

Senate and House Health Care Reform Legislation Side by Side Comparison Chart

	The Health Care & Education Affordability Reconciliation Act of 2010, H.R. 4872	Patient Protection and Affordable Care Act, H.R. 3590
Delivery System Reform: Accountable Care Organizations	n/a	<p>Medicare would allow groups of providers who voluntarily meet certain statutory criteria to be recognized as Accountable Care Organizations (ACOs) and be eligible to share in the cost-savings they achieve for the Medicare program. Beginning on January 1, 2012, eligible ACOs would have the opportunity to qualify for an incentive bonus.</p> <p>Qualifying criteria:</p> <ul style="list-style-type: none"> • Agree to become accountable for the overall care of their Medicare fee-for-service beneficiaries, • Agree to a minimum three-year participation, • Have a formal legal structure that would allow the organization to receive and distribute bonuses to participating providers, • Include primary care physicians for at least 5,000 Medicare fee-for-service beneficiaries, • Provide CMS with information regarding primary care and specialist physicians participating in the ACO as the Secretary deems appropriate • Have arrangements in place with a core group of specialist physicians, • Have in place a leadership and management structure to include clinical and administrative systems, • Define processes to promote evidence-based medicine, • Report on quality and cost measures, • Coordinate care (such as through the use of telehealth, remote patient monitoring, and other enabling technologies), • Demonstrate to the Secretary that it meets patient



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		<p style="text-align: center;">centeredness criteria determined by the Secretary.</p> <p>The ACO would also have to meet certain quality thresholds to receive payment and be required to submit data at the group and individual provider level. The Secretary would also be required to seek to improve the quality of care provided in ACOs over time.</p> <p>CMS would assign Medicare fee-for-service beneficiaries to ACOs based on their use of Medicare items and services during preceding periods of time. Spending baselines would be determined on an organizational level using the most recent three years of total per beneficiary spending for those beneficiaries assigned to the ACO.</p> <p>ACOs with three-year average Medicare expenditures that are determined by CMS to be below their benchmark for the corresponding period would be eligible for shared savings at a rate determined appropriate by the Secretary, who would also be required to set a minimum threshold of savings before savings would be shared. The Secretary would also have authority to adjust the savings thresholds to take into account the varying sizes of ACOs.</p> <p>Provides additional flexibility to the Secretary of HHS to implement innovative payment models for participating Accountable Care Organizations, including:</p> <ul style="list-style-type: none"> • partial capitation (with no additional program expenditures) • models currently used in the private sector (with no additional program expenditures) <p>PGP participants may continue in shared savings as an ACO,</p>



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		effectively “grandfathering” them. ACO demonstration for Pediatricians included in section 2706.
Delivery System Reform: Bundling	n/a	Directs the Secretary of HHS to develop a voluntary pilot program that encourages hospitals, doctors, and post-acute care providers to achieve savings to Medicare through increased collaboration and care coordination by allowing providers to share in the savings. The pilot covers 10 conditions and will test bundled payment in continuing care hospitals. The Secretary may expand the bundling program after January 1, 2016.
Delivery System Reform: CMS Innovation Center	n/a	Would establish an Innovation Center at CMS that would have the authority to explore new provider payment models. Payment reforms that are shown to improve quality and reduce costs would be expanded throughout the Medicare program. Studies would include models such as the patient centered medical home, medical homes unique to women’s needs, and models that transition primary care practices away from fee-for-service based reimbursement and toward comprehensive payment or salary-based payment, rural telehealth expansion, and a rapid learning network among other initiatives.
Delivery System Reform: Medical Home Pilot Program	n/a	Allows a qualified health plan to provide coverage through a qualified direct primary care medical home.
Medicare Sustainable Growth Rate	n/a	n/a



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Insurance Reform: Guarantee Issue	n/a	Beginning in January 2014, health plans in the individual market would be required to offer coverage on a guaranteed issue basis. Health plans would be prohibited from applying lifetime limits on benefits or rescinding coverage. Health insurance premiums could be varied based on tobacco use, age, family composition and geographic differences only.
Insurance Reform: Purchase Across State Lines	n/a	By July 1, 2013, requires the Secretary, in consultation with National Association of Insurance Commissioners, to issue regulations for interstate health care choice compacts, which would start beginning in 2016. In the compacts, qualified health plans could be offered in all participating States complying with consumer protection laws of the purchaser's State. Insurers would be required to be licensed in all participating States (or comply as if they were licensed), 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.
Insurance Reform: Exchanges	n/a	<ul style="list-style-type: none"> • State-based exchanges would be established to facilitate enrollment for individuals and separately for small groups through web portals on the internet. • Small businesses would have access to state-based Small Business Health Options Program (SHOP) exchanges. These exchanges, like the individual market exchanges, would be web portals that make comparing and purchasing health care coverage easier for small businesses.



