Health Legislation *House Bill vs Senate Bill*

January 2010

The comparison of the House and Senate versions of the health care legislation pending is not intended to be all encompassing of these massive legislative proposals, but is a reasonable comparison of some of the highlights of each.

KEY POINTS IN HR 3962 (HOUSE BILL) V HR 3590 (SENATE BILL)

MEDICARE

HOUSE

1. Institute of Medicine to conduct study of geographic variations in health care.
2. Establish Center for Medicare & Medicaid Innovation.
3. Conducts Medicare and Medicaid pilot programs to test payment incentive models for Accountable Care Organizations (ACOs) and to assess feasibility of reimbursing qualified patient-centered medical homes.
4. Provider Reimbursement Reform
   a. Secretary to regularly review fee schedule rates for physicians and has ability to adjust rates.
   b. Modifies equipment utilization rates for advanced imaging services from 50-75%.
5. Fraud & Abuse
   a. Reduces period for Medicare claims submission to no later than 12 months.
   b. Overpayments to be reported and returned within 60 days from date of the overpayment identified or date a cost report was due.
   c. Provider screening, enhanced oversight periods, enrollment moratoria where elevated risk of fraud in all public programs and requirement of compliance programs by all Medicare and Medicaid providers.
   d. Enhanced penalties for false statements on enrollment applications by providers and false claims.
   e. Secretary to establish screening procedures for new providers including licensing board checks, exclusionary actions, background checks, unannounced inspections and pre-enrollment or other site visits.
   f. New suppliers or providers to disclose affiliations within last 10 years with any provider or supplier that has uncollected debt or suspension from Medicare, Medicaid or CHIP.

SENATE

1. Creates 15 member Medicare Advisory Board to advise Congress on proposals to reduce costs and improve quality of care. Proposals will take effect unless Congress passes an alternative measure. No proposals for rationing care, raising taxes or Part B premiums, or changing Medicare benefit eligibility, or cost-sharing standards.
2. Establishes Center for Medicare and Medicaid Innovation within CMS. Purpose is to explore innovative payment and delivery arrangements to improve the quality and reduce cost of care.
3. Adopts Accountable Care Organization (ACO) concept.
4. Directs Secretary of HHS to develop and implement budget-neutral payment system that adjusts Medicare physician payments based on quality and cost of the care delivered. Measures will be risk-adjusted and geographically standardized. New payment system will be phased in over 2 year period beginning in 2015.
5. Funding for development of quality measures.
6. National pilot program on Medicare payment bundling between providers and hospitals.
7. Would prevent the physician fee cut in 2010 and replace with a .5% increase.
8. Starting in 2011 allots primary care practitioners, as well as general surgeons practicing in health professional shortage areas with a 10% Medicare payment bonus for five years. Half of the cost of the bonuses would be offset through an across the board reduction in all other services.
9. Directs Secy to regularly review fee schedule rates for provider services paid for by Medicaid, including services that have experienced high growth rates. Strengthens Secy's authority to adjust fee schedule.
10. Modifies equipment utilization rates for advanced imaging services from 50% to 75%.
11. Extends through 2014 payments under PQRI. IN 2014, physicians who do not submit measures to PQRI will have their Medicare payments reduced.
    a. Adds an additional requirement to the Medicare for in-office ancillary services to the prohibition on physician self-referral for certain imaging services.

