



Health Reform Proposals Being Considered by the 111th Congress

Issue	The Patient Protection and Affordable Care Act (H.R. 3590) (12/24/09 Passed by Senate 60-39; 3/21/10 Passed by House 219-212)	The Health Care and Education Reconciliation Act (H.R. 4872) (3/21/10 Passed by House 220-211)
Coverage		
Market Reforms	<p>Guaranteed issue and renewability.</p> <p>Modified community rating based on family structure, geography, actuarial value of benefit, age (premium variation limit of 3:1), and tobacco use (premium variation limit of 1.5:1).</p> <p>Prohibits lifetime and annual limits.</p> <p>Extends dependant coverage to age 26.</p> <p>Prohibits any group or individual coverage waiting period exceeding 90 days.</p> <p>Includes administrative simplification provisions (see HIT).</p> <p>Grandfathers current individual plans. Group plans may enroll new members and family members if plans were in operation before enactment.</p> <p>Rating reforms must apply to all health insurance issuers and group health plans by 2014.</p> <p>Beginning 2010, HHS and states will establish a process for annual review of increases in health insurance</p>	<p>No changes.</p> <p>No changes.</p> <p>No changes.</p> <p>No changes.</p> <p>No changes.</p> <p>No changes.</p> <p>Reforms apply to all existing insurance plans 6 months after enactment. Group health plans prohibits pre-existing condition exclusions in 2014.</p>
(cont'd next page)		

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Market Reforms (cont'd)	premiums. Requires states to make recommendations to their exchanges about whether health insurers should be excluded from participation based on unjustified premium increases.	
Benefit Design	<p>Qualified health plans must be certified by exchanges. Requires HHS to define essential health benefits, which must be equal in scope to the benefits of a typical employer plan.</p> <p>Establishes four plans that vary based on likely payments by a health plan: Bronze (60% AV); Silver (70% AV); Gold (80% AV); and Platinum (90% AV) with out-of-pocket limits no greater than limits of an HSA. AV = actuarial value.</p> <p>Covers and prohibits cost sharing for immunizations and for preventive benefits recommended by USPSTF.</p> <p>Provides first dollar coverage for women's preventive services.</p> <p>Requires that a plan enrollee must be allowed to select his or her primary care provider. Precludes prior authorization for emergency services.</p> <p>States may impose additional minimum requirements but must make payments to defray the cost of additional benefits for individuals enrolled in qualified health plans (regardless of eligibility for tax credits or subsidies).</p> <p>Catastrophic plans may be offered to individuals under the age of 30 or who are exempt from the individual mandate because they cannot obtain affordable coverage, or they have a hardship. Plan must cover essential health benefits and at least 3 primary care visits. Requires cost sharing up to the HSA out-of-pocket limit.</p>	No changes.

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Health Insurance Exchange (cont'd)	<p>and a model template for Internet portal, and determine an initial and annual enrollment period.</p> <p>Eligibility: Initially available to individuals and small employers (less than 100 employees). (States have option to limit employers with 50 employees as designated “small” before 2016.) After 2017, states may allow large employers (over 100 employees) to participate. (Over 50 if state elected lower employee definition of small employer.)</p> <p>Allows for an exchange to operate in more than one state, if approved by all participating states and HHS.</p> <p>HHS will establish and operate an exchange and implement standards if HHS determines before 2013 that a state will not have an operational exchange by 2014.</p> <p>Allows public and private entities to serve as “navigators” and contract with states to raise public awareness of the program, distribute information, and help with enrollment.</p> <p>Requires HHS to collect via the Internet information about enrollee satisfaction with health plans offered through the insurance exchange.</p> <p>Requires exchanges to consider the reasonableness of premium rate increases when determining whether to certify and offer plans.</p>	
Individual Tax Credit/Premium Subsidies (cont'd next page)	<p>Beginning 2014, sliding-scale advanceable, refundable tax credits between 133% and 400% FPL (paid directly to the insurance company for individuals in the exchange.) In addition to income level, there is a subsidy based on healthcare cost as a percent of income on a sliding scale between 2% and 9.8%.</p>	<p>Sliding scale tax credits for individuals up to 400% FPL (2% to 9.5% of income paid for premiums). Limits the growth of tax credits if premiums are growing faster than the CPI unless spending is more than 10% below CURRENT CBO projections.</p> <p>Sliding scale cost sharing subsidies of 73% to 94% for individuals with incomes up to 250% FPL. 70% cost sharing subsidies for individuals between 251%-400% FPL.</p>

