Washington Council Ernst & Young

Health Care Reform Side-by-Side Comparison

August 19, 2009

Overview

Attached is a side-by-side comparison of the House and Senate health care reform bills currently under consideration by Congress. It provides a comprehensive description of the major legislative provisions in: (1) the "House Tri-Committee" bill, H.R. 3200, "America's Affordable Health Choices Act of 2009," developed by the House Committees on Ways and Means, Energy and Commerce, and Education and Labor; and (2) the "Affordable Health Choices Act" developed by the Senate Health, Education, Labor and Pensions (HELP) Committee.

The side-by-side comparison primarily focuses upon Divisions A and B of the bills – relating to health insurance market reforms, health insurance coverage provisions, individual and employer mandates, insurance subsidies, tax provisions, Medicare delivery system reforms, and Medicaid reforms. It omits some minor provisions in Divisions A and B, and does not include provisions in Division C of the bills relating to "Public Health and Workforce Development," other than a summary of the National Medical Device Registry, provisions related to employer-based wellness programs, and provisions of interest to the pharmaceutical industry, including expanded participation in the 340B Drug Pricing Program, biosimilars, and reverse drug settlements.

The description of the provisions in H.R. 3200, the House Tri-Committee bill, is based on the text of the bill as introduced on July 14, 2009, and incorporates the significant amendments added to the bill when it was considered by the House Committees on Ways and Means, Energy and Commerce, and Education and Labor. The description of provisions in the Senate HELP Committee bill is based on the text of the bill released June 9, 2009, and the text of the additional Chairman's mark relating to Title I (the bill's coverage provisions), released July 1, 2009. The side-by-side comparison, however, does not incorporate all of the amendments added during the HELP Committee's month-long markup of the bill. The final text of the Senate HELP Committee bill, which was approved by the Committee on July 15, 2009, has not yet been released, nor have summaries of amendments adopted during the Committee's consideration of the bill been provided by the Committee. The comparison will be updated in September to include the final version of the Senate HELP Committee bill as approved on July 15, 2009, and any proposed legislation released by the Senate Finance Committee.

Navigating the Side-by-Side

The comprehensive side-by-side comparison is color-coded to provide easy identification of amendments and revenue estimates of the bills' provisions as estimated by the Congressional Budget Office and the Joint Committee on Taxation.[1] The revenue estimates provided in the chart are the aggregate amounts of cost savings/revenue increases resulting from the bills' provisions over the 10-year budget window from 2010 – 2019.

- Estimates of provisions that raise Federal revenues (either by increasing taxes or cutting Medicare or Medicaid spending relative to the current law baseline) are coded in green.
- Estimates of provisions that lose Federal revenues (either by adding new spending programs or cutting tax revenues relative to the current law baseline) are coded in red.
- Amendments added to the House Tri-Committee bill during the three Committee markups are coded in blue.

A list of acronyms used throughout the side-by-side comparison is also attached.\

If you have any questions, or need additional information, please contact Anne Phelps at (202)327-6236 or Donna Steele Flynn at (202)327-6664.

[1] Estimates for the House Tri-Committee bill are based on the Congressional Budget Office's July 17, 2009 letter to House Ways and Means Committee Chairman Charles Rangel (D-NY) setting forth CBO's preliminary analysis of H.R. 3200 as introduced on July 14, 2009 (and do not reflect any modifications or amendments made after that date), and the Joint Committee on Taxation's estimated effects of the Ways and Means Committee Chairman's Amendment in the nature of a substitute to the revenue provisions of H.R. 3200, dated July 16, 2009 (JCX-33-09). Estimates for the Senate HELP Committee bill are based on the Congressional Budget Office's July 2, 2009 letter to Senate HELP Committee Chairman Edward Kennedy (D-MA) setting forth CBO's preliminary analysis of the bill as released on July 1, 2009 and do not reflect modifications or amendments made after that date.

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Side-by-Side Acronyms

ACO	Accountable Care Organization
AGI	Adjusted Gross Income
AHRQ	Agency for Healthcare Research and Quality
AMP	Average manufacturer price
CBO	Congressional Budget Office
CCER	Center for Comparative Effectiveness Research
CERTF	Comparative Effectiveness Research Trust Fund
CHIO	Community Health Insurance Option
CHIP	Childrens Health Insurance Program
CLASS	Community Living Assistance Services and Support
CMS	Centers for Medicare and Medicaid Services
COBRA	Consolidated Omnibus Budget Reconciliation Act of 1985
CPI	Consumer Price Index
DGME	Direct graduate medical education
DRG	Diagnostic related group
DSH	Disproportionate share hospital
EBP	Essential benefits package
ERISA	Employee Retirement Income Security Act of 1974
Exchange	Health Insurance Exchange
FDA	Food and Drug Administration
FEHBP	Federal Employee Health Benefits Plan
FMAP	Federal Matching Assistance Percentage
FPL	Federal poverty level
FQHC	Federally-qualified health centers
GAO	Government Accountability Office
HBAC	Health Benefits Advisory Committee
HCA	Health Choices Administration
HCC	Health Choices Commissioner
HELP	Senate Health, Education Labor and Pensions Committee
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIT	Health Information Technology
HMO	Health Maintenance Organization
IME	Indirect medical education
IRC	Internal Revenue Code
MA	Medicare Advantage
MEWA	Multiple Employer Welfare Arrangement
MSA	Medical savings account
NAIC	National Association of Insurance Commissioners
NFs	Nursing facilities
OIG	Office of the Inspector General
PHSA	Public Health Service Act
PPS	Prospective payment system
PQRI	Physician Quality Reporting Initiative
QHBP	Qualified health benefits plan
SNFs	Skilled nursing facilities
SNPs	Special Needs Medicare Advantage Plan
VFC	Vaccines for children

Side-by-Side Comparison of House and Senate Health Care Reform Legislation

Provision	House Tri-Committee Bill, H.R. 3200, "America's Affordable Health Choices Act" (*as introduced on 7/14/2009, with Tri-Committee amendments adopted during consideration)	Senate HELP Committee bill "Affordable Health Choices Act" (as released on June 9 and July1, 2009)

Division A – Affordable Health Care Choices

I. Protections and Standards for Qualified Health Benefit Plans

A. Health Insurance Market Reforms

Provision	House Tri-Committee Bill	Senate HELP
Health Insurance Marketplace Reforms; Application and Definitions	Provides that on or after 1/01/2013, a health benefits plan shall not be a 'qualified health benefits plan' (QHBP) unless it meets the applicable requirements established by the bill relating to affordable coverage, essential benefits, and consumer protections (sec. 111-137 below). An individual shall be treated as being enrolled in an employment-based health plan if the individual is a participant or beneficiary in such plan (as defined in secs. 3(7) and 3(8), respectively, of the Employee Retirement Income Security Act (ERISA). The term 'employment-based health plan' means: (1) a group health plan (as defined under ERISA as an employee welfare benefit plan, including multiple employer plans) to the extent that the plan provides medical care to employees or their dependents under the terms of the plan, directly or through insurance, reimbursement, or otherwise; (2) Federal, State and Tribal government plans (as defined under ERISA), and church plans. For purposes of the market reform provisions, the terms `individual health insurance coverage' and `group health insurance coverage' mean health insurance coverage offered in the individual market or large or small group market, as defined in section 2791 of the Public Health Service Act. *Ed & Labor amendment offered by Rep. Wilson (R-SC) amends the definition of employment-based health plans in sec. 100(c) to exclude coverage described in section 202(d)(2)(E) of the bill (relating to TRICARE).* (sec. 101)	Amends the Public Health Service Act ("PHSA") (42 U.S.C. 300gg et. seq.) to reform the individual and group markets for health insurance in all 50 States (adds new secs. 2701-2711 of the PHSA, as detailed below). Amendments to sections 2701 (rating), 2702 (guaranteed availability) and 2704 (premium reporting) of the PHSA do not apply to self-funded group health plans. (secs. 101, 715)
Option to Maintain Current Plans; 5-year Grace Period	Grandfathers current employment-based health plans in existence as of 12/31/2012 with a 5-year grace period beginning on 1/01/2013 for such plans meeting the same requirements that apply to a QHBP under section 101, including the essential benefit package requirement under section 121. The grandfather does not apply to limited	Provides that there is no requirement that an individual terminate coverage in a plan in which the individual was enrolled prior to date of enactment. With respect to both group and individual plans, family members can continue to enroll in health plans operating prior to enactment. The insurance market reforms made by sec. 101 of the

Provision	House Tri-Committee Bill	Senate HELP
	benefit plans, including COBRA benefits (limited benefit plans under the Consolidated Omnibus Budget Reconciliation Act of 1985) provided for in the American Recovery and Reinvestment Act of 2009, and excepted benefits under ERISA sec. 733(c). Only individual plans in existence as of 12/31/2012 are grandfathered; generally limits new enrollment in individual health plans on or after that date. Provides that the issuer cannot vary the percentage increase in the premium for a risk group of enrollees in specific grandfathered health insurance coverage without changing the premium for all enrollees in the same risk group at the same rate, as specified by the Health Choices Commissioner (as defined below), and the issuer does not change any of its terms or conditions, including benefits and cost-sharing, from those in effect as of the day before 1/01/2013. Individual health insurance coverage that is not grandfathered may only be offered on or after 1/01/2013 as an Exchange-participating health benefits plan. *Ed & Labor amendment by Rep. Petri (R-WI) provides an exception from the exception for limited benefit plans (i.e., provides for grandfather) of group health plans consisting of a consumer-driven health plan or arrangement (including a high deductible plan under Code sec. 223(c)(2)).* (sec. 102)	bill will not apply to any individual or plan in which enrollment began prior to the date of enactment. Collective bargaining agreements ratified prior to the date of enactment and self-insured group health plans are also exempt. However, the reforms in sec. 101 will apply if significant changes are made to the existing plan, (regulations to be established by HHS). (secs. 131-133)
Health Insurance Market Standards	Requires all individual and employment-based plans to meet Federal standards (both existing standards (e.g., the Health Insurance Portability and Accountability Act (HIPAA)) and new market standards to be established), including – • Prohibition of exclusions based on pre-existing conditions (as defined in sec. 2701(b)(1)(A) of the PHSA) or any limit or condition on coverage under the plan based on health-related factors. (sec. 111) • Requires guaranteed availability/renewal of insurance coverage (except in cases of nonpayment of premiums and the issuer has provided the enrollee with notice and an opportunity to correct such nonpayment) and prohibits rescissions except in cases of fraud. (sec. 112) • Limits age rating to a ratio of 2 to 1, allows variation based only on geographic area and family enrollment. (sec. 113) • Provides authority to the Health Choices Commissioner ("HCC") (as defined below) to require QHBPs to comply with standards established by the HCC to prohibit non-discrimination in health benefits, parity in mental health and substance abuse disorder benefits, and genetic	Adds new sections to the PHSA (and conforming amendments to ERISA) with regard to health insurance coverage offered by health insurance issuers in group and individual markets as follows: • Provides that premium rates may vary based only on family composition, community rating area, the actuarial value of the benefits package, and age rating by a factor of not more than 2 to 1, and may not vary by health-related factors, gender, class of business, or claims experience. (sec. 2701) • Requires guaranteed issue for all health insurers and guaranteed renewability of coverage at the option of the plan sponsor or individuals. (secs. 2702-2703) • Requires health insurers to publically report the percentage of total premium revenue expended on clinical services, quality and all other non-claims costs as determined by the Secretary of Health and Human Services (HHS). (sec. 2704) • Prohibits health status underwriting and the imposition of pre-existing condition exclusions. (sec. 2705) • Prohibits discrimination based on any applicant's

Provision	House Tri-Committee Bill	Senate HELP
	nondiscrimination laws. (sec. 114) • Provides authority to the HCC to set provider network standards. (sec. 115) • Requires QHBPs to meet a specified medical loss ratio as defined by the HCC; if plans exceed limits, rebates to enrollees are required. (sec. 116)	health status, medical condition (including mental illness), claims experience, prior receipt of health care, medical history, genetic information, evidence of insurability, or disability. (sec. 2706) • Requires all insurance plans to implement a reimbursement structure that incorporates incentives for high quality health care (i.e., among others, activities to improve patient safety and reduce medical errors, promote wellness, provide culturally and linguistically appropriate care (as defined by the HHS Secretary, etc.). (sec. 2707) • Covers preventive health services and prohibits other than minimal cost sharing for certain preventive services endorsed by the U. S. Preventive Services Task Force, for immunizations recommended by the CDC, and for certain child preventive services recommended by the Health Resources and Services Administration. (sec. 2708) • Permits coverage of dependents on parents' policies until age 26. (sec. 2709) • Prohibits lifetime and annual limits on the dollar value of benefits. (sec. 2710) • Prohibits limits on eligibility based on wages or salaries of employees. (sec. 2719) Secs. 2701, 2702, 2705, and 2706 shall become effective with respect to group health plans or health insurance coverage offered in a State on the date that the State becomes an establishing State or a participating State as under PSHA ec. 3104 (as added by sec. 142 of the bill described below). All other provisions described above are effective on date of enactment, subject to the grandfather provisions in sec. 131-133 of the bill described above. (sec. 101)

B. Standards Guaranteeing Access to Essential Benefits

Provision	House Tri-Committee Bill	Senate HELP
Health Insurance Benefit Standards	QHBPs would be required to provide coverage that meets benefit standards for an essential benefit package that covers services recommended by the 'Health Benefits Advisory Committee' (HBAC) established by the bill and adopted by HHS Secretary. (sec. 121)	**Note**: Provisions relating to health insurance benefits standards apply only to the essential benefit package for which individuals can receive subsidies for plans offered through the American Health Benefit Gateway (Gateways) established by the bill (as described in Part II below, beginning on p. 11). Licensed health insurers will be able to sell health insurance policies outside of the Gateways. States will regulate health insurance sold outside the Gateway.