	HOUSE	SENATE
MEDICARE CONT.		12. Fraud & Abuse a. Reduces period for claims submission to no later than 12 months. b. Requires overpayments to be reported and returned within 60 days from the date the overpayment was identified or corresponding cost report was due. c. HHS to establish procedures for screening providers and suppliers participating in Medicare, Medicaid and CHIP. All providers and suppliers subject to license checks. Additional screening measures such as fingerprinting, criminal background checks, multi-State data base inquiries and random or unannounced site visits would be permitted. Application fees of $200 for individuals and $500 for institutions would be used to cover the costs of screening. Reverification every 5 years. d. Disclosure by providers or suppliers of current or previous affiliations with any provider or supplier that has uncollected debts, payments suspended, excluded from participation in a federal health care program, or has had their billing privileges revoked. Secretary could deny enrollment if affiliations pose undue risk to the program. e. Within 6 months of enactment, HHS to establish self-referral disclosure protocol to enable health care providers and suppliers to disclose actual or potential violations of the physician self-referral law. f. Requires CMS to include in the integrated data repository claims and payment data from the Medicare, Medicaid, CHIP, Veterans Affairs, Department of Defense, Social Security and the Indian Health Service.
MEDICAID	Expand Medicaid to all individuals under 65 with incomes up to 150% of federal poverty level (FPL).	Expands Medicaid to all non-elderly individuals with incomes up to 133% of the federal poverty level. States have the option to provide coverage to such individuals above 133% federal poverty level through a state plan amendment.
QUALITY INITIATIVES	1. Comparative Effectiveness a. Establish Center for Comparative Effectiveness Research (CER) within Agency for Healthcare Research and Quality. b. Independent CER Commission will oversee the activities of the Center. c. Comparative effectiveness research findings may not be construed as mandates for payment, coverage or treatment or used to deny or ration care. Establish the Comparative Effectiveness Research Trust Fund. 2. Quality Measure a. Establish Center for Quality Improvement to identify, develop, evaluate, disseminate and implement best practices. Develop national priorities for performance improvement and quality measures.	1. Patient-Centered Outcomes Research Institute governed by a public/private sector board appointed by Comptroller General to identify priorities for and provide for the conduct of comparative outcomes research established. Prohibits findings from being mandates on practice guidelines or coverage decisions. 2. Requires Secy to annually establish and update national strategy to improve the delivery of health care services, patient health outcomes and population health. To be established by January 1, 2011 a Federal health care quality internet website.

	HOUSE	SENATE
SHARED RESPONSIBILITY	1. Requires all individuals to have "acceptable health coverage". Those without coverage pay a penalty of 2.5% of adjusted income above the filing threshold up to the cost of the average national premium for self-only or family coverage under a basic plan in the Health Insurance Exchange. 2. Premium and cost sharing credits available to individuals/ families with incomes up to 400% of the federal poverty level.	1. All U.S. citizens and legal residents will be required to have qualifying health coverage by 2014 except for those covered by hardship exemptions. Those that do not comply will have a tax maximum penalty of $2250 per adult per year phased in by 2016. 2. Refundable and advanceable premium credits to individuals and families with incomes between 100-400% of the federal poverty level to purchase insurance though the health insurance exchanges. 3. Provides reduced cost-sharing for individuals and families with incomes between 100-400% of the federal poverty level enrolled in qualified health plans.
EMPLOYER RESPONSIBILITY	1. Requires employers to offer coverage to employees and contribute at least 72.5 % of the premium for single coverage and 65% of the premium cost for a family of the lowest cost plan that meets the essential benefits package requirements or pay 8% into the Health Insurance Exchange Trust Fund. 2. Annual payroll of less than $500,000 are exempt from the mandate. Those between $500,000-$750,000 have reduced "pay or play" penalties.	1. Does not include a comprehensive employer mandate. 2. Assessses employers with more than 50 employees and not offering coverage a $750/employee fee (for all employees) if just one of their employees receives a tax credit for health insurance through an exchange. (Certain additional employees are covered after 2013 where the employer is in the construction industry and gross receipts are greater than $250,000.00). 3. Employers who offer coverage but have a waiting period or offer unaffordable coverage so that at least one employee qualifies for federal premium assistance are subject to pay certain fees, i.e. $600 per full-time employee. 4. Full-time employee is one who provides thirty (30) hours of service. Definition of "hour of service" will be different than under qualified retirement plan rules. 5. 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 is available to employers with 10 or less employees and average annual wages less than $20,000 and who contribute 50% of total premium costs or 50% of a benchmark premium. The tax credit covers up to 50% of their contribution for 2 years by 2014.
HEALTH INSURANCE EXCHANGE OR GATEWAY	1. Create a National Health Insurance Exchange throughout which employers can purchase qualified insurance, including from private health plans and public health insurance option. 2. Creates a Consumer Operated and Oriented Program to facilitate establishment of non-member-run health insurance cooperatives to provide insurance through the Exchange. 3. Create 4 benefit categories of plans to be offered through the Exchange. 4. a. Basic plan…70% of the benefit costs of the plan and essential benefits package. b. Enhanced Plan…essential benefits package, reduced cost-sharing and covers 85% of benefit costs of the plan.	1. Creates state based exchanges for individual market and "small business health options program" exchanges (SHOP) for small group market to be operational by 2014. 2. Allow small businesses with up to 100 employees to purchase coverage through above SHOP exchanges beginning in 2014(states may limit this to 50 employees until 2016) and permit states to allow businesses with more than 100 employees to purchase coverage in the SHOP exchange beginning in 2017. 3. Creates Consumer Operated and Oriented Plan (CO-OP) program and appropriates money to qualified insurance issuers to create non-profit, member-run health insurance companies in all 50 states and DC.