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Individual Tax Credit/Premium Subsidies (cont'd)	<p>Employees whose employer insurance would cost more than 9.8% of their income or the plan's actuarial value is less than 60% are eligible to use the exchange and apply for credits.</p> <p>Credit is applicable to Silver Plan.</p> <p>If premiums for qualified employer-sponsored coverage represent 8.0 - 9.8% of an employee's income, the employer would be required to provide tax-free "free choice vouchers" to employees whose income does not exceed 400% FPL in order to purchase coverage through the exchange. Voucher is equal to the amount of employers' contribution to employer-sponsored coverage.</p>	
Small Business Tax Credit	<p>Creates a sliding scale tax credit up to 35% of the premium for firms with fewer than 25 employees and average wages below \$50K. Maximum credit of 35% of premiums available to firms with 10 employees or less with average wages below \$25K for 2010 for up to six years. Excludes seasonal workers. Employers must contribute at least 50% of premium cost. In 2014 and beyond, eligible employers who purchase coverage through the exchange can receive a tax credit for two years up to 50% of their contribution.</p> <p>Allows nonprofit companies to receive a credit up to 25% of their contribution in 2011 through 2013. In 2014, qualified nonprofits purchasing insurance in the exchange could receive a 35% tax credit for 2 years of contribution.</p>	<p>No changes.</p>
Government Health Plan (GHP) (cont'd next page)	<p>No government Health Plan. Allows Office of Personnel Management (OPM) to enter into contracts with health insurers to offer at least 2 multistate qualified health plans through the exchange in each state. At least one of the plans must be nonprofit. OPM state plans have a risk pool separate from the Federal Employees Health Benefits Plan.</p> <p>Establishes nonprofit cooperatives (co-ops) to compete with private insurers and the public insurance option.</p>	<p>No changes.</p>

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GHP (cont'd)	Creates a federally funded (85% of tax credits and cost-sharing reductions) non-Medicaid, state plan available to individuals between 133% and 200% FPL.	
Medicaid Expansion	<p>Expansion to 133% FPL in 2014.</p> <p>Creates a new eligibility category for all childless adults up to 133% FPL. New option for states to cover parents and childless adults up to 133% FPL in 2013.</p> <p>States have the option to provide Medicaid coverage to individuals above 133% FPL through a state plan amendment.</p> <p>100% federal match of covering newly eligible individuals in 2014 through 2016 (NE to receive in perpetuity). Other states” that initially covered less of the newly eligible population would receive FMAP increase of 34.3 percentage points (pp) in 2017 and 33.3 pp in 2018. “Expansion states” that covered at least some of the newly eligible population would receive FMAP increase of 30.3 pp in 2017 and 31.3 in 2018. All states would receive an FMAP increase of 32.3 pp in 2019 and thereafter.</p>	<p>No changes.</p> <p>No changes.</p> <p>No changes.</p> <p>100% Federal support for all States for newly eligible individuals from 2014 through 2016, 95% support in 2017, 94% in 2018, 93% in 2019 and 90% in subsequent years.</p>
Children’s Health Insurance Program (CHIP)	<p>Reauthorizes program through 2015.</p> <p>Beginning in 2015, states experiencing CHIP shortfalls can enroll targeted low-income children into qualified health plans participating in the exchange that are certified by HHS as providing CHIP-comparable coverage.</p>	No changes.
Reinsurance and Coverage for Ages 55-64	<p>Beginning 2010 creates a temporary reinsurance program to pay employers for coverage of retirees age 55-64, 80% of the claims between \$15,000 and \$90,000.</p> <p>Appropriates \$5 billion to the fund to be available until expended.</p>	No changes.