Provision	House Tri-Committee Bill	Senate HELP
Essential Health Benefits	The term `essential benefits package' (EBP) means health benefits coverage that: • Provides payment for the items and services described below in accordance with generally accepted standards of medical or other appropriate clinical or professional practice; • Limits cost-sharing for such covered health care items and services (i.e., deductibles, coinsurance, copayments and similar charges); • Does not impose any annual or lifetime limit on the coverage of covered health care items and services; • complies with section 115 (relating to network adequacy); and • Is equivalent, as certified by the Actuary of the Centers for Medicare & Medicaid Services (CMS), to the average prevailing employer-sponsored coverage. Benefits required to be included in the EBP: • hospital services; • outpatient hospital and outpatient clinic services, including emergency department services; • professional services of physicians and other health care professionals; • prescription drugs; • rehabilitative and habilitative services; • mental health and substance use disorder services; • preventive services *(E&C en bloc amendment by Rep. Doyle (D-PA) includes "behavioral health treatments);* • vaccines; • maternity care; and • well baby care, oral health, vision, and hearing services, equipment and supplies for children under 21 years of age. *E&C en bloc amendment by Rep. Doyle (D-PA) includes treatment of a congenital or developmental deformity, disease, or injury under well baby care services.* • *Ed & Labor amendment offered by Rep. Scott (D-VA) adds under well baby care: "early and periodic screening, diagnostic, and treatment services" as defined in sec. 1905(r) of the Social Security Act (which covers screening at periodic intervals for, among other things, a comprehensive health and developmental history (including assessment of both physical and mental health development), a comprehensive unclothed physical exam, appropriate immunizations, laboratory tests (including lead blood level assessment appropriate for age and risk factors), and health education (including anticipatory guidance).*	For essential benefit package requirements for plans sold through the Gateways, p. 12 below.

Provision	House Tri-Committee Bill	Senate HELP
	Provides that there will be no cost-sharing under the EBP for preventive items and services, including well baby and well child care. Annual out-of-pocket spending in the EBP is limited to $5,000 for individuals and $10,000 for families (indexed to CPI). *E&C amendment by Rep. Capps (D-C) prohibits the HBAC from recommending, and the HHS Secretary from adopting, that abortion services (as defined) be a part of the EBP, and allows a QHBP offering entity to determine whether to cover such services. Requires the HCC to assure that in each premium rating area, consumers have access to at least one plan that provides coverage of abortion services and at least one plan that does not.* *Ed and Labor Chairman's amendment in the nature of a substitute requires durable medical equipment, prosthetics, orthotics and related supplies to be included in the EBP.* (sec. 122)	
Creation of Health Benefits Advisory Committee	Establishes a Health Benefits Advisory Committee (HBAC) chaired by the Surgeon General, with up to 26 members: (1) 9 members are not Federal employees and are appointed by the President; (2) 9 members are not Federal employees and are appointed by the Comptroller General of the U.S.; and (3) up to 8 members are Federal employees, appointed by the President. Members shall include stakeholders made up of providers, consumer representatives, employers, labor, health insurance issuers, experts in health care financing and delivery, experts in racial and ethnic disparities, experts in caring for those with disabilities, representatives of relevant governmental agencies, at least one practicing physician or other health professional and an expert on children's health. The HBAC shall recommend to the HHS Secretary benefits standards and periodic updates to such standards that take into account innovation in health care and how such standards could reduce health disparities. The HBAC will recommend initial benefit standards within 1 year after date of enactment. *E&C amendment by Rep. Walden (R-OR) provides that not less that 25% of Committee members shall be practicing health care professionals who have practiced in a rural area for at least the 5-year period preceding their appointment. Ed & Labor amendment offered by Rep. Susan Davis (D-CA) requires the HBAC to examine health coverage laws and benefits of each State in developing recommendations and incorporate such coverage and benefits as the HBAC*	No similar provision.

Provision	House Tri-Committee Bill	Senate HELP
	determines to be appropriate. The HBAC shall also seek input from the States and consider recommendations on how to ensure that the quality of health coverage does not decline in any State. *Ed & Labor Chairman's amendment in the nature of a substitute makes several changes to the HBAC, including:* • *Requires the membership to also include one or more experts in scientific evidence and integrative health care services.* • *Requires the HBAC to also take into account integrative health care services and typical multiemployer plan benefit structures.* • *Requires the HBAC to create an Integrative Health Care Services Task Force, consisting of five experts in research and practice of integrative health care. The task force will make integrative care service recommendations which shall be included in the recommendations of the HBAC. The HBAC Committee will approve members of the Task Force based on the HHS Secretary's nominees.* *Ed & Labor amendment by Rep. Sestak (D-PA) strikes the term 'consumer representatives' and from the list of members to be included in the HBAC and inserts "educated patients or consumer advocates (or both), which means an individual who represents individuals affected by a specific disease or medical condition, is knowledgeable about the health care system, and has received training regarding health, medical, and scientific matters."* (sec. 123)	
Process for Adoption of Recommendations and Benefit Standards	Requires the HHS Secretary review the recommended initial standards within 45 days after receipt and determine whether to propose adoption of such standards as a package. If the Secretary determines to propose adoption as a package, the Secretary must use a rulemaking process to propose the recommended standards. The Secretary must notify the HBAC in writing if he or she decides not to adopt the standards as a package, with reasons for not proposing adoption and providing the HBAC with an opportunity to modify its recommendations on a timely basis. The initial benefit standards must be adopted within 18 months of date of enactment. (sec. 124)	
Prohibition of Discrimination in Health Care Services	*E&C amendment by Rep. Shimkus (R-IL) to provide that neither the HCC nor any health insurance issuer offering health insurance through the Exchange shall discriminate in*	

Provision	House Tri-Committee Bill	Senate HELP
	approving or covering a health care service on the basis of its religious or spiritual content if expenditures for such a service are allowable as a deduction under Code section 213(d). (Identical amendment added in Ed & Labor markup by Rep. Biggert (R-IL).) (adds new sec. 125)	
Consumer Protections	• Provides the HCC with authority to define uniform marketing standards that all insured QHBP offering entities must meet. (sec. 131) • Requires qualified plans to meet standards defined by the HCC for timely fair grievance and appeals mechanisms. (sec. 132) • Requires qualified plans to meet standards established by the HCC relating to transparency and timely disclosure of plan documents, terms and conditions, claims payment policies, periodic financial disclosure and other information. (sec. 133); • *E&C en bloc amendment offered by Rep. Baldwin (D-WI) and others (the "Progressives" amendment) would require pharmacy benefit managers who manage the prescription drug benefit under the public option (see sec. 223 below) to submit information to the HCC and the QHBP offering the benefit relating to the volume of prescriptions filled, pricing, and sales under new transparency requirements. (new sec. 133(d))* • Applies the consumer protection requirements described above to QHBP not offered through the 'Health Insurance Exchange' (Exchange, as defined below) only to the extent specified by the HCC. (sec. 134) • Applies Medicare's timely payment of claims standards to plans offering coverage through the Exchange. (sec. 135) • Requires the HCC to establish standardized rules for coordination and subrogation of benefits in cases involving individuals and multiple sources of coverage (e.g., workers compensation). (sec. 136) • Requires a QHBP offering entity to comply with standards for electronic financial and administrative transactions under section 1173A of the Social Security Act, as added by sec. 163 below. *E&C en bloc amendment offered by Rep. Baldwin (D-WI) and others (the "Progressives" amendment) adds a new sec. 1173B to title XI of the Social Security Act setting forth operating rules for each transaction under sec. 1173A as described above.* (sec. 137)	State insurance regulators will perform their traditional obligations regarding enforcement of consumer protections and market conduct. (Sec. 3101 of the PSHA as added by sec. 142 of the bill)

Provision	House Tri-Committee Bill	Senate HELP
Requirement for QHBPs to Record Patient and Prescriber-Specific Data	*Ed & Labor Chairman's amendment in the nature of a substitute adds a provision requiring QHBPs to record patient and prescriber-specific data for prescriptions. Any patient and prescriber-specific data may not be transferred by certified entities for commercial purposes including, but not limited to, advertising, marketing, improving pharmaceutical market share, influencing prescribing behavior, and evaluating pharmaceutical sales. (new sec. 138)*	
Information on End-of-Life Planning	*E&C en bloc amendment offered by Rep. Ross (D-AR) and others ("Blue Dog" amendment) requires QHBP offering entities to:* • *provide for dissemination of information related to end-of-life planning to individuals seeking enrollment in Exchange-participating health benefit plans offered through the Exchange;* • *present such individuals with the option to establish advanced directives and physician's orders for life sustaining treatment, and other planning tools; and* • *not promote suicide, assisted suicide, or the active hastening of death.* *(new sec. 138)*	
Health Choices Administration and Commissioner	Establishes the Health Choices Administration (HCA) as an independent executive branch agency. The Health Choices Commissioner is appointed by the President. The HCC's duties include establishment of qualified plan standards, operation of the Exchange, administration of affordability credits, and additional functions as laid out in the bill. The HCC shall undertake activities to promote accountability of QHBP offering entities (defined as a group plan, the plan sponsor in relation to such group plan, or in the case of a plan maintained jointly by one or more employers, such term means the employer). The HCC shall also conduct compliance examinations and audit QHBPs, collect data necessary to carry out his duties, including promoting quality and value and addressing disparities in health care. The HCC also has oversight and enforcement authority including the authority to impose sanctions and suspend enrollment of a plan. In carrying out the HCC's duties, the HCC shall consult with the National Association of Insurance Commissioners (NAIC), State attorney generals, appropriate State agencies, and other appropriate Federal agencies. In carrying out the HCC's enforcement functions, the HCC shall coordinate with existing Federal and State entities to prevent conflicts of interest and ensure effective enforcement. (secs. 141-143)	No similar provision.

Provision	House Tri-Committee Bill	Senate HELP
Health Insurance Ombudsman	Establishes a QHBP Ombudsman with expertise and experience in the fields of health care and education of individuals. The Ombudsman's duties include, among others, receiving complaints, grievances and requests for information submitted by individuals and assisting them in resolving such issues. The Ombudsman shall report annually to Congress on recommendations for improvements in the program. (sec. 144)	Establishes an Ombudsman only with respect to the community health insurance option. (sec. 3106 of the PHSA as added by sec. 142 of the bill)
Preemption of Federal and State Law	Clarifies that the Bill does not supersede existing Federal or State requirements under COBRA, HIPAA, the Genetic Nondiscrimination Act, Mental Health Parity Act, Women's Cancer Rights Act and Newborns and Mothers Protection Act. For plans sold through the Exchange only, State individual rights and enforcement remedies apply (i.e., are not preempted by ERISA). Otherwise reserves existing ERISA preemption of State law. (Sec. 151)	Includes a rule of construction that provides that Federal law does not preempt or modify the application of Hawaii's Prepaid Health Care Act. (sec. 186)
Private Right of Contract with Health Care Providers	*Ed & Labor amendment by Rep. Price (R-GA) provides that "Nothing in this Act shall be construed to preclude any participant or beneficiary in a group health plan from entering into any contract or arrangement for health care with any health care provider." (new sec. 153)*	
Meaningful Use of Electronic Health Records	*Ed & Labor amendment by Rep. Wu (D-OR) requires the HCC to conduct a study on methods that QHBP offering entities can use to encourage increased meaningful use of electronic health records by health care providers, and report the findings to Congress within 2 years of the date of enactment with recommendations concerning whether QHBPs plans should increase reimbursement rates to health care providers to increase meaningful use of electronic health records by such providers. (new sec. 156)*	
Ensuring Value and Lower Premiums	Amends the PHSA to require health insurance issuers to meet a specified medical loss ratio as defined by the HHS Secretary effective for plan years on or after 1/01/2011. If plans exceed that limit, rebates to enrollees are required. In setting the medical loss ratio, the Secretary is to set this at the highest level possible that is designed to ensure adequate participation by issuers, competition in the market, and value for consumers. (sec. 161)	
Health Insurance Rescissions	Prohibits health insurance companies from rescinding coverage except in instances of clear fraud and requires independent review of any rescission determination. Effective October 1, 2010. (sec. 162)	
Administrative Simplification (Health Information Technology (HIT) Standards)	Amends Part C of title XI of the Social Security Act to add a new sec. 1173A relating to standardizing electronic administrative transactions. Requires the HHS Secretary to adopt and regularly update standards that, among others:	Amends Title III of the PHSA to provide that not later than 180 days after the date of enactment, the Secretary, in consultation with the HIT Policy Committee and the HIT Standards Committee, shall develop

Provision	House Tri-Committee Bill	Senate HELP
	• are authoritative, permitting no additions or constraints for electronic transactions, including companion guides; • are comprehensive, efficient and robust, requiring minimal augmentation by paper transactions or clarification by further communications; • enable the real-time (or near real-time) determination of an individual's financial responsibility at the point of service and, to the extent possible, prior to service, including whether the individual is eligible for a specific service with a specific physician at a specific facility, which may include utilization of a machine-readable health plan beneficiary identification card; • enable near real-time adjudication of claims; • provide for timely acknowledgment, response, and status reporting applicable to any electronic transaction; • harmonize all common data elements across administrative and clinical transaction standards. Provides that requirements for specific standards shall be developed, adopted and enforced so as to: • clarify, refine, complete, and expand, as needed, the standards required under section 1173; • require paper versions of standardized transactions to comply with the same standards as to data content such that a fully compliant, equivalent electronic transaction can be populated from the data from a paper version; • enable electronic funds transfers, in order to allow automated reconciliation with the related health care payment and remittance advice; • require timely and transparent claim and denial management processes, including tracking, adjudication, and appeal processing; • require the use of a standard electronic transaction with which health care providers may quickly and efficiently enroll with a health plan to conduct the other electronic transactions provided for in this part; and provide for other requirements relating to administrative simplification as identified by the HHS Secretary, in consultation with stakeholders. Not later than 6 months after the date of enactment, the HHS Secretary shall submit to Congress a plan for the implementation and enforcement, by not later than 5 years after such date of enactment, of the standards under this section, and include, among other things: • an estimate of total funds needed to ensure timely	interoperable and secure standards and protocols that facilitate enrollment of individuals in Federal and State health and human services programs, as determined by the Secretary. The standards and protocols for electronic enrollment in the Federal and State programs shall allow for the following: • electronic matching against existing Federal and State data, including vital records, employment history, enrollment systems, tax records, and other data determined appropriate by the Secretary to serve as evidence of eligibility and in lieu of paper-based documentation; • simplification and submission of electronic documentation, digitization of documents, and systems verification of eligibility; • capability for individuals to apply, recertify and manage their eligibility information online, including at home, at points of service, and other community-based locations; • ability to expand the enrollment system to integrate new programs, rules, and functionalities, to operate at increased volume, and to apply streamlined verification and eligibility processes to other Federal and State programs, as appropriate; • notification of eligibility, recertification, and other needed communication regarding eligibility, which may include communication via email and cellular phones; • other functionalities necessary to provide eligibles with streamlined enrollment process. Upon approval by the HIT Policy Committee, the HIT Standards Committee, and the Secretary of the standards and protocols developed, the Secretary shall notify States of such standards and protocols; and may require, as a condition of receiving Federal funds for the HIT investments, that States or other entities incorporate such standards and protocols into such investments. Provides for grants to eligible entities to develop new, and adapt existing, technology systems to implement the HIT standards and protocols developed. Entities eligible for grants include States, political subdivision of a State, or a local governmental entity. Entities must submit an application to the Secretary at such time, in such manner, and containing a plan to adopt and implement appropriate enrollment technology that includes: • proposed reduction in maintenance costs of technology systems;