	HOUSE	SENATE
HEALTH INSURANCE EXCHANGE OR GATEWAY CONT.	c. Premium Plan…essential benefits package with reduced cost-sharing compared to the enhanced plan and covers 95% of the benefit costs of the plan. d. Premium plus plan provides additional benefits such as oral health and vision care. e. Restricts access coverage throughout the Exchange to individuals who are not enrolled in qualified or grandfathered employer or individual coverage, Medicare, Medicaid, TRICARE or VA coverage.	4. Creates 4 benefit categories of plans plus a separate "young invincible plan" to be offered throughout the exchange and in the individual and small group markets. Allows states to contract with 1 or more standard health plan for low-income individuals (below 200% federal poverty level) not eligible for Medicaid. 5. 4 benefit categories under which the plan pays for the specified percentage of costs: bronze-60%; silver-70%; gold-80% and platinum-90%. 6. Requires Secy to establish system for residents to utilize when applying for their respective state health subsidy programs.
PUBLIC OPTION	1. Required to negotiate rates with providers so that the rates are not lower than Medicare rates and not higher than the average rates paid by other qualified health benefit plans. Providers participating in Medicare are considered participating in public plan unless they opt out. 2. Public option must meet same requirements as private plans regarding benefit levels, provider networks, consumer protections and cost-sharing. Finance the cost of the Public Plans through premiums.	1. Community option will be included in the Gateway but allows states to opt out of offering the option by enacting state law to do so. 2. Would require provider participation or impose a penalty for non-participation. No requirement for an individual to participate in public option or be penalized for non-participation. 3. Unless state assumes cost for other offered benefits, the community option would only include essential benefits defined by Secy of HHS. 4. Community plan will be self-sustaining via premiums, but will require start up fund. 5. Secy of HHS will negotiate reimbursement rates with providers for community plan. Rate cannot be higher in the aggregate than the average reimbursement rates paid by health insurance issuers offering qualified health plans throughout the Gateway.
INSURANCE/ESSENTIAL BENEFITS	1. Private insurance must guarantee issue/renewability may not be based on gender. Prohibits exclusions for pre-existing conditions and rescinding coverage except in instances of fraud and requires independent review of any rescission determination. 2. All plans participating in the exchange must offer the following minimum benefits: preventive and primary care, emergency services, hospitalization, physician services, outpatient services, day surgery and anesthesia, diagnostic imaging and screenings, maternity and newborn care, pediatric services , including dental and vision, medical/surgical care, prescription drugs, radiation and chemotherapy and mental health and substance abuse services that meet minimum federal and state law standards. 3. Requires report within one year of enactment to Congress on the results of a study of determining the need and cost of providing accessible and affordable oral health care to adults as part of the essential benefits package. 4. Allows qualified health benefits plan to subcontract with stand-alone health insurance issuers or insurers for the provision of dental, vision, mental health and other benefits and services.	1. Must guarantee issue/renewability and not based on gender. Prohibits exclusion for pre-existing conditions or other discrimination based on health status. Also prohibits rescissions except in cases of fraud or misrepresentation. 2. Prohibits plans from establishing lifetime or unreasonable annual limits on dollar value of benefits. 3. Requires coverage of preventative health services recommended by Health Resources and Services Administration without cost sharing. 4. All plans in the individual and group markets are required to provide coverage for children up to age 26. 5. Allows employers to vary insurance premiums by as much as 30% for employee participation in certain health promotion and disease prevention programs. 6. Prohibits insurers from discriminating against health providers acting within the scope of their licensure and applicable state laws.