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Long-Term Care	<p>Establishes an “opt out” payroll deduction program (“CLASS Independence Benefit Plan”) for long-term care. Requires HHS to develop an actuarially sound benefit plan that ensures solvency for 75 years. (CLASS Act).</p> <p>Sense of the Senate to ensure savings resulting from the CLASS Act and the Social Security surplus remain in those programs.</p>	No changes.
High-Risk Pools	<p>Within 90 days of enactment, HHS will establish a temporary high-risk health insurance pool to provide coverage for individuals who have been uninsured for at least 6 months with pre-existing condition(s) until 2014.</p> <p>Provides up to \$5 billion for the program.</p>	No changes.
Individual Mandate	<p>Beginning 2014, everyone would be required to have health insurance, with exceptions.</p> <p>Exemptions: individuals without access to affordable coverage (more than 12.5% of AGI), taxpayers with income under 100% FPL, members of Indian tribes, illegal aliens, and those lacking coverage for fewer than 90 days in a year.</p> <p>Enforced via tax penalty (annual tax returns) individuals will pay the greater of \$95 in 2014; \$495 in 2015; and beginning in 2016, the greater of \$750 (indexed to COLA thereafter), or up to 2% of income, up to a cap of the national average Bronze plan premium. Parents pay 50% penalty for uncovered children under 18 capped at \$2,250 for the entire family.</p>	<p>Modifies tax penalty for those not obtaining coverage to \$325 in 2015 and \$695 in 2016. Alternative payment amounts of 1% in 2014, 2% in 2015 and 2.5% for 2016 and beyond.</p> <p>Maintains hardships exemptions and those with incomes below the filing threshold.</p>
Financing		
Medicare Payroll Tax	Increases the Medicare payroll tax rate by 0.9 percentage points on taxpayers earning over \$200k and couples earning over \$250k.	Modifies to include net investment income in the taxable base for joint filers earning more than \$250K/year (AGI) and \$200k/year for individuals. Tax assessed of 3.8%.

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Tax Preferred Health Accounts	<p>Beginning 2011, definition of qualified medical expenses conformed to the definition used for the itemized medical deduction. Over-the-counter drugs must have a prescription to qualify as a medical expense.</p> <p>FSA contributions limited to \$2,500/year, beginning 2011, indexed to CPI-U after 2011.</p> <p>Beginning 2011 increases from 10% to 20% the penalty for HSA withdrawals prior to age 65 that are not used for qualified medical expenses.</p> <p>HSA's do not have to meet the actuarial equivalent requirements for a minimum benefit plan.</p>	<p>No changes.</p> <p>Delays limited FSA contributions until 2013.</p> <p>No changes.</p> <p>No changes.</p>
Medical Expense Deduction	<p>Beginning 2013 increases the income threshold to 10% AGI for claiming the itemized deduction for medical expenses. Allows individuals over 65 to deduct medical expenses at current 7.5% AGI through 2016.</p>	<p>No changes.</p>
Indoor Tanning	<p>Beginning 2010 imposes a 10% excise tax.</p>	<p>No provision.</p>
Health Sector Fees (cont'd next page)	<p>Insurance plans. Exchange can assess user fees beginning 2015.</p> <p>Beginning in 2011, annual fee of \$2 billion based on market share; \$4 billion in 2012; \$7 billion in 2013; \$9 billion in 2014-2016; \$10 billion thereafter. Plans whose net premium revenues are \$25 million or less and whose revenues from administration of employer self-insured plans are \$5 million or less not included. Exempts certain nonprofit health plans with an MLR of at least 90 percent, nonprofit plans in NE and MI, long-term care insurance, and Medigap plans.</p> <p>Beginning 2013, excise tax of 40% levied on insurance companies and administrators for any health insurance plan that costs more than \$8,500 for individual and \$23K for family plans (\$9,850/individual and \$26K/family for workers with high-risk jobs (including longshoremen) or</p>	<p>Insurance plans. Delays industry fee until 2014. Annual fees total \$8 billion in 2014; \$11.3 billion in 2015-2016; \$13.9 billion in 2017; \$14.3 billion in 2018 and in years after the preceding year amount increased by the amount of premium growth. Only 50% of net premiums will be taken into account in calculating fee for tax-exempt insurers. Exempts voluntary employee benefit associations (VEBAs) and nonprofit providers who receive more than 80% of revenue from entitlement programs and target low income, elderly or disabled populations.</p> <p>Delays the implementation of the excise tax on high-cost employer-sponsored health coverage until 2018 and increases the dollar thresholds for high cost health insurance subject to the tax to \$10,200 for individuals and \$27,500 for families. Excludes stand-alone dental and vision plans from</p>