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		<ul style="list-style-type: none"> • Individuals who are undocumented are not allowed to use the exchange, even with personal funding. • Requires the Office of Personnel Management (OPM) to contract with health insurers to offer at least two multi-state qualified health plans (at least one non-profit) through Exchanges in each State. Please see the Insurance Reform: Public Option/COOPs. • Requires Exchanges to consider the reasonableness of premium rate increases when determining whether to certify and offer plans. • Requires plans seeking certification by Exchanges to publicly disclose information on claims payment policies, enrollment, denials, rating practices, out-of-network cost-sharing, and enrollee rights. • Requires GAO to study the cost and affordability of qualified health plans offered through Exchanges. • States may prohibit abortion coverage in qualified health plans offered through an Exchange if the State enacts a law for prohibition. • Requires a segregation of funds for subsidy-eligible individuals for plans that cover abortions for which the expenditure of Federal funds is not permitted. Subsidy-eligible individuals would make two payments, with one going to an allocation account to be used exclusively for payment for abortion services. • Requires State insurance commissioners to ensure compliance to segregate federal funds in accordance with generally accepted accounting requirements and guidance from the Office of Management and Budget (OMB) and Government Accountability Office (GAO).



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Insurance Reform: Tax Credits	<ul style="list-style-type: none"> • Increases financing for premiums and cost sharing for individuals with incomes up to 400% of the federal poverty level to make premiums more affordable as a percent of income and increases support for cost sharing, focusing on those with incomes below 250% of the federal poverty level. Starting in 2019, constrains the growth in tax credits if premiums are growing faster than the consumer price index, unless spending is more than 10% below current CBO projections. • Modifies the definition of income that is used for purposes of subsidy eligibility and the individual responsibility requirement. The modifications conform the income definition to information that is currently reported on the Form 1040 and to the present law income tax return filing thresholds. • Extends the exclusion from gross income for employer provided health coverage for adult children up to age 26. 	<ul style="list-style-type: none"> • Beginning in 2014, a tax credit is established on a sliding scale starting at 2% of income for those at or above 100% of the federal poverty level (FPL), up to 9.8% of income for those at 400% of FPL. Premium assistance credits do not take into account state-mandated health benefits. Also eligible are employees offered coverage by their employer in which the plan's share of total allowed costs is less than 60 percent of these costs, or the premium exceeds 9.8 percent of the of the employee's income. • Small business tax credit would start in 2010, expands the full credit to firms with average wages up to \$25,000 from \$20,000, and makes the credit available to firms with average wages up to \$50,000 instead of \$40,000. • Children who cannot enroll in CHIP because of the allotment cap are eligible for tax credits in the Exchanges.
Insurance Reform: Public Plan/COOPS	n/a	<ul style="list-style-type: none"> • Co-Ops: Authorizes funding for the program to foster creation of nonprofit, member-run health insurance companies that serve individuals in one or more states. Eligibility requirements must be met in order for an organization to receive the federal funds, and entities would be permitted to enter into collective purchasing arrangements for services and items. Requires COOPs to repay loans within five years and grants within 15 years. • Multi-state plans. • Requires a level playing field for multi-state qualified health plans. • Requires the Office of Personnel Management (OPM) to contract with health insurers to offer at least two multi-