Provision	House Tri-Committee Bill	Senate HELP
	completion of the implementation plan; and • an enforcement process that includes investigation of complaints, random audits to ensure compliance, civil monetary and programmatic penalties for non-compliance consistent with existing laws and regulations, and a fair and reasonable appeals process. (sec. 163)	• elimination or updating of legacy systems; and • demonstrated collaboration with other entities that may receive a grant under this section. (sec. 185)
Expansion of Electronic Transactions in Medicare	*E&C en bloc amendment offered by Rep. Baldwin (D-WI) and others (the "Progressives" amendment) amends sec. 1862(a) of the Social Security Act (relating to exclusions from coverage and Medicare as a secondary payer) to add a new paragraph 25 that provides: "subject to subsection (h) not later than 1/01/2015, for which the payment is other than by electronic funds transfer or an electronic remittance… ." (new sec. 164)*	
Reinsurance Program for Retirees	Within 90 days after the date of enactment, the HHS Secretary shall establish a temporary reinsurance program to provide reimbursement to participating employment-based plans for part of the cost of providing retiree health benefits to individuals (ages 55-64) and their families. Employment-based plans must apply to participate and be approved by the HHS Secretary. The program reimburses participating employment-based plans for 80% of the cost of benefits provided per enrollee in excess of $15,000 and below $90,000. The plans are required to use the funds to lower costs borne directly by participants and beneficiaries. The Act appropriates $10 billion for this fund and funds are available until expended. (sec. 164) (-$10 billion)	Not later than 90 days after enactment, the HHS Secretary will create a temporary reinsurance program to provide reimbursement to participating employment-based plans for the cost of providing health benefits to retirees (ages 55-64) and their dependents who live in States that have not yet established Gateways. Employment-based plans are group health benefits plans maintained by one or more current or former employers (including State or local governments), employee organizations, voluntary employees' beneficiary associations, or a multiemployer plan (as defined in section 3(37) of ERISA) and provides health benefits to retirees. The program will end on the date that a State becomes a participating State or an establishing State (as under sec. 3104). The reinsurance program will be funded through a $10 billion appropriation to a Retiree Reserve Trust Fund. (sec. 181) (CBO July 2nd preliminary analysis estimates cost is -$10 billion)
Protection Against Reduction of Retiree Health Benefits	*Ed & Labor Chairman's amendment in the nature of a substitute amends sec. 715 of ERISA to prohibit any group plan from reducing retiree benefits after the employee has retired, provided that no provision exists that allows the group health plan to amend, terminate, or make post-retirement reductions to the retiree benefits. (new sec. 165)*	
Limitations on Preexisting Condition Exclusions	*E&C amendment offered by Rep. Sutton (D-OH) to impose certain limitations on preexisting condition exclusions in group health plans and health insurance coverage in the group and individual markets in advance of the bill's new prohibition on preexisting condition exclusions. For group plans, the limitations take effect for plan years beginning*	

Provision	House Tri-Committee Bill	Senate HELP
	after the end of the 6th calendar month after enactment. For individual market plans, the limitations take effect to health insurance coverage offered, sold, issued, renewed, in effort or operating in the individual market after the 6th calendar month after enactment. (Note: Identical Ed & Labor amendment offered by Rep. Courtney (D-CT.) (new sec. 165)	
Extension of COBRA Continuation Coverage	*Ed & Labor amendment by Rep. Susan Davis (D-CA) provides for extension of COBRA continuation coverage in the case of any individual who is covered under COBRA on or after the date of enactment to the earlier of the date on which such individual becomes eligible for coverage under an employment-based health plan or the date on which such individual becomes eligible for health insurance coverage through the Exchange (or a State-based Gateway operating in a State or group of States). Any required period of COBRA continuation coverage which is extended under the amendment shall terminate upon the occurrence, prior to the date of termination otherwise provided under the amendment, of any terminating event specified in the applicable continuation coverage provision other than the expiration of a period of a specified number of months. Preempts State law to the extent that such provision has the effect of limiting or precluding access by a qualified beneficiary whose COBRA continuation coverage has been extended under this section to a State health benefits risk pool recognized by the HCC Commissioner for purposes of this section solely by reason of the extension of such coverage beyond the date on which such coverage otherwise would have expired. (new sec. 165)*	

II. Health Insurance Exchange/Gateways and Related Provisions

A. National Health Insurance Exchange (House Bill)/State Gateways (Senate Bill)

Provision	House Tri-Committee Bill	Senate HELP
Establishment of National Health Insurance Exchange; State Gateways	Establishes a National Health Insurance Exchange within the HCA under the direction of the HCC to give individuals and employers access to a variety of health insurance coverage options, including a public health insurance option. The HCC will establish standards for, obtain bids from, and negotiate and enter into contracts with QHBP offering entities for the offering of health benefit plans through the Exchange, with different levels of benefits required by sec. 203 below. (sec. 201)	Adds a new Title XXXI to the PHSA setting forth rules relating to the establishment of State-run health benefit Gateways. Each State will have an American Health Benefit Gateway, established either by the State or by the HHS Secretary that will be administered through a governmental agency or non-profit entity established by the State. Within 60 days of enactment, the Secretary will make planning grant awards to States to undertake activities related to establishing their own Gateway.

Provision	House Tri-Committee Bill	Senate HELP
		The Gateways exist to facilitate voluntary purchase of health insurance coverage and related insurance products at an affordable price by qualified individuals and qualified employer groups. The Gateways will include a public option (known as a community health insurance option (CHIO). (new sec. 3101 of the PHSA, as added by sec. 142 of the bill)
Eligible Individuals and Employers	Provides that all individuals are eligible to obtain coverage through enrollment in an Exchange-participating health benefits plan offered through the Exchange unless such individuals are enrolled in another QHBP or have other acceptable coverage. In 2013, the first year of the program, only individuals not enrolled in other acceptable coverage and smallest employers (with 10 or fewer employees) are allowed into the Exchange. In 2014, smaller employers (with 20 or fewer employers) are allowed in; in 2015 and beyond, the HCC is granted authority to expand to larger employers. Acceptable coverage is defined as enrollment in coverage under a QHBP, grandfathered plans descried in sec. 102 above, Medicare, Medicaid, Tricare, VA health care, and such other coverage as the HCC, in coordination with the HHS Secretary recognizes. Medicaid-eligible individuals are generally not eligible to participate in the Exchange, except for childless adults with incomes under 133% of poverty who had other qualifying coverage within the previous 6 months, who can choose to obtain coverage through the Exchange. *E&C amendment offered by Rep. Buyer (R-IN) provides that veterans and members of the Armed Forces would be eligible to obtain enrollment in an Exchange-participating health benefits plan.* *Ed & Labor Chairman's amendment in the nature of a substitute provides that group health plans that are multiemployer plans may obtain coverage through the Exchange as an Exchange-eligible employer.* *Ed & Labor amendment offered by Rep. Titus (D-NV) changes the categories of employers as follows: (1) smallest employers are those with 15 or fewer employees; (2) smaller employers are those with 16-25 employees; (3) larger employers are those with 26-50 employees; and (4) largest employers are those with more than 50 employees. Thus, in 2013, employers with up to 15 employees could participate; in year 2014, employers with 16-25 employees could participate, and in 2015, larger employers would be allowed in and largest employers as permitted by the HCC.* (sec. 202)	Defines eligible individuals as: • citizens or nationals of the U.S. or aliens lawfully admitted to the U.S. for permanent residency or aliens lawfully present in the U.S.; • "qualified individuals"; • individuals enrolled in a 'qualified health plan'; and • individuals not receiving full benefits under a State child health plan. Defines a 'qualified individual' as an individual residing in a participating or establishing State, not incarcerated, not eligible for Medicare or Medicaid, TRICARE, FEHBP, or any qualifying employer-sponsored coverage. Defines a 'qualified employer' as an employer who elects to make all full-time employees eligible for a qualified health plan. If enrollment takes place through a Gateway, the employer must meet State or Federal criteria. The initial Federal criteria are set so that only small employers are qualified. Participating employers with up to 50 employees may continue participation in the Gateway if they subsequently grow to more than 50 employees. Defines a 'qualified health plan' as a plan that has certification issued by a Gateway and is offered by a licensed health insurance company. The health insurer must agree to offer at least one qualifying health plan with appropriate cost sharing levels, comply with all regulations and pay any surcharges required. This includes the CHIO. (sec. 3113 of the PHSA, as added by sec. 142 of the bill)

Provision	House Tri-Committee Bill	Senate HELP
Benefits Package Levels	The HCC will specify the benefits to be made available under Exchange-participating health benefits plans during each plan year, including a requirement that participating QHBPs must offer one basic plan (which covers the EBP) in each service area in which they operate. QHBPs can choose whether to offer other tiers of benefits packages. Establishes four tiers of benefit packages, based on the levels of cost-sharing required: • Basic plan – 70 percent • Enhanced plan – 85 percent • Premium plan – 95 percent • Premium plus plan – at least 95 percent, plus additional benefits at the plan's discretion. The HCC shall establish a permissible range of variation of cost-sharing for each basic, enhanced, and premium plan (other than preventative benefits as under the EBP). If States require a health insurance issuer offering health insurance coverage to include benefits beyond the EBP, this mandate will continue to apply to an Exchange-participating health benefits plan, if the State enters into an arrangement to reimburse the Department of Health and Human Services (HSS) for any net increase in affordability premium credits (described below) as a result of an increase in premiums from application of the State mandate. (sec. 203)	Provides that the HHS Secretary shall establish the essential health care benefit design for plans offered through the Gateways, which shall include at least – • ambulatory patient services; • emergency services; • hospitalization; • maternity and newborn care; • mental health and substance abuse services; • prescription drugs; • rehabilitative services and habilitative services and devices; • laboratory services; • preventive and wellness services; • pediatric services, including oral and vision care. States may require benefits in addition to the essential health benefits package described below, but must assume additional costs. Risk pools include all enrollees in an individual plan or a group health plan. The HHS Secretary must submit a report to Congress certified by the Chief Actuary of CMS that the health benefits meet these requirements. Provides for a one-time, temporary, and independent commission to advise the Secretary in the development of the EBP. Insurance policies covering required benefits that are sold through the Gateways would have minimum actuarial values set at three specified levels: • 93 percent (for the highest tier), • 84 percent (for the middle tier), and • 76 percent (for the lowest tier). A plan's actuarial value reflects the share of costs for covered services that is paid by the plan.) (new sec. 3103 of the PSHA, as added by bill sec. 142)
HCC's Contracting Authority; Criteria for Certifying Plans as Qualified Plans	Lays out the responsibilities for the HCC's contracting authority including solicitation of bids from QHBP offering entities, negotiate with and enter into contracts with approved plans (for at least one year of duration with automatic renewal). Requirements include that plans be licensed in the State in which they will do business, abide by data reporting requirements as outlined by the HCC, provide for implementation of affordability credits, participate in risk pooling, provide for culturally and linguistically appropriate services and communications, and with respect to the basic plan, contract for outpatient services with essential community providers as defined in the 340B program. The HCC will outline the bid process, the term of the contract is for a minimum of a year, and the Commissioner enforces	The HHS Secretary shall, by regulation, establish criteria for certification of health plans as qualified health plans. Such criteria shall require that, to be certified, a plan must: • not employ marketing practices that have the effect of discouraging the enrollment in such plan by individuals with significant health needs; • employ methods to ensure that insurance products are simple, comparable, and structured for ease of consumer choice; ensure a wide choice of providers (in a manner consistent with applicable network adequacy provisions under section 2702(c)); • make available to individuals enrolled in, or seeking to enroll in such plan a detailed description of

Provision	House Tri-Committee Bill	Senate HELP
	network adequacy, including an allowance for enrollees to receive services out-of-network at no greater cost if the provider network does not meet the standards for adequacy. The HCC is required to establish processes to oversee, monitor, and enforce plan requirements. The HCC also has the authority to terminate plans that fail to meet the required standards. (sec. 204)	benefits offered, including: maximums; limitations (including differential cost-sharing for out of network services); exclusions and other benefit limitations; the service area; required premiums; cost-sharing requirements; the manner in which enrollees access providers; and the grievance and appeals procedures. The Secretary shall request the NAIC to develop and submit to the Secretary model criteria for the certification of qualified health plans, that addresses the elements described in above. In developing such criteria, the NAIC shall consult with appropriate Federal agencies, consumer representatives, insurance carriers, and other stakeholders. If the model criteria is submitted within 9 months after requested, the Secretary shall take such model criteria into consideration in promulgating the regulations required above. (new sec. 3101 of the PSHA, as added by sec. 142 of the bill)
Outreach and Enrollment of Eligible Individuals and Employers	Requires the HCC to conduct outreach and enrollment activities to ensure that Exchange-eligible individuals and employers are informed and educated about the Exchange, and assist eligible individuals in selecting Exchange-participating health benefit plans. Requires the HCC to set up an annual open enrollment period as well as special enrollment periods for special circumstances. Requires the HCC to create an auto-enrollment process for non-Medicaid individuals who are Exchange-eligible, but have not selected a plan. Provides that children born in the U.S. who are not covered under acceptable coverage will be automatically covered by Medicare for the first 60 days of life. Provides for automatic enrollment of Medicaid eligible individuals into Medicaid. *E&C en bloc amendment offered by Rep. Ross (D-AR) and others ("Blue Dog" amendment) to add a clarification at the end of sec. 205 that nothing in this division shall be construed to affect the role of enrollment agents and brokers under State law, including with respect to the enrollment of individuals and employers in QHBPs and the public option.* (sec. 205)	Gateways will develop tools to enable consumers to make coverage choices, and set up open enrollment periods to enroll in qualified health plans. Gateways will establish enrollment procedures to enable individuals to sign up for coverage, including Gateway plans with premium credits, Medicaid, CHIP, and others. The HHS Secretary will establish a website through which individuals may connect to their State Gateway to purchase coverage. (new sec. 3101 of the PHSA) States will receive Federal support to contract with private and public entities to act as health coverage "navigators" to assist employers, workers, and self-employed individuals seeking to obtain coverage through Gateways. Entities eligible to become navigators include trade, industry and professional organizations, unions, chambers of commerce, small business development centers, and others. The navigators will conduct public education activities, distribute information about enrollment and premium credits, and provide enrollment assistance. Health insurers or parties that receive financial support from insurers to assist with enrollment are ineligible to serve as navigators. (new sec. 3105 of the PHSA, as added by sec. 142 of the bill)
Other Functions	The HCC coordinates the distribution of affordability premium and cost-sharing credits. The Commission will also establish a risk-pooling mechanism used to adjust premium amounts among QHBP offering entities offering Exchange-	HHS will oversee the financial integrity of Gateways by conducting annual audits, requiring financial reporting, and other measures, and the HHS Secretary may rescind payments from State Gateways that fail to follow