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HIT (cont'd)	<p>Beginning 2012, HHS shall develop a plan to integrate reporting on quality measures with reporting requirements relating to the meaningful use of electronic health records.</p> <p>Establishes a process for HHS to consult stakeholders, the National Committee on Vital and Health Statistics, and the Health Information Technology Standards and Policy Committees to create uniform standards for financial and administrative healthcare transactions (not identified by HIPAA) to improve the operation of the health system and reduce costs.</p>	
Privacy	<p>HHS required to ensure all appropriate privacy and security safeguards are followed for activities relating to data collection (including healthcare disparities), analysis, and sharing.</p>	No changes.
Independence and Medical Homes	<p>Authorizes grants or contracts to establish and fund the development of community health teams to support the patient-centered medical home.</p> <p>Creates "independence at home" demonstration program for chronically ill Medicare beneficiaries to test a payment incentive and service delivery system that utilizes physician/ nurse practitioner-directed home-based primary care teams.</p> <p>State option of enrolling Medicaid beneficiaries with chronic conditions into a health home composed of a team of health professionals and would provide a comprehensive set of medical services including care coordination.</p> <p>Permits nurse practitioners and other primary care providers to participate in community care teams.</p>	No changes.
Prevention & Wellness (cont'd next page)	<p>Establishes a Prevention and Public Health Investment Fund to provide expanded and sustained investment in prevention and public health programs to improve health and restrain cost growth.</p>	No changes.

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Workforce (cont'd)	<p>Reinstates dental funding in Title VII of PHSA. Allows dental schools and education programs to use grants for pre-doctoral training, faculty development, dental faculty loan repayment, and academic administrative units.</p> <p>Establishes grants and loan repayment programs for various fields, including nursing and allied health professionals.</p> <p>Establishes new training opportunities for direct care workers providing long-term care services and support.</p> <p>Provides grants and financial assistance to trainees and faculty to develop and operate training programs in family medicine, general internal medicine, general pediatrics, and physician assistants. Priority given to programs that educates students in team-based approaches to care.</p> <p>Authorizes funding to geriatric education centers to support training in geriatrics, chronic care management, and family care-giving.</p> <p>Includes enhancements to workforce provisions through additional funding.</p>	
Medicare Payment Changes		
Medicare Benefits	<p>Prohibits reducing guaranteed benefits and requires any savings to support the program's solvency and beneficiaries (Bennet Amendment, adopted 100-0).</p> <p>Prohibits cutting home health benefits</p>	No changes.
Medicare Physician Payments (cont'd next page)	<p>No SGR fix included.</p> <p>Beginning 2011, provides primary care practitioners and general surgeons practicing in health professional shortage areas with a 10% Medicare bonus payment for five years. Half of cost of bonuses offset through an across-the-board reduction in all other services.</p>	No changes.