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		<p>state qualified health plans (at least one non-profit) through Exchanges in each State.</p> <ul style="list-style-type: none"> • Requires OPM to negotiate contracts in a manner similar to the manner in which it negotiates contracts for Federal Employees Health Benefits Program (FEHBP), and allows OPM to prohibit multi-state plans that do not meet standards for medical loss ratios, profit margins, and premiums. Requires multi-state plans to cover essential health benefits and meet all of the requirements of a qualified health plan; States may require multi-state plans to offer additional benefits, but must pay for the additional cost. • Multi-state plans must comply with 3:1 age rating, except States may require more protective age rating. Multi-state plans must comply with the minimum standards and requirements of FEHBP, unless they conflict with the PPACA. Guarantees that FEHBP will maintain a separate risk pool and remain a separate program.
Insurance Reform: Mandates	<ul style="list-style-type: none"> • Personal Responsibility: This law lowers the flat payment from \$495 to \$325 in 2015 and from \$750 to \$695 in 2016. • Employer Responsibility: Employers with 50 or more full-time equivalent workers (FTE) may subtract the first 30 full time employees from the payment calculation (e.g., a firm with 51 workers that does not offer coverage will pay an amount equal to 51 minus 30, or 21 times the applicable per employee payment amount). Increases the fee for not covering a FTE to \$2,000. Eliminates the assessment for workers in a waiting period, while maintaining the 90-day limit on the length of any waiting period beginning in 2014. 	<ul style="list-style-type: none"> • Personal Responsibility: Beginning in 2013, all US citizens and legal residents would be required to purchase health insurance or have health coverage from an employer or through a public program, with exceptions provided for religious conscience. • Employer Responsibility: Employers would not be required to offer health insurance to their employees, but employers with more than 50 full-time employees that do not offer coverage must pay a fee for each employee who receives the tax credit for health insurance through an exchange. Medicaid eligible individuals can choose to leave the employer's coverage and enroll in Medicaid.



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Insurance Reform: Medicaid Expansion	<ul style="list-style-type: none"> Federal funding for States. Strikes the provision for a permanent 100% federal matching rate for Nebraska for the Medicaid costs of newly eligible individuals. Provides federal Medicaid matching payments for the costs of services to expansion populations at the following rates: 100% in 2014, 2015, and 2016; 95% in 2017; 94% in 2018; 93% in 2019; and 90% thereafter. In the case of expansion states, reduces the state share of the costs of covering non-pregnant childless adults by 50% in 2014, 60% in 2015, 70% in 2016, 80% in 2017, and 90% in 2018. In 2019 and thereafter, states would bear the cost of covering non-pregnant childless adults as non-expansion states (e.g., 7% in 2019, 10% thereafter). 	<p>States would be given the option to cover non-elderly, non-pregnant adults through a state plan amendment at their current match rate.</p> <ul style="list-style-type: none"> April 1, 2010, the start-up date for the Medicaid state option to cover adults at or below 133% of the federal poverty level (FPL). To qualify as an “Medicaid expansion state,” for purposes of covering adults at or below 133% of FPL, the benefit package must include inpatient hospital services; for “newly eligible” beneficiaries, current coverage levels are pegged to December 1, 2009; provides a limited matching rate increase to states that have begun Medicaid expansion and would not have any “newly eligible “ beneficiaries; requires states to share the increased federal match with political subdivisions (like counties) that contribute to the non-federal share of Medicaid costs; and applies the pre-2017 matching rate to subsequent years in Nebraska. Makes mandatory the previous Medicaid state option to cover foster children; moves the effective date up to 2014; and limits coverage only to those children who have “aged out” of foster care system as of the enactment date. Provides Hawaii with a Medicaid Disproportionate Share Hospital (DSH) allotment and scales back the reductions in federal DSH allotment. Clarifies that children are considered ineligible for the Children’s Health Insurance Program (CHIP) if they are unable to enroll because allotments are capped, but they are eligible for tax credits in the Exchanges.



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Medicare Commission	n/a	Independent Payment Advisory Board by: <ul style="list-style-type: none"> • Will make annual recommendations to the President, Congress and the private sector on action the latter can take to improve quality and limit the rate of growth in health care costs; • Will make non-binding Medicare recommendations to Congress in those years in which Medicare growth is less than the targeted growth rate; • Prohibited from making recommendations that would reduce price supports for low-income Medicare beneficiaries; and, • Beginning in 2020, the Commission is required to make binding biennial recommendations to Congress if the growth in overall health spending exceeds the growth in Medicare spending, with such recommendations focused on slowing overall health spending while maintaining or enhancing beneficiary access to quality care under Medicare.
Imaging	<ul style="list-style-type: none"> • Sets the assumed utilization rate at 75% for the practice expense portion of advanced diagnostic imaging services. 	<ul style="list-style-type: none"> • Increases utilization rate assumption for calculating the payment for advanced imaging equipment from 50% to 65%, effective 2010-2012, 70% in 2013, and 75% in 2014 onward. • Reduction for imaging conducted on contiguous body parts increased from 25% to 50%. • Starting in 2010, physicians must disclose ownership interest in imaging equipment to their patients.
Reimbursement for Primary Care	<ul style="list-style-type: none"> • Requires that Medicaid payment rates to primary care physicians for furnishing primary care services be no less than 100% of Medicare payment rates in 2013 and 2014. 	<ul style="list-style-type: none"> • Beginning in 2011-2016, primary care services and general surgeons will receive a 10% bonus in shortage areas. • Establishes in fiscal 2011 hospital wage index and



