manufacturers Fee	<ul style="list-style-type: none"> Imposes an annual flat fee of \$2 billion on the medical devices manufacturing sector, beginning in 2010. This nondeductible fee would be allocated across the industry according to market share and would not apply to companies with sales of medical devices in the U.S. of \$5 million or less. The fee does not apply to any sale of a Class I product or any sale of a Class II product that is primarily sold to 	<ul style="list-style-type: none"> Establishes a 2.5 percent excise tax on medical devices sold for use in the U.S. The excise tax does not apply to exported devices and does not apply to retail sales of devices.

Health Reform Plans	Senate Health Reform Bill ¹	House Health Reform Bill ²
	<p>consumers at retail for not more than \$100 per unit (under the FDA product classification system).</p>	
Health Insurance Provider Fee	<ul style="list-style-type: none"> • Imposes an annual flat fee of \$6.7 billion on the health insurance sector, beginning in 2010. • This non-deductible fee would be allocated across the industry according to market share and would not apply to companies whose net premiums written are \$25 million or less and whose fees from administration of employer self-insured plans are \$5 million or less. • The public option, as well coops and the national plan, will be subject to the insurance provider fee. 	
Modify the Itemized Deduction for Medical Expenses	<ul style="list-style-type: none"> • Increases the adjusted gross income threshold for claiming the itemized deduction for medical expenses from 7.5 percent to 10 percent. • Individuals age 65 and older would be able to claim the itemized deduction for medical expenses at 7.5 percent of adjusted gross income through 2016. 	
Credit to Encourage New Therapies	<ul style="list-style-type: none"> • Creates a temporary credit subject to an overall cap of \$1 billion to encourage investments in new therapies to prevent, diagnose, and treat acute and chronic diseases 	
Executive Compensation	<ul style="list-style-type: none"> • Creates a special rule regarding the deductibility of excessive remuneration by an insurance provider, if at least 25% of the insurance provider's gross premium income from health business is derived from health insurance plans that meet the minimum creditable coverage • No deduction shall be allowed if remuneration exceeds \$500,000 	
Cosmetic Surgery Tax	<ul style="list-style-type: none"> • Imposes a 5% excise tax on voluntary cosmetic surgical and medical procedures performed by a licensed medical professional. • The tax would be collected by the medical professional at the point of service. 	

Health Reform Plans	Senate Health Reform Bill ¹	House Health Reform Bill ²
	<ul style="list-style-type: none"> The definition of voluntary cosmetic procedures generally would be the same as the definition of cosmetic surgery or similar procedures that are not treated as included in medical care under the current Section 213(d)(9) definition. 	
Additional hospital insurance tax on high-income taxpayers	Increases the hospital insurance tax rate by 0.5 percentage points on an individual taxpayer earning over \$200,000 (\$250,000 for married couples filing jointly).	
Health Care Surcharge		<ul style="list-style-type: none"> Establishes a 5.4 percent tax on modified adjusted gross income in excess of \$1 million in the case of a joint return (\$500,000 in the case of other returns). The tax is estimated to affect only 0.3 percent of all households and only 1.2 percent of sole proprietors, partners, and s-corporation shareholders operating a business.
Other Health Care Related Revenue Raisers	<ul style="list-style-type: none"> Study and report of effect on veterans health care Special deduction for Blue Cross Blue Shield 	<ul style="list-style-type: none"> Extends current rules for Medicaid payments to pharmacists for multiple source drugs through December 31, 2010. Thereafter, limits Medicaid payments for such drugs to 130% of the weighted average manufacturer price (AMP). Redefines AMP to exclude certain price concessions, including those provided to pharmacy benefit managers, not passed through to retail pharmacies. Prescription drug rebates to 22.1% Extend prescription drug discounts to enrollees of Medicaid managed care organizations Clarifies that State Medicaid programs may receive federal matching payments for the costs of graduate medical education. Medicare non-payment for certain health care-acquired conditions Minimum medical loss ratio for Medicaid managed

Health Reform Plans	Senate Health Reform Bill ¹	House Health Reform Bill ²
		care organizations • Making QI program permanent
Delay Implementation of worldwide allocation of interest		Provision delays the application of a liberalized rule for allocating interest expenses between U.S. and foreign sourced income for purpose of a taxpayer's foreign tax credit limitation.
Limitation on treaty benefits for certain deductible payments		Prevents foreign multinational corporations incorporated in tax havens from avoiding tax on income earned in the U.S.
Clarification of the economic substance doctrine		Clarifies the application of the economic substance doctrine, which has been used by courts to deny tax benefits for transactions that lack economic substance.