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Hospitals (cont'd)	<p>Readmission policy: Beginning in 2012, hospitals with preventable readmission rates above a certain threshold would have payments for original hospitalization reduced based on the dollar value of each hospital's percentage of preventable Medicare readmissions for the 3 conditions with risk-adjusted readmissions measures that are currently endorsed by the National Quality Forum. Provides HHS authority to expand to additional conditions. HHS to calculate and make publicly available info on all patient hospital readmission rates for certain conditions.</p> <p>Beginning FY 2011, establishes 1.0 hospital wage index for hospitals located in states in which at least 50% of counties in the state are "frontier" (benefits MT, SD, ND, WY).</p>	<p>No changes.</p> <p>No changes.</p>
Payment Bundling	<p>Beginning 2013, HHS will implement a 5-year pilot program on payment bundling for hospitals and post-acute care providers on 10 conditions. If the pilot improves patient outcomes, reduces costs, and improves efficiency, HHS is required to submit an expansion plan to Congress before 2016 to expand.</p>	<p>No changes.</p>
Gainsharing	<p>Extends gainsharing demonstration to September 30, 2011.</p>	<p>No changes.</p>
Physician-Owned Hospitals	<p>Prohibits physician-owned hospitals without a Medicare provider agreement before August 1, 2010, from participating in Medicare, with some exceptions.</p> <p>Grandfathers physician-owned hospitals with a Medicare provider agreement before August 1, 2010, to continue to participate in Medicare, subject to limitations on expansion as well as certain requirements addressing conflict of interest, bona fide investments, and patient safety issues.</p>	<p>Changes limitations date to December 31, 2010.</p>
Graduate Medical Education (GME)	<p>Beginning 2011, redistributes unused GME training positions (for the prior 3 cost reports) to primary care training. Special preference to be given to programs in states with a low physician-to-patient ratio.</p> <p>Encourages training in outpatient settings and ensures communities retain training slots if a hospital closes.</p>	<p>No changes.</p>

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Medicare Advantage	<p>Sets payments rates in the Medicare Advantage program based on the average of the bids submitted by Medicare Advantage plans in each market. Provides 4-year transition to new benchmarks beginning in 2011.</p> <p>CBO estimates this would yield savings of an estimated \$118 billion over the 2010-2019 period.</p> <p>Prohibits reducing guaranteed Medicare Advantage benefits.</p>	<p>Freezes Medicare Advantage payments in 2011. Reduces MA benchmarks relative to current levels beginning 2012. Benchmarks will vary from 95% to 115% of Medicare spending in high cost and low cost areas respectively. Phased in payment changes over 3.5 or 7 years.</p> <p>Creates increased payments of at least 5% to high quality plans.</p> <p>Extends CMS authority to adjust risk scores for observed differences in coding patterns relative to fee-for-service.</p> <p>Increases Medicare Advantage coding intensity adjustments for 2014 through 2018.</p>
Dialysis	<p>Incorporates “productivity improvements” into payment updates.</p>	
Special Needs Plans (SNPs)	<p>Extends authority through 2013 and requires SNPs to be NCQA-approved.</p> <p>Allows HHS to apply a frailty payment adjustment to fully integrated, dual-eligible SNPs that enroll frail populations.</p> <p>Requires HHS to transition SNP beneficiaries who do not meet target definitions.</p> <p>Requires an evaluation of Medicare Advantage risk adjustment for chronically ill populations.</p>	
Medicare Part D (cont'd next page)	<p>Beginning July 1, 2010, requires manufacturers to provide a 50% discount off the negotiated price for brand name drugs covered on plan formularies in the coverage gap (“doughnut hole”).</p> <p>So that fewer people reach the Part D coverage gap (donut hole), increases the initial coverage limit in the standard Part D benefit by \$500 for 2010. Does not apply to subsequent years.</p>	<p>Provides a one-time \$250 rebate (gov’t funded) to beneficiaries who have any spending in the coverage gap in 2010; strikes the \$500 increase in the initial coverage limit in the Senate bill.</p> <p>Delays 50% discount provided by manufacturers on brand name drugs in the coverage gap until January 1, 2011.</p>