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		<p>geographic practice floors for hospitals and physicians located in “frontier” states in which at least 50% of the counties are defined as “frontier” counties.</p> <ul style="list-style-type: none"> • A “frontier state” is defined as having at least 50% of its counties designated as “frontier” counties. • A “frontier” county is defined as having less than six residents per square mile. This provision is thought to benefit the states of North Dakota, South Dakota, Montana, Utah, and Wyoming.
Physician Payment Sunshine	n/a	<ul style="list-style-type: none"> • Starting March 31, 2013, physicians must publicly report any payments received from drug or medical device manufacturers.
“Pay Fors”: Fees	<ul style="list-style-type: none"> • Delays the pharmaceutical fee to 2011 and raises the fee by \$4.8 billion. • Delays the excise fee on device manufacturers to 2013 and changes the fee to an excise tax of 2.3% at the point of sale. • Health insurance providers’ fee is delayed to 2014 and modifies the annual industry fee for revenue neutrality. In the case of tax-exempt insurance providers, provides that only 50 percent of their net premiums that relate to their tax-exempt status are taken into account in calculating the fee. 	<ul style="list-style-type: none"> • Eliminates the medical device manufacturers’ fee of \$2 billion for 2010, but sets a fee in that amount for the years 2011 through 2017, and \$3 billion in the years beyond. • Removes third-party administration fees from the allocation to health insurance providers, and eliminates the fee for 2010; • Sets the annual fee at \$2 billion for 2011, \$4 billion for 2012, \$7 billion for 2013, \$9 billion for the years 2014 through 2016, and \$10 billion after 2016; • Creates a limited exemption from the fee for certain non-profit insurers having a medical loss ratio of 90% or more.
“Pay Fors”: Taxes	<ul style="list-style-type: none"> • High-cost insurance “Cadillac Plans”. Reduces the revenue collected by the tax by 80 percent by delaying the application of the tax until 2018, increasing the dollar thresholds to \$10,200 for single coverage and \$27,500 for family coverage (\$11,850 and \$30,950 for retirees and employees in high risk professions); excluding stand-alone 	<ul style="list-style-type: none"> • High cost insurance “Cadillac Plans” excise tax, 40% on individual plans over \$8,500 and family plans over \$23,000 starting in 2018. • Starting in 2016, a tax of \$750 on individuals who do not have acceptable health insurance with phase in, \$95 for 2014, \$350 for 2015, and \$750 for 2016.



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	<p>dental and vision plans from the tax; and permitting an employer to reduce the cost of the coverage when applying the tax if the employer's age and gender demographics are not representative age and gender demographics of a national risk pool.</p> <ul style="list-style-type: none"> • Unearned Income Medicare Contribution. Modifies the Medicare contribution with a 3.8% tax on net investment income in the taxable base for families earning \$250,000 or individuals earning \$200,000. • Increases Medicare Hospital Insurance Tax rate by .9% for families earning \$250,000 or individuals earning \$200,000. 	<ul style="list-style-type: none"> • No penalty if premium exceeds 8% of individual income. • After 2016, penalties will increase with an annual cost of living adjustment. • Parents pay 50% for uncovered children, but the penalty will not exceed 3x the cost of an adult penalty. • Beginning January 1, 2011, an increase from 10% to 20% in the distributions tax imposed on health savings account expenditures not used for qualified medical expenses. • Employer responsibility tax should an employer not provide health insurance coverage: • Requires an employer with more than 50 full-time employees with at least one full-time employee receiving the premium assistance tax credit to make a payment of \$750 per full-time employee. • Fee for waiting period: 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: <ul style="list-style-type: none"> ○ \$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. • The Secretary of Labor shall conduct a study to determine whether employees' wages are reduced by reason of the application of the assessable payments. • Starting in 2013, increases the hospital insurance tax rate from 1.45% to 1.95% for an individual taxpayer earning over \$200,000 and \$250,000 for married couples filing jointly. • 10% indoor tanning tax.