Provision	House Tri-Committee Bill	Senate HELP
	participating health plans. Establishes an Office of the Special Inspector General for the Health Insurance Exchange, to be headed by a Special Inspector General for the Health Insurance Exchange (in this subsection referred to as the `Special Inspector General') to be appointed by the President, by and with the advice and consent of the Senate. The Special Inspector General shall-- • conduct, supervise, and coordinate audits, evaluations and investigations of the Exchange to protect the integrity of the Exchange, as well as the health and welfare of participants in the Exchange; • report both to the HCC and Congress regarding program and management problems and recommendations to correct them; • have other duties (described in paragraphs (2) and (3) of section 121 of division A of Public Law 110-343) in relation to the duties described in the previous subparagraphs. *Ed & Labor amendment by Rep. Fudge (D-OH) provides that the HCC, in consultation with the Small Business Administration, shall provide to small employers (defined as those with less than 100 employees) counseling and technical assistance with respect to the provision of health insurance to employees of such employers through the Exchange, including:* • *Educational activities to increase awareness of the Exchange and available small employer health plan options.* • *Distribution of information with respect to enrollment and selection processes for health plans available under the Exchange, including standardized comparative information on health plans available under the Exchange.* • *Distribution of information with respect to available affordability credits or other financial assistance.* • *Referrals to appropriate entities of complaints and questions relating to the Exchange.* • *Enrollment and plan selection assistance for employers with respect to the Exchange.* • *Responses to questions relating to the Exchange.* *The HCC is authorized to provide such services directly or by contract with nonprofit entities that the HCC determines capable of carrying out such services.* (sec. 206)	Federal requirements. The HHS Secretary shall also establish procedures and protections to guard against fraud and abuse. Additionally, the Comptroller General of the U.S. will conduct ongoing reviews of Gateway operations and administration. (sec. 3102 of the PHSA as added by sec. 142 of the bill)
Health Insurance Exchange Trust Fund	Creates a Health Insurance Trust Fund to provide funding for the HCA, consisting amounts to be appropriated or credited to the Trust Fund. There is an initial $2 billion appropriation to the Fund. The HCC shall pay from the Trust Fund	Gateways may assess a surcharge on all health insurance issuers offering qualified health plans through the Gateway to pay for the administrative and operating expenses of the Gateway. The surcharge may not

Provision	House Tri-Committee Bill	Senate HELP
	amounts to operate the Exchange, including payments relating to affordability credits (see below). Automatic transfers to Trust Fund will include amounts received in the Treasury: • under Code section 59B (relating to the requirement of health insurance coverage for individuals). • under Code section 3111(c) (relating to employers electing to not provide health benefits). • under Code section 4980H(b) (relating to the excise tax with respect to failure to meet health coverage participation requirements). (sec. 207)	exceed 4% of the premiums collected by a qualified plan. (sec. 3101 of the PHSA, as added by sec. 142 of the bill)
Optional Structures	Permits States to offer their own Exchange, or join with a group of States to create their own Exchange in lieu of the National Exchange. The HCC may not approve a State Exchange unless it meets all of the requirements and functions relating to the Federal health insurance Exchange. The HCC has authority to terminate State Exchanges if they are not meeting their obligations. *E&C en bloc amendment offered by Rep. Ross (D-AR) and others ("Blue Dog" amendment) adds that in the case of a State operating an Exchange prior to January 1, 2010 that seeks to operate a State-based Health Insurance Exchange shall be presumed by the HCC to meet the requirements under this section unless the HCC determines, after working with the State to provide assistance necessary to come into compliance, that the State Exchange does not comply with such requirements.* *E&C en bloc amendment by Rep. Doyle (D-PA) provides that States are eligible to receive incentive payments for enacting and implementing medical liability reforms. Requires the Secretary to determine if the law is "effective" and outlines criteria for the liability reforms, including:* • *making the medical liability system more reliable through prevention of or prompt and fair resolution of disputes;* • *encouraging the disclosure of health care errors; and* • *maintaining access to affordable liability insurance.* *Requires the State liability reforms to contain one or both of the following litigation alternatives: Certificate of Merit and Early Offer.* (sec. 208)	During the 4-year period following the date of enactment, States have 3 options for participation in the Gateway system. • An "establishing State" is one that sets up its Gateway as early as possible and adopts the insurance reform provisions in sec. 101 above, and agrees to make employers who are State or local government subject to sec. 162 (relating to 'Notification on the Availability of Affordable Health Choices' described below) and sec. 163 (relating to "Shared Responsibility of Employers" described below. If the HHS Secretary determines that the State has complied, residents of that State who are eligible for premium subsidies become eligible for such subsidies 60 days after such determination. • A "participating State" is one that requests the HHS Secretary to operate a Gateway (for a minimum period of 5 years), adopts the insurance reform provisions in sec. 101 above, and agrees to make employers who are State or local governments subject to sec. 162 (relating to 'Notification on the Availability of Affordable Health Choices' described below) and sec. 163 (relating to 'Shared Responsibility of Employers') described below. If the HHS Secretary determines that the State has complied, residents of that State who are eligible for premium subsidies become eligible for such subsidies 60 days after such determination. • In a State that does not act to conform to the new requirements, the Secretary shall establish and operate a Gateway in the State after a period of six years, and such State will become a "participating State." Until a State becomes either an establishing or participating State, the residents of that State will not be eligible for premium subsidies, an expanded Medicaid match, or small business

Provision	House Tri-Committee Bill	Senate HELP
		credits. States may also form regional Gateways operating in more than one State; States may establish subsidiary regional Gateways, as long as each Gateway serves a distinct region. (sec. 3104 of the PHSA added by sec. 142 of the bill)
Participation of Small Employer Benefit Associations	*Ed & Labor Chairman's amendment in the nature of a substitute provides that the HCC may enter into arrangements with small employer benefit associations to provide consumer information, outreach, and assistance in the enrollment of small employers (and their employees) who are members of such an association under Exchange-participating health benefits plans. The term ''small employer benefit association'' means a not-for-profit agricultural or other cooperative that:* • *consists solely of its members and is operated for the primary purpose of providing affordable employee benefits to its members;* • *only has as members 'small' employers in the same industry or line of business;* • *has no member that has more than a 5 percent voting interest in the cooperative; and* • *is governed by a board of directors elected by its members.* *Ed & Labor amendment offered by Rep. Hare (D-IL) amends the Chairman's amendment in the nature of a substitute above to replace the term 'associations' with 'arrangements' and provide that the HCC may enter in 'contracts' instead of 'arrangements'.* *(new sec. 209)*	No provision.
Limitation on Premium Increases under Exchange Participating Health Benefit Plans	*E&C amendment added by Rep. Schakowsky (D-IL) and others to provide that the increase in the premiums charged under any Exchange-participating health benefit plans may not exceed 150% of the annual percentage increase in medical inflation for the 12-month period ending in June of the prior year. Provides exceptions to this limitation in the case of QHBPs that provide additional benefits, and in cases where the QHBP demonstrates to the HCC (or the insurance commissioner for States that operate Exchanges) that complying with the limitation would threaten the plan's viability or its ability to provide timely benefits to plan participants. (new sec. 209)*	No provision.

B. Public Health Insurance Option

Provision	House Tri-Committee Bill	Senate HELP
Public Option	Requires the HHS Secretary to develop a new national public health insurance option to be offered through the Exchange beginning 1/01/2013. The public option must offer same benefits required of private plans, offer basic, enhanced and premium plans (and may offer premium plus plans) and meet same insurance market reforms, consumer protections, etc. The HHS Secretary shall establish an Office of the Ombudsman for the public option with duties similar to the Medicare Beneficiary Ombudsman under sec. 1808(c)(2) of the Social Security Act. The Secretary shall collect data to establish premiums and payment rates and for other purposes, including to improve quality and to reduce racial, ethnic, and other disparities in health care. The Secretary may enter into contracts for the purpose of performing administrative functions (as described in sec. 1874A(a)(4)) for the public option in the same manner as the Secretary may enter into contracts under subsection (a)(1) of such section. The provisions of Medicare related to access of Medicare beneficiaries to Federal courts for enforcement of rights shall apply to the public option and individuals enrolled in the public option. *E&C en bloc amendment offered by Rep. Ross (D-AR) and others ("Blue Dog" amendment) would further "level the playing field" for the public option by providing that the following sections will also apply to the public option:* • *sec. 113 (Insurance Rating Rules);* • *sec. 114 (Nondiscrimination in benefits; mental health and substance abuse parity);* • *sec. 133 (Transparency and plan disclosures);* • *sec. 222(a)(2) (Contingency margin requirements).* • *Ed & Labor amendment offered by Rep. Polis (D-CO) to strike ''racial, ethnic, and other disparities in health and health care'' and insert ''disparities in health and health care based on race, ethnicity, primary language, sex, sexual orientation, gender identity, disability, socio-economic status, rural, urban, or other geographic setting, and any other population or subpopulation as determined appropriate by the Secretary, but only if the data collection is conducted on a voluntary basis and consistent with the standards, including privacy protections, established pursuant to section 1709 of the Public Health Service Act''.* (sec. 221)	The HHS Secretary will establish a nationwide community health insurance option ("CHIO") that would offer the same tiers of benefits and essential benefits as other plans operating in the Gateways (as described above). There are no requirements that health care providers participate in the plan or that individuals join the plan. Each State will establish a State Advisory Council to provide recommendations to the Secretary on the policies and procedures of the CHIO. The HHS Secretary shall contract with qualified nonprofit entities to administer the CHIO in the same manner as Medicare program contracting. The contractor will receive a fee from the HHS, which may be increased or reduced depending on the contractor's performance in reducing costs and providing high-quality health care and customer service. Contracts will last between 5 and 10 year terms, at the end of which there will be a competitive bidding process for new and renewed contracts. (new sec. 3105 as added by sec. 142 of the bill) Establishes an Ombudsman with respect to the CHIO. (sec. 3106 of the PHSA as added by sec. 142 of the bill)

Provision	House Tri-Committee Bill	Senate HELP
Premiums and Financing	The Secretary will establish geographically adjusted premiums that must cover the costs of the health benefits and administrative costs. The premium must include a contingency margin to cover unexpected cost variations. The public option will be given $2 billion for start up costs and a one-time investment of 3 months of reserves; start-up funds must be amortized into the premiums to repay the Treasury over the first ten years of operation. (sec. 222)	Premiums must be sufficient to cover the plan's cost. A "Health Benefit Plan Start-up Trust Fund" will be created to provide loans for the initial operations of the community health insurance plan, which the plan will be required to pay back no later than 10 years after the payment is made. After the first 90 days of operation, the CHIO will be subject to a Federal solvency standard, established by the Secretary, and required to have a reserve fund that is at least equal to the dollar value of incurred claims. (sec. 3106 of the PHSA) (sec. 142)
Payment Rates	HHS Secretary will establish geographically-adjusted provider payment rates for the public option. For the first 3 years (2013-2015), rates will be based on Medicare rates; Exchange-participating providers who also participate in Medicare will get an additional 5 percent. The 5% add-on amount will also apply to practitioners, like pediatricians, who do not typically participate in Medicare. The Secretary is provided authority to create payment rates for services not covered by Medicare, pursue delivery system reforms within the public option, and generally adjust rates as necessary to assure competitiveness with other Exchange-participating plans. Medicare providers will be assumed to participate in the public option unless they opt out. Payment rates for prescription drugs not paid for under Medicare Parts A or B shall be negotiated by the Secretary. *E&C en bloc amendment offered by Rep. Ross (D-AR) and others ("Blue Dog" amendment) provides that payments for the first three years would not be based on Medicare rates. Instead, the HHS Secretary shall negotiate payment rates for the public health insurance option for services and health care providers in a manner that results in payments rates that are not lower, in the aggregate, than Medicare rates (under title XVIII of the Social Security Act) and not higher, in the aggregate, then the average rates paid by other QHBP offering entitles for services and health care providers. The amendment also strikes the 5% add-on payment and provides for a process for providers to opt out of the public option, opt back in, and provides for an annual enrollment period for providers to decide whether they want to participate in the public option.* *E&C en bloc amendment offered by Rep. Baldwin (D-WI) and others (the "Progressives" amendment) would require the Secretary to establish a prescription drug formulary*	The HHS Secretary shall negotiate rates for provider reimbursement, which shall not be higher than the average of all Gateway reimbursement rates. To account for regional premium variations, credits will be based on a reference premium. The reference premium will be calculated on the average premiums of the three lowest cost qualified plans offered in each area. Premiums will be risk adjusted to adjust for variations in patient characteristics or risk factors. Services not included in the essential benefits design package will not be paid for with premium credits. States are permitted to make payments for individuals that exceed required amounts or to defray costs of services in addition to the essential benefits package. (sec. 3111 of the PSHA as added by bill sec. 151)