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Medicare Part D (cont'd)	<p>Codifies existing six protected classes and gives HHS the authority to identify drug classes of clinical concern through rulemaking.</p> <p>Income-relates the Part D premium subsidy based on Part B income thresholds.</p> <p>Beginning 2011, eliminates the deduction for employer Part D subsidy for eligible retirees.</p>	<p>Begins phase out of coverage gap beginning in 2011 for generics and 2013 for brand name drugs. Eliminates the donut by 2020 with beneficiary coinsurance reduced to 25% or actuarial equivalent. (Gov't funded benefit built on top of the 50% discount).</p> <p>Clarifies that manufacturers' discounts for the coverage gap discount program are excluded from the definition of average manufacturer price (AMP).</p> <p>Eliminates the deduction for employer Part D subsidy beginning in 2013.</p>
Imaging	No provision.	Sets the assumed utilization rate at 75 percent for the practice expense portion of advanced diagnostic imaging services.
ACOs	<p>Beginning 2012, rewards Accountable Care Organizations (ACOs) that assume responsibility for the costs and quality of care provided. ACOs can include physician groups, hospitals, nurse practitioners, physician assistants, and others. ACOs enter into a 3-year contract and are eligible to receive reward payments (determined by HHS) if the average per capita Medicare expenditure is at least the specified percent below the applicable benchmark established by HHS.</p> <p>Allows HHS to incorporate private-sector payment models into ACO program.</p>	No changes.
Geographic Disparities	<p>Extends a floor on geographic adjustments to the work portion of the fee schedule through the end of 2010 to increase practitioner fees in rural areas.</p> <p>Provides immediate relief to areas negatively affected by the geographic adjustment for practice expenses and requires HHS to improve the methodology for calculating practice expense adjustments beginning in 2012.</p>	<p>\$800 million to address geographic disparities for doctors and hospitals for 2010-2011.</p> <p>IOM study study on geographic disparities beginning April. CMS to implement IOM recommendations by December 2012.</p> <p>IOM study on high quality low cost care and path toward implementation on recommendations by 2014.</p> <p>Automatic implementation of a Value Index for doctors beginning in 2015 (high value efficient care).</p>

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Independent Payment Advisory Board (IPAB)	<p>Establishes an independent 15-member Payment Advisory Board to present the president, Congress, and private entities with comprehensive proposals to reduce excess growth (beginning January 15, 2014).</p> <p>Congress would have an expedited opportunity to amend the proposal or pass an alternative proposal with an equivalent amount of budget savings. Original recommendations to be put into effect if legislation is not enacted by August 15.</p> <p>Policies included in Advisory Board or HHS proposal must reduce Medicare cost growth by 0.5% for 2015 (1.0% in 2016; 1.25% in 2017; 1.50% in 2018 and beyond) if, in 2013, Medicare Trustees project the Medicare per-capita growth rate in 2015 will exceed the average of growth rates in CPI and CPI-M.</p> <p>Board to issue an annual report beginning July 2014, with standardized information on system-wide healthcare costs, access to care, utilization, variation, and quality of care.</p> <p>Requires the board to make nonbinding Medicare recommendations to Congress in years in which Medicare growth is below the targeted growth rate.</p> <p>Beginning 2020, requires the board to make binding biennial recommendations to Congress if the growth in overall health spending exceeds growth in Medicare spending.</p> <p>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. Prohibits recommendations that would reduce premium support for low-income Medicare beneficiaries.</p>	<p>No changes.</p>