	HOUSE	SENATE
INSURANCE/ESSENTIAL BENEFITS CONT.		7. All insurers operating in the exchange must offer the following minimum benefits: preventative and primary care, emergency services, hospitalization, physician services, outpatient services, day surgery and related anesthesia, diagnostic imaging and screenings, maternity and newborn care, pediatric services (including dental and vision), medical/surgical care, prescription drugs, radiation and chemotherapy and metal health and substance abuse series that meet minimum standards set by federal and state laws. 8. Stand alone dental plans would be permitted to offer pediatric dental benefits directly and to offer benefits through the exchange. Consumer protection benefits would be applicable and required to participate.
PUBLIC HEALTH/ WORKFORCE DEVELOPMENT	1. Establish a multi-stakeholder Advisory Committee on Health Workforce Evaluation and Assessment to develop and implement a national health workforce strategy. 2. Dental Training Program a. Funding to support training programs for general pediatric and public health dentists and dental hygienists, including faculty loan repayment benefits.	1. Must guarantee issue/renewability and not based on gender. Prohibits exclusion for pre-existing conditions or other discrimination based on health status. Also prohibits rescissions except in cases of fraud or misrepresentation. 2. Prohibits plans from establishing lifetime or unreasonable annual limits on dollar value of benefits. 3. Requires coverage of preventative health services recommended by Health Resources and Services Administration without cost sharing. 4. All plans in the individual and group markets are required to provide coverage for children up to age 26. 5. Allows employers to vary insurance premiums by as much as 30% for employee participation in certain health promotion and disease prevention programs. 6. Prohibits insurers from discriminating against health providers acting within the scope of their licensure and applicable state laws. 7. All insurers operating in the exchange must offer the following minimum benefits: preventative and primary care, emergency services, hospitalization, physician services, outpatient services, day surgery and related anesthesia, diagnostic imaging and screenings, maternity and newborn care, pediatric services (including dental and vision), medical/surgical care, prescription drugs, radiation and chemotherapy and metal health and substance abuse series that meet minimum standards set by federal and state laws. 8. Stand alone dental plans would be permitted to offer pediatric dental benefits directly and to offer benefits through the exchange. Consumer protection benefits would be applicable and required to participate.

	HOUSE	SENATE
LIABILITY REFORM	Incentive program for states to adopt and implement alternatives to traditional medical malpractice litigation. Such alternatives may not include provisions that limit attorney's fees or impose caps on damages.	Sense of the Senate to reform the medical malpractice and medical liability insurance and 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.
ORAL HEALTH PROVISIONS	HHS will make grants to or enter into contracts to develop, operate or participate in accredited professional training program for oral health professionals. Will also provide financial assistance to oral health professionals, who are participants in any such program and plan to work in general, pediatric, or public health dentistry, or dental hygiene.	Establishes an oral health care prevention education campaign at CDC focusing on preventive measures and targeting key populations including children and pregnant women.
CARES ACT	Requires insurance companies to cover corrective procedures to address congenital crainiofacial anolmalies for children age 21 and under. The procedures would be clarified as reconstructive rather than cosmetic.	
ANTITRUST REFORM	Repeals the antitrust exemption that was established in the 1945 McCarran-Ferguson Act for health insurance companies.	
RESIDENCY ISSUES (GME)	Incentives for training of primary care physicians and encourages medical residency training in non-hospital settings.	1. Incentives for training primary care physicians and encourages medical residency training in non-hospital settings. 2. Secy directed to redistribute residency positions that have been unfilled for training for primary care physicians.
DENTAL EMERGENCY RESPONDERS	Amends Homeland Security Act to include dentistry as part of the national preparedness system.	
COST	$894 Billion over 10 years	1. CBO cost estimate of $849 Billion over 10 years.