Provision	House Tri-Committee Bill	Senate HELP
	under the public health option. QHBPs shall enter into contracts with pharmacy benefit managers (PBMs) to manage the prescription drug coverage added by the amendment. (sec. 223)	
Modernized Payment Initiatives and Delivery System Reforms	The HHS Secretary is authorized to utilize innovative payment mechanisms and policies to determine payments for items and services under the public option, including patient-centered medical home and other care management systems, accountable care organizations, value-based purchasing, bundling of services, performance or utilization based payments, partial capitation and direct contracting with providers. The Secretary shall design and implement payment mechanisms designed to improve health outcomes, reduce health disparities, address geographic variation in the provision of medical services, prevent or manage chronic illnesses, or promote integrated patient-centered care. *E&C Chairman's amendment in the nature of a substitute directs the HHS Secretary to examine payment and delivery system reforms under the public option and Medicare that improve quality and reduce costs. For reforms that the Secretary deems successful, requires the Secretary to adopt these new models on as large a geographic scale as practical and economical.* (sec. 224)	State councils shall consider innovative payment mechanisms and make proposals to the HHS Secretary. (sec. 3106 of PHSA) (sec. 142)
Conditions for Provider Participation	HHS Secretary is provided authority to develop conditions for provider participation in the public option. Providers must be licensed in the State in which they do business. Two types of physician participation – (1) preferred physicians: those who agree to accept the public option's payment rate (without regard to cost-sharing) as payment in full; (2) participating non-preferred physicians: those who agree not to impose charges in excess of the balance billing limitations in Medicare. Providers excluded from other Federal health programs are excluded from participating in the public option. *E&C en bloc amendment offered by Rep. Ross (D-AR) and others ("Blue Dog" amendment) strikes the provisions relating to the two types of physician participation noted above and instead provides that the Secretary shall establish terms and conditions for the participation of providers under the public option, "for which payment may be made for services furnished during the year."* (sec. 225)	

Provision	House Tri-Committee Bill	Senate HELP
Fraud and Abuse	Provides that Medicare's anti-fraud and abuse protections will be applied to the public option. (sec. 226)	Amends ERISA to add a number of new fraud and abuse provisions, including: • Creates a new senior advisor for health care fraud at HHS and a new senior counsel for health care fraud at the Justice Department. (secs. 501, 502) • Creates a new Health Care Program Integrity Council to coordinate, report and evaluate ways to ensure that private and public health insurance are included in investigative and data sharing programs to reduce fraud and abuse. (sec. 511) • Prohibits persons from making false statements in connection with a Multiple Employer Welfare Arrangement (MEWA) concerning solvency, benefits and regulatory status under State or Federal law by creating a new section 519 under ERISA. Creates criminal penalties for violations. (sec. 521) • Makes violations of sections 411, 511 and 518 of ERISA (pertaining to convicts holding fiduciary positions and interference with beneficiaries' rights under a plan) 'Federal health care offenses,' which gives the DOL investigative powers. (sec. 531) • NAIC will develop a uniform report for private insurers seeking to refer suspected fraud and abuse to State insurance departments and agencies for investigation. (sec. 541) • Permits the Labor Secretary to issue an order or regulations that subject a person engaged in business with a MEWA to State law for the purpose of preventing and prosecuting fraud and abuse. (sec. 551) • Permits DOL to issue cease and desist or seizure order to MEWAs determined to be fraudulent, a danger to the public or financially hazardous. (sec. 561) • Requires MEWAs to register with the DOL prior to operation. (sec. 571) • Permits the Labor Secretary to provide for privileged communications for agents, consultants and employees of DOL, Treasury, DOJ, HHS and other agencies in connection with an audit, examination, or inquiry. (sec. 581)
HIPAA Requirements Applied to the Public Option	*E&C en bloc amendment offered by Rep. Ross (D-AR) and others ("Blue Dog" amendment) would apply HIPAA requirements to the public option. (new sec. 227)*	
Additional Standards for the Public Option	*E&C en bloc amendment offered by Rep. Ross (D-AR) and others ("Blue Dog" amendment) would add new sec. 1173A*	

Provision	House Tri-Committee Bill	Senate HELP
	of the Social Security Act (above) relating to health information privacy, security and electronic Exchange of health care information to the public option. (new sec. 228)	
Health Insurance Cooperatives	*E&C en bloc amendment offered by Rep. Ross (D-AR) and others ("Blue Dog" amendment) inserts a new sec. 251 to the bill providing for the establishment of a "Consumer Operated and Oriented Plan" program under which the HCC may make grants and loans for the establishment and initial operation of not-for-profit, member-run health insurance cooperatives that provide insurance through the Federal Exchange or a State-based Exchange. The amendment also sets forth the conditions for awarding of grants and loans, and the conditions that the cooperatives must meet to be eligible for participation. (new sec. 251)*	

III. Individual Mandate and Employer Requirements

A. Individual Mandate and Related Provisions

Provision	House Tri-Committee Bill	Senate HELP
Individual Mandate	Requires all individuals to maintain 'acceptable health care coverage'. Individuals (or married couples in the case of a joint return) who do not maintain coverage under acceptable health insurance for themselves and qualifying children are subject to an additional tax (described on p. 24 below). 'Acceptable coverage' includes coverage under a qualified health plan (e.g., grandfathered plans, Medicare, Medicaid, Tricare, VA coverage) and other coverage approved by the Treasury Secretary in coordination with the HCC. (sec. 401).	Requires all individuals to obtain qualifying health insurance coverage. Exemptions will be made for individuals for whom affordable health care coverage is not available or for those for whom purchasing coverage creates an exceptional financial hardship. Individuals deemed to lack availability to "affordable coverage", Indians, individuals living in States where Gateways are not yet established, and individuals without coverage for fewer than 90 days operating are exempt from the mandate and penalty. Coverage is determined to be unaffordable if the premium paid by the individual is greater than 12.5 percent of the individual's adjusted gross income. The HHS Secretary shall establish an affordability standard and procedures for updating this standard linked to the Consumer Price Index for urban consumers. "Qualifying coverage" includes any coverage under which an individual is enrolled on the date of enactment of the law, and after the date of enactment, coverage that meets the criteria for minimum qualifying coverage to satisfy personal responsibility standards, and coverage that meets grandfather standards. Coverage through Medicare,

Provision	House Tri-Committee Bill	Senate HELP
		Medicaid, the CHIP, TRICARE, Veteran's Health, the Federal Employees Health Benefit Plan, Indian Health Service medical program, State health benefit high risk pools, and others meeting the conditions for minimum qualifying coverage. A religious exemption will also apply to these standards. (sec. 161)
Tax Imposed on Individuals without Health Care Coverage	Adds a new Code sec. 59B (Tax on Individuals without Acceptable Health Care Coverage) that imposes a tax of the lesser of: (1) 2.5% of the excess of the taxpayer's modified AGI over the threshold amount of income required for filing a return for that taxpayer under section 6012(a)(1); or (2) the 'applicable national average premium', which means, with respect to any taxable year, the average premium (as determined by the HHS Secretary, in coordination with the HCC) for self-only coverage under a basic plan offered in the Exchange for the calendar year in which the taxable year begins. This tax is in addition to both regular and alternative minimum tax. The additional tax does not apply if maintenance of acceptable coverage would result in a hardship to the individual (as determined through a waiver application process developed by the Treasury Secretary in consultation with the HCC). For taxpayers who maintain insurance for only part of the year, the tax is pro-rated for the duration of time when insurance was not maintained. The tax does not apply to: • individuals properly claimed as a dependent on the income tax return of another taxpayer for the taxable year (however, parents or guardians claiming qualified children as dependents on their Federal income tax returns are required to maintain coverage for these dependents); • nonresident aliens; • individuals residing outside the U.S (as defined under sec. 911(d)); • individuals residing in Possessions of the U.S.; • individuals with a religious conscience exemption granted by the Secretary. Also adds new Code section 6050X imposing information reporting requirements on every person who provides acceptable coverage to any individual during the calendar year, requires Statements to be furnished to individuals with respect to whom information reporting is required, and provides for penalties for failure to file information returns. *Ways and Means Chairman's amendment in the nature of a substitute clarifies that if an individual is required to provide health coverage pursuant to a child support order, the child*	The minimum penalty to accomplish the goal of enhancing participation in qualifying coverage will be no more than $750 per year. (sec. 161) (CBO July 2nd preliminary analysis of Title I estimates that payments by uninsured individuals will raise +$36 billion.)

Provision	House Tri-Committee Bill	Senate HELP
	is treated as the qualifying child of such individual (and not as a qualifying child of another individual). (sec. 401) (CBO estimates that the tax on individuals without acceptable coverage would raise +$29 billion.)	
Individual Subsidies	Creates "affordability premium credits" and "affordability cost-sharing credits" for people with incomes above 133% and up to 400% of the Federal poverty level ("FPL"). Affordability premium credits are applied against the cost of premiums for the Exchange plan in which the individual is enrolled, and affordability cost sharing credits reduce annual out-of-pocket spending for cost-sharing. The credits are phased out on a sliding scale designed to limit premium spending to 1.5 percent of income for people at 133% of FPL, increasing to 11% of income for individuals with incomes up to 400% of FPL. In 2013 and 2014, affordable credit eligible individuals may only use an affordability credit with respect to a basic plan. *E&C amendment by Rep. Capps (D-CA) prohibits affordability credits from being used to pay for abortion services.* (sec. 241) (CBO estimates that the total cost of Exchange subsidies is -$773 billion, not including amendments to the affordability credit provisions made during the E&C markup.)	Low- and moderate-income Americans who enroll in plans through the Gateways will be eligible for premium credits on sliding scale. Gateways will administer these credits. The premium credits would be on a sliding scale up to 400% of the poverty line ($88,080 for a family of 4), with those at lower end receiving more. To account for regional premium variations, credits will be based on a reference premium calculated on the average premiums of the three lowest cost qualified plans offered in each area. The subsidies would be tied to the average of the three lowest premium bids submitted by insurers in each area of the country for each tier of coverage (the "reference bid"). For people with income between 150 and 200% of the FPL, the subsidies would apply to that reference bid for the highest-tier plans; for people with income between 200 and 300% of the FPL, the subsidies would apply to that reference bid for the middle-tier plans; and for people with income between 300 and 400% of the FPL, the subsidies would apply to that reference bid for the lowest-tier plans. Premiums will be risk adjusted for variations in patient characteristics or risk factors. Services not included in the essential benefits design package will not be paid for with premium credits. States are permitted to make payments for individuals that exceed required amounts or to defray costs of services in addition to the essential benefits package. (sec. 3112 of PHSA as added by bill sec. 151) (CBO July 2nd preliminary analysis of Title I (coverage provisions) estimates that the total cost of subsidies is -$723 billion.)
Eligibility for Subsidies	Eligibility for affordability credits is limited to individuals enrolled in an Exchange-participating health benefits plan with family income below 400% of the FPL for a family of the size involved, who is not Medicaid eligible. In general, employees who are offered employer coverage are ineligible for affordability credits. However, beginning in year 2014, employees who meet an affordability test under which coverage under the employer-provided plan would cost more than 11% of their income *(12% as amended in the E&C markup, further explained in the section below)*, are eligible	In general, individuals with an offer of employer-based coverage would not be eligible for Gateway subsidies under the proposal. However, employees with an offer from an employer that was deemed unaffordable could receive subsidies. The bill would define an employer's offer of coverage as unaffordable if the portion of worker paid premiums exceeded 12.5 percent of the worker's adjusted gross income in 2013 (a cap that would grow over time at the rate of medical price inflation). Eligible individuals are citizens or lawfully admitted

<table>
<tr><th>Provision</th><th>House Tri-Committee Bill</th><th>Senate HELP</th></tr>
<tr><td></td><td>to obtain health coverage and income-based affordability credits through the Exchange. (sec. 242)</td><td>permanent residents of the U.S. who are enrolled in a qualified health plan. Those eligible for other public programs are not eligible for subsidies, but a special rule applies to CHIP. Those in CHIP (or their parents) are able to determine whether to remain in CHIP, or whether to enroll in the public option offered through the Gateway. Either choice is permissible, but the individual cannot "double dip" by getting funding from both the Gateway and CHIP. (sec. 3112 of the PHSA as added by bill sec. 151)</td></tr>
<tr><td>Subsidy Amounts</td><td>The affordable premium credit amount is calculated on a sliding scale starting at 1.5% of income for those at or below 133% of the FPL and phasing out at 11% of income for those at 400% of poverty.
<table>
<tr><th>% of FPL</th><th>Initial Premium</th><th>Final Premium</th><th>Actuarial value</th></tr>
<tr><td>133-150%</td><td>1.5%</td><td>3%</td><td>97%</td></tr>
<tr><td>150-200%</td><td>3%</td><td>5%</td><td>93%</td></tr>
<tr><td>200-250%</td><td>5%</td><td>7%</td><td>85%</td></tr>
<tr><td>250-300%</td><td>7%</td><td>9%</td><td>78%</td></tr>
<tr><td>300-350%</td><td>9%</td><td>10%</td><td>72%</td></tr>
<tr><td>350-400%</td><td>10%</td><td>11%</td><td>70%</td></tr>
</table>

E&C en bloc amendment offered by Rep. Ross (D-AR) and others ("Blue Dog" amendment) would increase the phase out of the affordable premium amount to 12% and change the above table as follows:
<table>
<tr><th>% of FPL</th><th>Initial Premium</th><th>Final Premium</th><th>Actuarial value</th></tr>
<tr><td>133-150%</td><td>1.5%</td><td>3%</td><td>97%</td></tr>
<tr><td>150-200%</td><td>3%</td><td>5.5%</td><td>93%</td></tr>
<tr><td>200-250%</td><td>5.5%</td><td>8%</td><td>85%</td></tr>
<tr><td>300-350%</td><td>8%</td><td>10%</td><td>78%</td></tr>
<tr><td>350-400%</td><td>11%</td><td>12%</td><td>70%</td></tr>
</table>

E&C amendment by Rep. Schakowsky (D-IL) and others would add a new sec. 243(d)(4) providing for a contingency adjustment to the affordable premium credits by the HCC based on savings realized as a result of new sec. 209 (relating to limitations on premium increases under Exchange-participating health benefit plans) and new sec. 1186 (relating to negotiation of lower covered Part D drug prices on behalf of Medicare beneficiaries), as described elsewhere in this document.