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Medicaid Payments		
FMAP	<p>100% federal match of covering newly eligible individuals in 2014 through 2016 (NE to receive in perpetuity). Other states that initially covered less of the newly eligible population would receive FMAP (Federal Medical Assistance Percentages) increase of 34.3 percentage points (pp) in 2017 and 33.3 pp in 2018. "Expansion states" that covered at least some of the newly eligible population would receive FMAP increase of 30.3 pp in 2017 and 31.3 in 2018. All states would receive an FMAP increase of 32.3 pp in 2019 and thereafter.</p> <p>States that opt to provide Medicaid coverage and remove cost sharing for all recommended preventive services and immunizations will receive a 1% increase in FMAP for those services.</p>	<p>100% Federal support for all States for newly eligible individuals from 2014 through 2016, 95% support in 2017; 94% in 2018; 93% in 2019 and 90% in subsequent years. Eliminates NE FMAP provision. For expansion states, reduced the state share of the cost of covering non-pregnant childless adults by 50% in 2014; 60% in 2015; 70% in 2016; 80% in 2017; 90% in 2018. In 2019 and thereafter expansion states would bear the same state share as non-expansion states (7% in 2019 and 10% thereafter).</p>
Primary Care	No provision.	Requires Medicaid payment rates to primary care physicians furnishing primary care services be no less than 100% of Medicare rates in 2013 and 2014. Provides 100% federal funding for the incremental costs to States to meet requirement.
Prescription Drugs	<p>Beginning 2010, rebate increases from 15.1% to 23.1% for single source and innovator multiple source drugs; 11% to 13% for generics; 15.1% to 17.1% for clotting factors and pediatric drugs. Drugs to promote smoking cessation, barbiturates, and benzodiazepines would be non-excludable.</p> <p>Rebates apply to Medicaid MCOs.</p>	No changes.
Disproportionate Share Hospitals (DSH)	<p>Beginning 2013, reduces a state's DSH allotment by 50% once the number of uninsured is reduced by 45% in the state (low DSH states would receive a 25% reduction).</p> <p>Beginning 2015, further DSH adjustments of -1.5 percentage points. DSH allotment further reduced at a rate that corresponds with any further reduction in the rate of uninsured. DSH allotments cannot be reduced by more than 65% compared to 2012 allotment.</p>	DSH adjustments moved up to 2014 (vs. 2015). Adjustments of -0.1 percentage points (pp) in 2014 and -0.2 in 2015-2019.