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“Pay Fors”: Cuts	<ul style="list-style-type: none"> • Medicare Advantage: Freezes Medicare Advantage payments in 2011. Beginning in 2012, the provision reduces Medicare Advantage benchmarks relative to current levels. Benchmarks will vary from 95% of Medicare spending in high-spending areas to 115% of Medicare spending in low-cost areas. The changes will be phased-in over 3, 5 or 7 years, depending on the level of payment reductions. Creates an incentive system to increase payments to high-quality plans by at least 5%. • Disproportionate share hospital (DSH) payments. Advances Medicare disproportionate share hospital payment cuts to start in 2014, reduces cuts by \$3 billion. • Market Basket Cuts: Revises the hospital market basket reduction that is in addition to the productivity adjustment as follows: -0.3 in FY14 and -0.75 in FY17, FY18 and FY19. Removes Senate provision that eliminates the additional market basket for hospitals based on coverage levels for inpatient, long term care, rehabilitation facilities, psychiatric hospitals, and outpatient hospitals. 	<ul style="list-style-type: none"> • Rebases home health payments in 2013 using an analysis of the current mix of services and intensity of care provided to home health patients. • Based on MedPAC recommendations, this provision would require the Secretary to update Medicare hospice claim forms and cost reports by 2011. Certain requirements designed to increase accountability in the Medicare hospice program would also be implemented. • The utilization assumption for calculating payments for advanced imaging services would be increased from 50 to 65% for 2010-2013, going up to 75% in 2014. The Secretary of HHS would be required to conduct a study by January 1, 2013 on the estimated impact of the utilization rate. In addition, the Chairman’s Mark would increase the technical component payment reduction for sequential imaging services on contiguous body parts during the same visit from 25% to 50%. • Medicare Advantage: Would base the calculation of MA benchmarks on actual plan costs as reflected in plan bids rather than statutorily set rates. In 2011, the national MA per capita growth percentage would be reduced by 3 percentage points. Starting in 2012, local MA benchmarks would be blended with plan bids. Local MA benchmarks would be based on 33% of the enrollment weighted average of plan bids for each payment area and 67% of the present law MA benchmarks. In 2011, 2012, and 2013, local and regional MA plans would still receive 75% of the difference between their bids and the benchmark rates as a rebate payment. Beginning in 2014, MA plans that bid below the new benchmark rates would receive a rebate



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		<p>amount equal to 100% of the difference between their bids and the new benchmarks.</p> <ul style="list-style-type: none"> • \$43 billion in cuts to Medicaid and Medicare Disproportionate Share Hospital payments.
“Pay Fors”: Other	n/a	<ul style="list-style-type: none"> • Elimination of the exclusion for employer Part D subsidy. • Standardized definition of qualified medical expenses. • Increase in penalty for use of health savings account funds for non-qualified medical expenses. • Corporate information reporting. • Increasing reporting in employer W-2 listing of value of health benefits. • Savings from Medicare Commission. • Indexes the \$2500 limit on contributions to flexible spending accounts by the CPI-U beginning January 1, 2012.
Other	<ul style="list-style-type: none"> • <u>Closes the Part D “Donut Hole”</u>: Provides a \$250 rebate for all Medicare Part D enrollees who enter the donut hole in 2010. Builds on pharmaceutical manufacturers' 50% discount on brand-name drugs beginning in 2011 to completely close the donut hole with 75% discounts on brand-name and generic drugs by 2020. • <u>Physician Owned Referral</u>: Changes to December 31, 2010 the date after which physician ownership of hospitals to which they self refer is prohibited and provides a limited exception to the growth restrictions for grandfathered physician owned hospitals that treat the highest percentage of Medicaid patients in their county. • <u>Payment for Qualifying Hospitals</u>: Provides \$400 million for fiscal years 2011 and 2012 for additional payments to hospitals in the bottom quartile of counties ranked by 	



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	Medicare spending per beneficiary. <ul style="list-style-type: none"><li data-bbox="432 308 987 370">• <u>HHS Funding</u>: HHS will receive \$1 billion for implementation of health insurance reform.	



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