E&C en bloc amendment offered by Rep. Baldwin (D-WI) and others (the "Progressives amendment") includes several provisions that are designed to achieve savings that are</td><td>The subsidies would cap premiums as a share of income on a sliding scale starting at 1% for those with income equal to 150% of the FPL, rising to 12.5% of income at 400% of the FPL. After 2013, those income caps would be indexed to medical price inflation, so that individuals would (on average) pay a higher portion of their income for Gateway premiums over time. Individuals and families with incomes below 150% of the FPL or above 400% of the FPL would not be eligible for subsidies. (sec. 3111)
Note: The bill contemplates that families with incomes below 150% of the FPL will be made eligible for Medicaid, but Medicaid is not within the HELP Committee's jurisdiction.</td></tr>
</table>

Provision	House Tri-Committee Bill	Senate HELP
	detailed in the relevant sections of this document. The amendment stipulates that all savings achieved by these provisions will be used to increase subsidies for households using the Exchange who are eligible for subsidies ("affordability credits"). (sec. 243)	
Affordability Cost-Sharing Credit	The affordability cost-sharing credit for individuals and families at or above 133% of poverty up to 400% of the FPL limit is in the form of cost-sharing reductions based on the individual's family income as specified by the HCC. (sec. 244)	
Income Determinations	The HCC will use income data from the individual's most recent tax return to conduct income determinations. The FPL applied is the level in effect as of the date of the application. If an individual's income for a plan year is expected to be significantly different from the previous taxable year, the HCC will establish rules requiring the individual to report such a change to the Commissioner. There are penalties for misrepresentation of income. The HCC shall study the feasibility of adjusting the FPL for different geographic areas and submit recommendations to Congress. (sec. 245)	The Gateways will conduct eligibility determinations in accordance with guidelines established by HHS. Exchange credits would be determined on the basis of AGI for the current year, with prescreening based on prior-year income. Participants would have to provide information from their prior year's tax return during the fall enrollment period for coverage during the next calendar year. The Gateways would be given authority to have the IRS verify this information for prescreening purposes. Individuals who would not qualify for a subsidy on the basis of their prior year income would be allowed to apply for a subsidy based on specified changes in circumstances. In all cases, income eligibility would be re-verified based on the current year's tax return (e.g., the one filed in April 2014 reporting income for 2013), subject to a "safe harbor." For filers whose current income turns out to be less that 400% of the FPL—but who received too large a subsidy—the "safe harbor" would limit the amount that they would have to repay to $250 for single filers and $400 for joint filers (and for those filing as the head of household). For filers whose current income turns out to exceed 400% of the FPL, however, no safe harbor would apply—they would have to repay any subsidies they had received. (sec. 3111 of the PHSA as added by bill sec. 151)
No Federal Payment for Undocumented Aliens	Provides that nothing in the bill "shall allow Federal payments for affordability credits on behalf of individuals who are not lawfully present in the United States." (sec. 246)	
Optional State Single Payer Systems	*Ed & Labor amendment offered by Rep. Kucinich (D-OH) adds a new sec. 261 to the bill which provides that a State may request from the Labor Secretary, in consultation with the HHS Secretary, and the Secretary must grant, except under extraordinary circumstances, a waiver of application of ERISA section 514 (relating to preemption of State law) with respect to a State single payer system enacted into law by*	No provision.

Provision	House Tri-Committee Bill	Senate HELP
	such State that would be structured and operated consistent with the requirements listed below. The Secretary shall provide for the revocation of waivers upon a determination that the requirements are not being met. The waiver provides that States have the option to operate a State single payer system in lieu of the public health insurance option or the Exchange. *A State single payer system is required to:* • *provide benefits that meet or exceed the standards of coverage and quality of care set forth in this Act; and* • *ensure that the cost to the Federal Government resulting from the waiver is neither substantially greater nor substantially less than would have been the case in the absence of such waiver, except that: (1) the State may seek and benefit from planning and start-up funds with respect to the system; and (2) nothing in the amendment shall be construed to preclude allowance for normal variations in population demographics, health status, and other factors exogenous to the health care system that may affect differences in costs.* *The term 'State single payer system' means a non-profit program of the State for providing health care:* • *in which a single agency of the State is responsible for financing health care benefits for all residents of the State and for the administration or supervision of the administration of the program;* • *under which private insurance duplicating the benefits provided in the single payer program is prohibited;* • *which provides comprehensive health benefits to all residents of the State, and provides measures to assure free choice of providers for covered services, to promote quality, and to help resolve complaints and disputes between consumers and providers;* • *under which participation by health maintenance organizations (HMOs) is limited to non-profit HMOs that own their own delivery facilities and employ physicians on salary, and funding is limited to services that the HMOs deliver; and* • *may be maintained by such State or with one or more other States in a geographic region. (new sec. 261)*	

B. Employer Requirements and Related Provisions

Provision	House Tri-Committee Bill	Senate HELP
Employers Required to Offer Health Coverage to their Employees ("Play" Portion of "Play or Pay")	Provides that employers must meet the following requirements with respect to offering health coverage to their employees (to avoid paying an additional 8% payroll tax, as described on p. 28 below): • The employer offers each employee individual and family coverage under a qualified health benefits plan (or under a current employment-based health plan (within the meaning of section 102(b)) in accordance with section 312 below. • If an employee accepts such offer of coverage, the employer makes timely contributions towards such coverage in accordance with section 312. • If an employee declines such offer but otherwise obtains coverage in an Exchange-participating health benefits plan (other than by reason of being covered by family coverage as a spouse or dependent of the primary insured), the employer shall make a timely contribution to the Exchange with respect to each such employee in accordance with section 313 below. *Ed & Labor amendment by Rep. Hunter (R-CA) provides for a hardship exemption for employers. Employers may apply to the Secretary for a waiver from the health coverage participation requirements for any 2-year period, in a form and manner prescribed by the HHS Secretary. The Secretary shall grant the waiver within 30 days after submission of the application if the application reasonably demonstrates to the Secretary that meeting the requirements of this part would result in job losses that would negatively impact the employer or the community in which the employer is located.* (sec. 311)	
Minimum Employer Contributions	Employers who offer the coverage described in sec. 311 are required to make a minimum contribution for coverage of full-time employees and their spouses and dependents. The minimum employer contribution in the case of an offering employer is 72.5% of the premium for individual coverage and 65% of the premium for family coverage for the lowest cost plan offered by the employer. In the case of part-time employees, the amount of the minimum employer contribution is a proportion of the minimum contribution for full-time employees that reflects the proportion of (a) the part-time worker's average weekly hours of employment to (b) the minimum weekly hours specified by the HCC for an employee to be a full-time employee. Provides for automatic	Minimum employer contribution is 60% of monthly premiums. (sec. 3116 of the PSHA as added by bill sec. 163)

Provision	House Tri-Committee Bill	Senate HELP
	enrollment of employees into the employment-based plan with the lowest employee premium, and requires employer to provide notice of automatic enrollment and other information, including the employee's right to opt out or to elect coverage under another health benefit plan offered by the employer (sec. 312)	
Employer Contributions to the Exchange for Employees Who Decline Employer Coverage and Obtain Health Insurance through the Exchange	Requires an offering employer to contribute to the Exchange for each employee who declines the employer's coverage and enters the Exchange via the affordability test in sec. 242 noted above. The contribution is generally 8% of the average wages paid by the employer during the period of enrollment. In the case of small employers (i.e., with annual payroll of $400,000 or less in the preceding year), the contribution percentage for employees who decline employer coverage and enter the Exchange is as follows: Up to $250,000 0 percent $250,000 - $300,000 2 percent $300,000 - $350,000 4 percent $350,000 - $400,000 6 percent Contributions are not applied against the premiums of the employee under the Exchange-participating health benefits plan in which the employee is enrolled. (sec. 313) (CBO estimates that payments by employers to Exchanges for employees who decline employer coverage will raise +$45 billion.)	
Satisfaction of Health Coverage Requirements under ERISA	Adds new sections 801-806 to ERISA to conform ERISA to the national health coverage provisions added by the Act, including: • Election of employers to be subject to national health coverage participation requirements (sec. 801); • Treatment of coverage resulting from election (sec. 802); • Health coverage participation requirements (sec. 803); • Rules for applying requirements (sec. 804); • Termination of election in cases of substantial noncompliance (sec. 805); • Regulations, including authority to impose civil penalties for employers who fail to satisfy health coverage participation requirements. (sec. 321)	
Election of Employer to Provide Health Coverage	Adds a new section 4980H to the Code providing for employers to make an election with the Treasury Secretary with regard to employer responsibility to provide health coverage. The Treasury Secretary may terminate the election for substantial noncompliance. Sec. 4980H also provides for an excise tax for failures to satisfy the health coverage participation requirements with respect to any	

Provision	House Tri-Committee Bill	Senate HELP
	employee to whom the election applies in the amount of $100 per day per employee. Limits the penalty for failures due to reasonable cause to the lesser of (1) 10% of the aggregate amount paid or incurred by the employer during the preceding taxable year for employment-based health plans, or (2) $500,000. Waives the excise tax if the failure is corrected within 30 days. (sec. 411)	
Payments by Employers; Small Business Exclusion ("Pay" Portion of "Play or Pay")	Amends section 3111 of the Code to provide that employers who fail to elect or substantially comply with health coverage participation requirements will be subject to the payroll tax in the amount of 8% of the wages that an employer pays to its employees. Certain small employers are exempt from the payroll tax (i.e., employers with an annual payroll that does not exceed $250,000). The 8% payroll tax is phased in for employers with annual payroll from $250,000 - $400,000. If the annual payroll of such employer for the preceding calendar year is (see below), the applicable percentage is: Up to $250,000 0 percent $250,000 - $300,000 2 percent $300,000 - $350,000 4 percent $350,000 - $400,000 6 percent *E&C Chairman Waxman's agreement with Rep. Ross (D-AR) and others ("Blue Dog" amendment) proposes to increase the small business exclusion to employers with an annual payroll of $500,000 and phases in the payroll tax as follows:* *Up to $500,000 0 percent* *$500,000 - $585,000 2 percent* *$585,001 - $670,000 4 percent* *$670,001 - $750,000 6 percent* *This was a key feature of their agreement, but according to the E&C's summary of amendments adopted to the bill, this language was not included in the Ross amendment because it was not within the E&C Committee's jurisdiction.* (sec. 412) (CBO estimates that the "play or pay" payroll tax on employers will raise +$163 billion.)	Employers with more than 25 employees who do not offer qualifying coverage or who pay less than 60 percent of their employees' monthly premiums are subject to a $750 annual fee per uninsured full-time employees and $375 per uninsured part-time employees. For employers subject to the assessment, the first 25 workers will be exempted. Beginning in 2013, the penalty amounts would be adjusted using medical price inflation. (sec. 3116 of the PHSA) (sec. 163) (CBO July 2nd preliminary analysis of Title I estimates by assessment on employers will raise +$52 billion.)
Subsidies for Small Business Employee Health Coverage Expenses	Adds a new Code section 45R providing for a 'Small Business Employee Health Coverage Credit.' The amount of the tax credit is 50% of the amount paid for employee health coverage by qualified small employers (employers with no more than 25 qualified employees employed during the employer's taxable year, and whose average annual employee compensation does not exceed $400,000). The full amount of the credit is available only to an employer with no more than 10 qualified employees and whose average annual employee compensation does not exceed $20,000. The credit is phased out based on average	Beginning in 2010, employers with 50 or fewer full-time workers who pay 60% or more of their employees' health insurance premiums will be permitted to receive subsidies for providing health care coverage. Subsidy amounts are based on the type of employee coverage, size of the employer, and the proportion of time the employer paid employee health insurance expenses. The amount of the subsidy would vary with the size of the firm (up to the limit of 50 workers), and firms that contribute larger amounts toward their workers' insurance would receive larger subsidies (up to a limit of

Provision	House Tri-Committee Bill	Senate HELP
	compensation of employees and on employer size. The credit is not allowed with respect to highly compensated employees (i.e., aggregate compensation over $80,000). Average annual employee compensation is determined by dividing the total aggregate compensation for the taxable year of all employees by the number of qualified employees. Effective for tax years beginning after 12/31/2012. *Ways and Means Chairman's amendment in the nature of a substitute clarifies that the small business tax credit is available for contributions to provide health coverage on behalf of employees who perform services for the employer's trade or business.* (sec. 421) (CBO estimates the small business credits will cost -$53 billion.)	$1,800 per worker for single coverage at firms with fewer than 10 employees who do not require any worker contribution toward health insurance premiums). The credit would be available indefinitely, but firms would be allowed to take the credit in only three out of every four years. Self-employed individuals who do not receive credits for purchasing coverage through the Gateway are eligible. (sec. 3112 of the PHSA as added by bill sec. 151) (CBO July 2nd preliminary estimate of Title I estimates that the cost of small business credits will be $52 billion.)
Disclosures to Carry Out Health Insurance Subsidies	Amends Code section 6103(l) to permit the Treasury Secretary to disclose individual tax return information to officers and employees of the HCC or State-based Gateways to carry out Exchange subsides. (sec. 431)	Similar to House bill. (sec. 152)

C. Additional Tax Provisions

Provision	House Tri-Committee Bill	Senate HELP
Surcharge on High Income Individuals	Adds new Code sec. 59C, imposing a surtax at the rates of 1%, 1.5%, and 5.4% on certain high-income individuals. For joint returns, the 1% rate applies to the taxpayer's modified adjusted gross income of above $350,000 - $500,000; the 1.5% rate applies to modified adjusted gross income above $500,000 - $1 million; and the 5.4% rate applies to modified adjusted gross income in excess of $1 million. Modified adjusted gross income is the taxpayer's adjusted gross income reduced by the deduction allowed for investment interest expense. In the case of a married individual filing a separate return, the dollar amounts are 50% of the above dollar amounts. In the case of unmarried individuals, heads of households and trusts and estates, the dollar amounts are 80% of the above dollar amounts. The surtax applies to tax years beginning after 12/31/2010, and the dollar amounts are indexed for inflation for taxable years beginning after 12/31/2011. Beginning 1/01/2013, the first two surtax rates would be adjusted up to 2% and 3% respectively in the event that certain Federal health reform savings are not achieved. The 1% surtax would not apply if Federal health reform	No provision.