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Other Provisions		
Medical Liability Reform	<p>Expresses the Sense of the Senate that states should be encouraged to develop and test alternatives to the current civil litigation system and that Congress should consider creating state demonstration programs to evaluate alternatives.</p> <p>Authorizes grants to states to test alternatives to civil tort litigation. Models required to emphasize patient safety, disclosure of medical errors and the early resolution of disputes. Patients would be able to opt out of these alternatives at any time. Requires HHS to conduct an evaluation to determine the effectiveness of these alternatives.</p>	No changes.
Antitrust	No provision.	No provision.
Comparative Effectiveness	<p>Beginning 2010, establishes a private, nonprofit, Patient-Centered Outcomes Research Institute. Research conducted would compare the clinical effectiveness, risk, and benefits of two or more medical treatments, services, or items. Establishes a 17-member board of governors (appointed by Comptroller General) from public sector and private industry as well as the directors of NIH and AHRQ. Members would serve 6-year staggered terms and could serve no more than two terms.</p> <p>Duties of the institute:</p> <ul style="list-style-type: none"> - Tasked with identifying national priorities for comparative clinical effectiveness research and establishing a research project agenda. - Specifies that patient subpopulations will be considered during the research. <p>Allows the institute to enter into contracts with federal agencies or with private-sector entities for the management and conduct of research. Preference given to AHRQ and NIH.</p> <p>Requires the institute to disseminate the research and report to Congress annually.</p>	No changes.
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Payment Innovation Center (cont'd)	<p>and achievement of beneficiary and family-caregiver satisfaction. HHS required to focus on models that improve quality and reduce costs.</p> <p>HHS has authority to expand the duration or the scope of any project undertaken by the center.</p>	
Waste, Fraud & Abuse	<p>No provision.</p>	<p>Establishes new requirements for community mental health centers that provide Medicare partial hospitalization services.</p> <p>Streamlines procedures to conduct Medicare prepayment reviews to facilitate additional reviews.</p> <p>Requires a 90-day period to withhold payment and conduct enhanced oversight in cases where the Secretary identifies risk of fraud among DME suppliers.</p>
Biosimilars (Generic Biologics)	<p>Establishes 12 years of exclusivity for innovative biologics.</p> <p>Establishes parity between brand name biologics and biosimilars. Sets the add-on payment rate for biosimilar products reimbursement under Medicare Part B at 6% of the Average Sales Price of the brand biological product.</p>	<p>No changes.</p>
Tax Credit for Therapeutic Discovery	<p>Allocates \$1 billion to establish a 50% non refundable investment tax credit for qualifying therapeutic discovery projects for 2009 and 2010. The credit is available only to companies with 250 or less employees. Awards will be granted by Treasury Secretary in consultation with Secretary of HHS.</p>	<p>No changes.</p>
Sunshine Physician Payments (cont'd next page)	<p>Requires manufacturers that provide a payment or other transfer of value to a covered recipient (including providers) to annually report to the Secretary name of recipient, dates and amount of payment or other transfer value, and a description of the form of payment or other transfer of value (includes stocks, honoraria, consulting fees, travel, food, education research, charitable contributions, research, grants. Requires manufacturers or GPOs to annually submit to the Secretary any</p>	<p>No changes.</p>

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Sunshine Physician Payments (cont'd)	ownership or investment interest (in non publicly traded security and mutual funds) held by physicians or their immediate family members. Civil monetary penalties apply between \$1,000 and \$10,000 for each instance not reported, capped at \$150,000. Higher penalties apply for knowing failure to report but capped at \$1 million.	
340B Expansion	<p>Expands participation to additional entities, including free-standing children's hospitals, free-standing cancer hospitals, rural referral centers, sole community hospitals that have disproportionate share higher than 8%, and all critical access hospitals.</p> <p>Expands program to include any drug used in connection with an inpatient service by participating hospitals.</p> <p>Allows participating hospitals to obtain inpatient drugs through a GPO agreement or the 340B Prime Vendor Program.</p> <p>Requires participating hospitals to provide a credit to each state on the estimated annual costs of covered drugs provided to Medicaid patients for inpatient use.</p>	<p>Targets 340B program expansion to the outpatient settings of qualifying children's hospitals, free-standing cancer hospitals, critical access hospitals, rural referral centers and sole community hospitals. Exempts orphan drugs from required discounts for new 340B entities.</p> <p>Removes GPO provision.</p>
Immigration	Makes legal immigrants whose income is less than 133% of FPL and who are not eligible for Medicaid by virtue of the five- year waiting period eligible for the basic health program in the exchange.	No changes.
Abortion and Adoption	<p>Abortion services cannot be a mandated benefit of a minimum benefits package. No federal funds for abortion coverage in government health plan beyond those allowed under the Hyde Amendment.</p> <p>OPM multistate plans must include one plan option that does not cover abortion services.</p> <p>States are given the option to opt out of providing insurance coverage for abortions.</p> <p>Increases the adoption tax credit and adoptions assistance exclusion and makes the credit refundable.</p>	No changes. (Note: Abortion to be done through Executive Order to maintain current law re: Hyde language.)

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CBO 10-Year Score	\$875 billion	\$940 billion (preliminary and reflects interactions between H.R. 3590 AND H.R. 4872)

FPL = Federal Poverty Level (2009 HHS Poverty Guidelines): 100% FPL = Individual \$10,830; Family of 4 \$22,050)

Prepared by the Healthcare Leadership Council and The Ross Group

As of March 22, 2010