	HOUSE	SENATE
MEDICARE/ MEDICAID SAVINGS	Partially financed by saving $426 Billion over 10 years and primary sources of these savings include incorporating productivity improvements into Medicare market basket updates, reducing payments to Medicare Advantage plans, changing the Medicaid drug rebate provisions and cutting Medicaid and Medicare DSH payments.	Primarily financed through reducing payments to Medicare Advantage Plans, expected savings via newly created Medicare Commission, changing drug rebate provisions and cutting Medicaid and Medicare DSH payments.
INCOME TAX SURCHARGE	Largest source of new revenue comes from 5.4% surcharge imposed on families with incomes above $1 Million and individuals with incomes above $500,000.	Certain employer sponsored coverage will be included on employee W-2s.
FLEXIBLE SPENDING ACCOUNTS & HEALTH SAVINGS ACCOUNTS	1. Limit the amount of contributions to FSA for medical expenses to $2500 per year. 2. Increase tax on distributions for an HAS that are not used for qualified medical expenses to 20% from 10% of the disbursed amount.	1. Limits the amount of contributions to FSA for medical expenses to $2500 per year. 2. Increases the tax on distributions form HAS (prior to age 65) that are not used for qualified medical expense to 20% (from 10%) of the disbursed amount.
MEDICAL DEVICE TAX	Include a 2.5% annual tax on medical device to be assessed at point of sale.	1. Medical device tax …flat fee of $2 billion beginning in 2010. The non-deductible fee would be allocated across the industry according to market share and would not apply to companies with sales of $5 Million or less. Does not apply to Class I or Class II products that is primarily sold to consumers at retail for not more than $100 per unit.
TRAUMA CARE		1. Grants to state and trauma centers to strengthen the nations trauma system. 2. Reauthorizes the Wakefield Emergency Medical Services Children Act which supports emergency medical services for children.

	HOUSE	SENATE
DIAGNOSTIC EQUIPMENT STANDARDS		Within 2 years the FDA will set minimum technical criteria for medical diagnostic equipment used in physicians' offices, clinics, emergency rooms, hospitals and other medical settings to ensure they are handicapped accessible. Includes exam chairs and x-ray machines.
FINANCING		1. EXCISE TAX ON HIGH-COST HEALTH PLANS Revenue from a new excise tax of 40% on insurance companies and plan administrators for any plan that is above the threshold of $8500 for single coverage and $23,000 for family coverage with limited exception of certain high-cost states and for high-risk employees or those installing or repairing electrical or telecommunication lines where the cap is increased. High risk professions include police and fire emergency medical care outside the hospital and individuals engaged in construction; mining, agriculture, forestry, and fishing industries. 2. FLEXIBLE SPENDING ACCOUNTS & HEALTH SAVINGS ACCOUNTS a. Limits the amount of contributions to FSA for medical expenses to $2500 per year. b. Increases the tax on distributions form HSA (prior to age 65) that are not used for qualified medical expense to 20% (from 10%) of the disbursed amount. 3. 10% excise tax on suntanning. 4. Medical device tax …flat fee of $2 billion beginning in 2010. The non-deductible fee would be allocated across the industry according to market share and would not apply to companies with sales of $5 Million or less. Does not apply to Class I or Class II products that is primarily sold to consumers at retail for not more than $100 per unit. 5. 501(c)(3) hospitals must meet community health needs assessment and if not will pay a $50,000 tax. 6. An annual fee is imposed on branded prescription pharmaceutical manufacturers and importers in the amount of $2.5 billion. 7. Health insurers also pay an annual fee of $6.7 billion. Self-insureds and governmental plans are exempt. Third Party Administrators are covered. 8. The Medicare tax is increased by .9% of wages on joint returns for those earning $250,000 and for single filers for those earning $200,000 or more. 9. Simple cafeteria plans are authorized for small employers. 10. Insurance industry subject to pay czar. 11. Itemized deduction threshold to increase from 7.5% to 10% with minor exceptions.