Provision	House Tri-Committee Bill	Senate HELP
	savings exceed a base amount ($525 billion) by $150 billion, and the 2% surtax amount would not apply if savings exceed the base amount by $175 billion. (sec. 441) (+$543.9 billion)	
Restrict Deductions for Over-the-Counter Medicines under HRAs, Health FSAs, HSAs, and Archer MSAs	*Ways and Means Chairman's amendment in the nature of a substitute provides that with respect to medicines, the definition of medical expense for purposes of HRAs, Health FSAs, HSAs, and Archer MSAs is conformed to the definition for purposes of the itemized deduction for medical expenses. Thus, the cost of over-the-counter medicines may not be reimbursed with excludible income through a Health FSA, HRA, or HSA. Effective for expenses incurred after 12/31/2009. (new sec. 442)* (+$8.2 billion)	No provision.
Delay in Application of Worldwide Allocation of Interest	Delays the effective date of worldwide interest allocation rules for nine years, until taxable years beginning after 12/31/2019. The required dates for making the worldwide affiliated group election and the financial institution group election are changed accordingly. The bill also eliminates the special phase-in rule that applies in the case of the first taxable year to which the worldwide interest allocation rules apply. Effective for taxable years beginning after 12/31/2010. (sec. 443) (+$26.1 billion)	No provision.
Limitation on Treaty Benefits	Limits tax treaty benefits with respect to U.S. withholding tax imposed on deductible related-party payments. The amount of U.S. withholding tax imposed on deductible related-party payments may not be reduced under any U.S. income tax treaty unless such withholding tax would have been reduced under a U.S. income tax treaty if the payment were made directly to the foreign parent corporation of the payee. A payment is a deductible related-party payment if it is made directly or indirectly by any entity to any other entity, it is allowable as a deduction for U.S. tax purposes, and both entities are members of the same foreign controlled group of entities. Note: This provision has been modified from the version approved by the House as part of H.R. 2419 (110th Congress) to ensure that foreign multinational corporations incorporated in treaty partner countries will not be affected by this provision. Applies to payments made after the date of enactment. (sec. 451) (+$7.5 billion)	No provision.
Clarification of the Economic Substance Doctrine	In any case in which the economic substance doctrine is relevant to a transaction, the economic substance doctrine would be satisfied only if (1) the transaction changes in a meaningful way (apart from Federal income tax consequences) the taxpayer's economic position, and (2) the taxpayer has a substantial non-Federal tax purpose for	No provision.

Provision	House Tri-Committee Bill	Senate HELP
	entering into such transaction. This provision was previously approved by the House as part of H.R. 4351 (110th Congress). Effective for transactions entered into after the date of enactment. (sec. 452) (+$3.6 billion with interactions with sec. 453 below)	
Penalties for Underpayments Attributable to Transactions Lacking Economic Substance	The bill imposes a 20% penalty on understatements attributable to a transaction lacking economic substance (penalty increased to 40% in the case of transactions in which the relevant facts affecting the tax treatment of the transaction are not adequately disclosed). Effective for transactions entered into after the date of enactment. (sec. 453)	No provision.
Certain Health Related Benefits Applicable to Spouses and Dependents Extended to Eligible Individuals	*Ways and Means Chairman's amendment in the nature of a substitute provides that the income and payroll tax exclusion for employer provided health coverage includes an individual who is eligible to receive coverage under the employer's health plan, and makes similar changes with respect to the deduction for health coverage for self employed individuals. (sec. 461)* (-$4 billion)	No provision.

D. Community Living Assistance Services and Supports ("CLASS Act")

Provision	House Tri-Committee Bill	Senate HELP
CLASS Program	*E&C Amendment offered by Rep. Pallone (D-NJ) amends the PHSA (as amended by the bill) to add a version of the Class Act similar to the provisions in the Senate HELP Committee bill, effective on the effective date of a statute establishing a voluntary payroll deduction to support the program.*	Amends the PHSA (as amended by the bill) to establish a national voluntary disability insurance program (the CLASS program) under which: • all employees are automatically enrolled (but are allowed to opt out of enrollment); • payroll deductions pay monthly premiums (as established by the Secretary, with alternative payment mechanisms to be established for those without employment); and • two-tiers of benefits are provided based on the beneficiary's level of functional disability. (new PSHA sec. 3201-3205 as added by sec. 191 of the bill) (CBO's July 2nd preliminary analysis estimates that the CLASS program will raise +$58 billion in the 10-year budget window.)
Independence Trust Fund	*Similar to Senate HELP bill. Directs the HHS Secretary to promulgate rules as necessary and to take other actions to maintain program solvency and ensure the program remains deficit neutral.*	Establishes the Independence Trust fund within the Treasury consisting of amounts derived from premium and additional amounts derived from income from investment of those funds, and are used to pay administrative expenses of operating the Fund and the payment of cash benefits to eligible beneficiaries. The Fund will be administered by a Board of Trustees

Provision	House Tri-Committee Bill	Senate HELP
		composed of the Social Security Commissioner, the Secretaries of Treasury, Labor and HHS and two members of the public to be appointed by the President. (PSHA sec. 3206)
CLASS Independence Advisory Council	*Similar to Senate HELP bill.*	Creates the 'CLASS Independence Advisory Council' consisting of up to 15 individuals (not employed by the Federal government) appointed by the President, a majority of whom will be, among others: • representatives of individuals with disabilities; • family caregivers of individuals who require services and supports to maintain their independence; • individuals with expertise in long-term care or disability insurance, actuarial science, economics and other relevant disciplines, as determined by the Secretary. The Council's duties will include advising the Secretary on matters of general policy in the administration of the program, including the development of the benefit plan and the determination of monthly premiums. (PHSA sec. 3207)
Tax Treatment	*Similar to Senate HELP bill.*	Requires the CLASS program to be treated for tax purposes in the same manner as qualified long-term care insurance contracts for qualified long-term care services, and includes long-term care insurance under cafeteria plans. (PHSA Sec. 3209)
Determination of Eligibility	*Similar to Senate HELP bill.*	Requires the Secretary to enter into agreements with the Disability Determination Service for each State to provide for eligibility assessment of active enrollees who apply for benefits. (PHSA sec. 3205)
Benefits	*Similar to Senate HELP bill.*	Eligible beneficiaries will receive: • a cash benefit established by the Secretary; • advocacy services; • advice and assistance counseling. Cash benefits can be used to purchase nonmedical services and supports that the beneficiary needs to maintain personal and financial independence. PHSA Sec. 3205)

Division B – Medicare and Medicaid Changes

I. Delivery System Reforms

A. Provisions Relating to Hospitals (Medicare Part A)

Provision	House Tri-Committee Bill	Senate HELP
Market Basket Changes	The bill makes a number of adjustments to the market basket updates for various facilities, including: • Freeze the market basket updates for the 2nd, 3rd, and 4th quarters of FY 2010 for skilled nursing facilities (SNFs). (sec. 1101) (+$26 billion) • Freeze the market basket updates for the 2nd, 3rd, and 4th quarters of FY 2010 inpatient rehabilitation facilities. (sec. 1102) (+$5.3 billion).	No provisions. (Senate HELP Committee does not have jurisdiction over Medicare or Medicaid.)
Incorporate Productivity Adjustments in Market Basket Updates that Do Not Already Have Them	Amend sec. 1886(b)(3)(B) of the Social Security Act to incorporate productivity adjustments (defined as a reduction in the market basket percentage equal to the percentage change in the 10-year moving average of annual economy-wide private nonfarm business multi-factor productivity) to the market basket updates for: • Inpatient acute hospitals; (+$84.7 billion) • SNFs, as calculated by the HHS Secretary; • Long-term care hospitals for discharges occurring during the rate year 2010 and thereafter; (+$3.7 billion) • Inpatient rehabilitation facilities; • Psychiatric hospitals for discharges occurring • during the rate year beginning in 2011; (+$3.4 billion) • Hospice care after the market basket percentage increase beginning in FY 2010 (+$9.8 billion) In the case of inpatient acute hospitals, SNFs, and inpatient rehabilitation facilities, the productivity adjustments also would apply to annual increases for fiscal years beginning with FY 2010. Sets a floor for inpatient market basket updates so that they will not go below zero. (sec. 1103)	
Payments to SNFs	Directs the HHS Secretary to conduct, using calendar year 2006 claims data, an initial analysis comparing total payments for SNFs under the RUG-53 and RUG-44 classification systems. Based on that initial analysis, the Secretary shall adjust the case mix indices for FY 2010 by the appropriate recalibration factor as proposed in the FY 2010 Notice of Proposed Rulemaking for the Medicare SNF prospective payment system issued on May 12, 2009. Provides a budget neutral adjustment within the payment system to improve payment accuracy for non-therapy ancillary services and therapy services. Directs the Secretary to analyze payments for non-therapy ancillary	

Provision	House Tri-Committee Bill	Senate HELP
	services for inclusion in a future SNF case mix reclassification system, and creates an outlier payment for nontherapy ancillary services. (sec. 1111) (+$6 billion)	
Medicare Disproportionate Share Hospital (DSH) Report and Payment Adjustments	Requires the HHS Secretary, not later than 1/01/2016, to submit a report to Congress on Medicare DSH taking into account the impact of the health care reforms under Division A in reducing the number of uninsured. The report shall include recommendations relating to (1) the appropriate amount, targeting, and distribution of Medicare DSH to compensate for higher Medicare costs associated with servicing low-income beneficiaries, and (2) the appropriate amount, targeting, and distribution of Medicare DSH to hospitals given their continued uncompensated care costs, to the extent that such costs remains. Beginning in FY 2017, payment adjustments would be made to DSH based on the amount of decrease in the national rate of the uninsured. (sec. 1112) (+$10.2 billion)	
Extension of Hospice Regulation Moratorium	*Ways and Means Chairman's amendment in the nature of a substitute extends the hospice moratorium regulation enacted in sec. 4301(a) of the American Recovery and Reinvestment Act through FY 2010. (new sec. 1113)*	

B. Provisions Affecting Providers (Medicare Part B)

Provision	House Tri-Committee Bill	Senate HELP
Physicians' Services	Changes payment rates for physicians' services to replace the 21% reduction in payment rates scheduled for January 1, 2010 under the "sustainable growth rate" formula, with an inflation-based update. Updates payment rates by the Medicare Economic Index in 2010. The revised formula, which is effective for 2011 and beyond, will rebase the update adjustment factor based on actual expenditures for physician services in 2009. It will also allow primary care services to grow at a higher rate than other services, and does not reduce physician pay rates for increases in spending on drugs or lab services. Encourages physicians to form Accountable Care Organizations by providing such organizations with their own targets and update factors beginning 1/01/2012. (sec. 1121) (-$245 billion, including CBO's estimate of interactions).	

Provision	House Tri-Committee Bill	Senate HELP
Misvalued Codes under the Physician Fee Schedule	Directs the HHS Secretary to regularly review physician services, including those with a high growth rate. For purposes of identifying potentially misvalued codes, the Secretary will examine codes using specified criteria (e.g., codes where there has been the faster rate of growth, codes that have experienced substantial changes in practice expenses, etc.) Strengthens the Secretary's authority to adjust fees schedule rates that are found to be misvalued or inaccurate. (sec. 1122) (+$.2 billion)	
Payments for Efficient Areas	Provides incentives payments to physicians practicing in areas that are identified as the most cost-efficient areas of the country. Sets forth criteria for identification of efficient areas and precludes administrative or judicial review of the Secretary's determinations. (sec. 1123) (+$.5 billion)	
Modifications to Physician Quality Reporting Initiative (PQRI)	Extends through 2012 payments under the PQRI program, which provide incentives to physicians who report quality data to Medicare. Creates a review process for physicians who choose to have their PQRI submissions reviewed and directs the Secretary to integrate the PQRI program and the "meaningful use" measures used by the health information technology incentive program. (sec. 1124) (+$1.6 billion)	
Adjustment to Medicare Payment Localities	Provides for a transition to use of Medical Savings Accounts (MSAs) as the method used to determine the localities used for Medicare's geographic adjustment factor in California. (sec. 1125) (+$.3 billion)	
Measure Physicians' Utilization of Services	*E&C Chairman's amendment in the nature of a substitute requires the HHS Secretary to measure physicians' utilization of services under Medicare and report such information to individual physicians in order to permit physicians to compare their patterns of utilization with their peers. Permits the Secretary to target the application of the program and dissemination of the report to physicians who practice in geographic areas with high utilization, physicians with high service use, or in other ways as appropriate. Allows physicians to opt out from receiving such reports. (new sec. 1126)*	
Medicare Part B Market Basket Updates	Incorporates a productivity adjustment to the market basket update for outpatient hospital services beginning 1/1/2010, setting a floor so the update will not be below zero. Incorporates a productivity adjustment beginning 1/1/2010, for ambulance services and ambulatory surgical centers. Incorporates a productivity factor for durable medical equipment not subject to competitive bidding effective 7/01/2012. Replaces the existing update for laboratory services of CPI minus 0.5 with an update of CPI less productivity, beginning in 2010. (sec. 1131) (+$40.1 billion)	

Provision	House Tri-Committee Bill	Senate HELP
Other Part B Provisions	Makes a number of adjustments to Part B, including: • Rental and purchase of power-driven wheelchairs, effective 1/01/2011. (sec. 1141) (+$.8 billion) • Cancer Hospitals – HHS Secretary to study whether existing cancer hospitals that are exempt from the inpatient prospective payment system (PPS) have costs under the outpatient PPS that exceed costs of other hospitals, and to make payment adjustments to the outpatient PPS based on the study. (sec. 1145) • Places $8 billion in the Medicare Improvement Fund under sec. 1898(b) of the Social Security Act (which is available to the Secretary to make improvements under the original fee-for-service program under parts A and B for individuals entitled to, or enrolled for, benefits under part A or enrolled under part B). (sec. 1146) (+$22.3 billion with interactions with sec. 1158 relating to revision of Medicare payment systems to address geographic inequities). • Requires ambulatory surgical centers to submit cost and other data. • Makes several changes to the durable medical equipment program. (sec. 1148) (-$.1 billion)	
Payment Rates for Imaging Services	Adjusts the payment rates for imaging services: (1) provides for an adjustment in practice expense relative value units with respect to advanced diagnostic imaging services from a presumed rate of 50% of utilization of imaging equipment to a presumed rate of 75%, and (2) adjusts the technical component discount on single-session imaging involving consecutive body parts from 25% to 50%. Changes are effective for services on or after 1/01/2011. (sec. 1147) (+$4.3 billion)	
Services of Certified Respiratory Therapists	*E&C en bloc amendment by Rep. Doyle (D-PA) requires Medicare to cover services provided by certified respiratory therapists under the general supervision of a physician for the diagnosis and treatment of a respiratory illness. Requires that reimbursement for services furnished by a respiratory therapist be equal to 80% of either the actual service charge or 85% of the fee schedule for a physician providing the same service, whichever is less. Effective January 1, 2010. (new section 1149)*	
Timely Access to Post-Mastectomy Items	*E&C en bloc amendment offered by Reps. Green (D-TX) and Sutton (D-OH) to amend sec. 1834(h)(i) of the Social Security Act to provide for payment for post-mastectomy external breast prosthesis garments, regardless of whether such items are supplied prior to or after the mastectomy procedure. (new sec. 1150)*	

Provision	House Tri-Committee Bill	Senate HELP
Moratorium on Medicare Reductions in Payment Rates for Interventional Pain Management Procedures	*E&C amendment offered by Reps. Whitfield (R-KY) and Stupak (D-MI) to amend the payment rates under sec. 1833(i)(2) of the Social Security Act to provide that the payment rate for interventional pain management procedures furnished on or after 1/01/2010 and before 1/01/2012, shall not be less than the payment rate for such procedures in effect as of 1/01/2007. (new sec. 1150)*	

C. Provisions Related to Medicare Parts A and B

Provision	House Tri-Committee Bill	Senate HELP
Hospital Readmissions	Beginning in FY 2012, adjusts payments for inpatient hospitals, critical access hospitals and hospitals paid under 1814(b)(3) of the Social Security Act (cancer hospitals reimbursed for services pursuant to a reimbursement system approved as a demonstration project under section 402 of the Social Security Amendments of 1967 or section 222 of the Social Security Amendments of 1972). Adjustments are based on the dollar value of each hospital's percentage of potentially preventable Medicare readmissions for 3 conditions with risk-adjusted readmission measures endorsed by the National Quality Forum. Directs the HHS Secretary to expand the policy to additional conditions in future years and authorizes the Secretary to modify the adjustment based on a hospital's performance in readmissions compared to a ranking of hospitals nationally. Provides assistance to certain hospitals for transitional care activities to address patient noncompliance issues that may result in high readmission rates. Prohibits administrative and judicial review of the determination of base operating diagnostic related group (DRG) payment amounts, the methodology for determining the adjustment factor, or the measures of readmissions. Creates an interim readmissions policy for post-acute providers beginning in FY 2012, and directs the Secretary to develop risk adjusted readmission rates for post-acute providers and implements a readmissions payment system for those providers similar to the hospital system on or after FY 2015. Directs the HHS Secretary to submit a report to Congress within one year of enactment on how physicians can be incorporated into the readmissions policy. Directs the Secretary to monitor inappropriate changes in admission practices by hospitals and post-acute providers and authorizes the Secretary to penalize providers that are avoiding patients at risk of a readmission. (sec. 1151) (+$19.1 billion)	

Provision	House Tri-Committee Bill	Senate HELP
Post-Acute Care Services Payment Reform	Directs the HHS Secretary to submit a detailed plan to Congress considering specific issues within three years after enactment on how to implement post-acute bundled payments (services furnished by SNFs, inpatient rehabilitation facilities, long term care hospitals, hospital based outpatient rehabilitation facilities and home health agencies). Converts the existing Acute Care Episode demonstration project to a pilot program and expands it to include bundling of payments for hospitals and post-acute care providers, effective 1/1/2011; requires a study and demonstration for bundling of payments for outpatient services. *Ways and Means Chairman's amendment in the nature of a substitute clarifies the types of bundled payments included, requires an evaluation of the pilot program, and adds a study on and demonstration authority for bundling of payments for outpatient services.* (sec. 1152)	
Market Basket Update for Home Health Care	Freezes the market basket update for home health agencies for 2010. (sec. 1153) (+$7.7 billion)	
Payment Adjustments for Home Health Care	Accelerates the regulatory adjustment for case mix changes scheduled for 2011 to 2010; directs the HHS Secretary to rebase the home health prospective payment system amount for 2011, taking specific factors into account. (sec. 1154) (+$34.2 billion)	
Incorporating Productivity Improvements in Market Basket Update for Home Health Services	Incorporates productivity improvements into the market basket for home health care services beginning in 2010. Sets a floor for the home health market basket so that the combination of the productivity adjustment and any adjustments for quality reporting cannot cause the market basket update to go below zero. (sec. 1155) (+$14.9 billion)	
Limitation on Medicare Exceptions to the Prohibition on Physician Referrals to Hospitals	Limits Medicare exceptions to the prohibition on certain physician referrals to hospitals in which they have a financial interest; prohibits physician ownership in new hospitals as of 1/01/2009; grandfathers ownership structures of physician-owned hospitals existing prior to 1/01/2009, but generally prohibits them from expanding facilities (i.e., prohibits increases in operating rooms, procedure rooms and beds in existence as of 1/1/2009). Provides a process under which a hospital can apply for an exception to the prohibition up to once every 2 years. (sec. 1156) (+$1 billion)	

Provision	House Tri-Committee Bill	Senate HELP
Institute of Medicine Study of Geographic Adjustment Factors	Requires the HHS Secretary to enter into a contract with the Institute of Medicine to conduct a comprehensive study of the validity and accuracy of the geographic adjusters used for Medicare physician and hospital payments, and provide a report and recommendations for improvements to CMS within one year of enactment. (sec. 1157)	
Revise Medicare Payment Systems to Address Geographic Inequities	CMS is instructed to respond to recommendations under section 1157 and publish proposed rules to implement changes to payment systems for physicians and hospitals and proposals to revise geographic adjustment factors for such payment systems. The HHS Secretary is authorized to spend up to $4 billion per year, for two years, to effect any needed increases in payment rates. (sec. 1158) (+$8 billion)	
Institute of Medicine Study of Geographic Variation in Health Care Spending	*Ways and Means Chairman's amendment in the nature of a substitute initiates a study by the Institute of Medicine on geographic variation in health care spending, and directs the Institute to make recommendations on how to incentivize providers to furnish high-value care. (new sec. 1159)*	

D. Medicare Advantage Reforms

Provision	House Tri-Committee Bill	Senate HELP
Phase-in of Payment Based on Fee-for-Service Costs	Phases in changes to Medicare Advantage (MA) payments by adjusting blended benchmarks to fee-for-service levels over three years, reaching 100% of fee-for-service payment rates in 2013. (sec. 1161) (+$156.3 billion)	
Quality Bonus Payments	Creates an incentive system to increase payments to high quality MA plans and plans that demonstrate improvement, phased-in over 2011-2013, consistent with the changes in section 1161. *Ways and Means Chairman's amendment in the nature of a substitute clarifies which plans are eligible for bonus payments, increases bonus payments for eligible plans, and eliminates bonus payments to improved plans. Defines a qualifying plan to be a plan that had a quality ranking in a preceding year defined by the Secretary of four stars or higher based upon the quality ranking system established by CMS.* *Defines a quality county to meet all of the following conditions:* • *the county is in the lowest quartile of counties in per capita FFS spending;* • *as of June of the specified year, at least 50% of all Medicare beneficiaries were enrolled in an MA plan; and;*	

Provision	House Tri-Committee Bill	Senate HELP
	• *as of such date, at least 50% of all beneficiaries enrolled in an MA plan were enrolled in a plan with four stars or higher.* *Provides that the Secretary may determine that an MA plan is not a qualifying plan as a result of deficiencies in compliance with applicable MA rules, and requires notification to MA plans of quality bonus payment adjustments at the time of the annual MA rate announcement on the first Monday in April each year and requires publication of this information on the CMS website.* *E&C amendment by Rep. Gonzalez (D-TX) directs CMS to issue a study within one year of enactment on the effect of "calculating MA payment rates on a more aggregated geographic basis" such as a metropolitan statistical area "or other regional delineations." Requires CMS to consult with experts in health care financing, representatives of foundations and other non-profit entities that have supported research of MA payment issues and representatives of MA plans when conducting this analysis.* (sec. 1162) (CBO estimates that quality bonus payments will increase spending by -$9.6 billion, not taking into account Chairman's amendment).	
Coding Intensity Adjustment Authority	Extends CMS's authority to adjust risk scores in MA for observed differences in coding patterns relative to fee-for-service. (sec. 1163) (+$15.5 billion)	
Other Revenue Neutral MA Changes	Makes a number of revenue neutral changes to MA plans, including: • simplification of annual beneficiary period elections (sec. 1164); • extension of reasonable cost contracts (sec. 1165); • restricts the ability of MA plans to offer coverage outside their service area and grandfathers current contracts (sec. 1166); • requires a study of the effectiveness of MA risk adjustment system for low-income and chronically-ill populations. (sec. 1167)	
Elimination of MA Regional Plan Stabilization Fund	Eliminates the MA regional plan stabilization fund. (sec. 1168) (+$.2 billion)	
Beneficiary Protections and Anti-Fraud	Provides for several revenue neutral beneficiary protections and anti-fraud measures, including: • Places limits on cost-sharing for individual health services to ensure that beneficiaries in MA plans do not have higher cost-sharing than they would face in fee-for-service Medicare, and provides that beneficiaries dually eligible for Medicare and Medicaid are not subject	

Provision	House Tri-Committee Bill	Senate HELP
	to higher cost-sharing than they would face under Medicaid were they not enrolled in Medicare. (sec. 1171) • Provides for continuous open enrollment for enrollees in plans with enrollment suspension. (sec. 1172) • Requires CMS to publish standardized information on medical loss ratios and other plan information to beneficiaries and the public. For plans with medical loss ratios below 85%, requires rebates and increasing penalties over time, including eventual termination of contracts. (sec. 1173) • Strengthens the ability of CMS to recover overpayments to plans discovered by audits. (sec. 1174) • Clarifies that CMS is not obligated to accept any or every bid submitted by a MA or Part D plan. (sec. 1175)	
Treatment of Special Needs Plans	Amends Special Needs MA Plans (SNPs) to: • Limit enrollment into SNPs effective 1/01/2011 other than through the annual open enrollment period or the time of the diagnosis of the disease or condition that qualifies the individual for SNPs. (sec. 1176) • SNPs are reauthorized through 12/31/2013 (unless the SNP had a contract with the State to provide an integrated Medicare-Medicaid SNP, in which case the reauthorization is through 12/31/2016). (sec. 1177)	
Standardized Marketing Requirements Applicable to MA and Part D Program	*E&C amendment by Rep. Castor (D-FL) adds a new section requiring the HHS Secretary to request NAIC to develop standardized marketing requirements for MA plan sponsors and makes the same requirements applicable to Part D plan sponsors. Provides that the requirements must include, in addition to the prohibitions and limitations in current law:* • *Prohibition on completion of any portion of the election form by a MA or Part D plan sponsor.* • *Agent/broker commission standards that ensure incentives for brokers and agents to enroll beneficiaries in the MA or Part D plan that is intended to best meet their needs.* • *Standards for the conduct of agents engaged in on-site promotion at a facility of an organization with which the Medicare Advantage organization or PDP sponsor has a co-branding relationship.* • *Such other standards relating to unfair trade practices and marketing as the NAIC determines appropriate.* *Requires the NAIC to submit the requirements to the HHS Secretary not later than 9 months after enactment. Requires the Secretary to promulgate regulations adopting the requirements, which would be effective for the first open*	

Provision	House Tri-Committee Bill	Senate HELP
	enrollment period beginning 12 months after enactment. If the NAIC does not act, requires the Secretary to develop the requirements. Requires the Secretary to submit an annual report to Congress on the enforcement of the standardized marketing requirements, including a list of any alleged violations and their disposition. Changes scope of preemption to permit State enforcement of the standardized marketing requirements and provides that State laws enacting the standardized marketing requirements are not preempted. Specifies that State market conduct examinations and State imposition of sanctions against MA or Part D plan sponsors or their agents or brokers for violations of the standardized marketing requirements are not preempted. (new sec. 1906)	

E. Changes to Medicare Part D (Prescription Drug Benefits)

Provision	House Tri-Committee Bill	Senate HELP
Elimination of Coverage Gap	Eliminates Part D coverage gap (i.e., "donut hole"), beginning with a $500 reduction in 2011. Beginning in 2011, provides for a phased increase of the initial coverage limit and a phased decrease in the annual out of pocket threshold, eliminating the donut hole by 2023.	
Prescription Drug Rebates for Dual Eligibles	Requires prescription drug manufacturers to provide drug rebates for full-benefit dual eligibles, effective 1/01/2011). (sec. 1181); and (CBO estimates that secs. 1181 and 1182 combined will raise +$29.7 billion)	
Discounts for Certain Part D Drugs in Original Coverage Gap	Requires prescription drug manufacturers to provide 50% discounts for brand-name drugs and biologics used by Part D enrollees in the Part D donut hole. (sec. 1182)	
Repeal Provision Relating to Submission of Claims by Pharmacies	Eliminates deadlines for long-term care pharmacists to file Part D claims to allow more time for improved coordination with State Medicaid programs. (sec. 1183)	
Include Costs Incurred by AIDS Drug Assistance Programs and Indian Health Service toward Part D Out-of-Pocket Threshold	Allows drugs provided to patients by AIDS Drug Assistance Programs or the Indian Health Service to count toward out-of-pocket costs, allowing these individuals to qualify for Part D catastrophic benefits. (sec. 1184) (-$.8 billion)	
Permit Mid-year Changes in Enrollment	Allows Part D enrollees to change drug plans if the plan makes a change to the formulary that increases cost-sharing or otherwise reduces coverage. (sec. 1185)	
Negotiation of Lower Covered Part D Drug Prices	*E&C amendment offered by Rep. Schakowsky (D-IL) and others) to amend sec. 1860D-11 of the Social Security Act by striking subsection (i) (relating to noninterference) and inserting a new subsection (i) requiring the Secretary to*	

Provision	House Tri-Committee Bill	Senate HELP
	negotiate drug prices with pharmaceutical manufacturers for all covered Part D drugs for Part D eligible individuals. Requires semi-annual reports to Congress beginning 6/01/2011) on negotiations conducted by the Secretary, and the prices and price discounts achieved. (new sec. 1186)	

F. Medicare Rural Access Protections

Provision	House Tri-Committee Bill	Senate HELP
Telehealth Expansions	Expands Medicare's telehealth benefit to beneficiaries who are receiving care at freestanding dialysis centers. Also establishes a Telehealth Advisory Committee to provide HHS with additional expertise on the telehealth program. *Ways and Means Chairman's amendment in the nature of a substitute adds a new subsection that provides additional means for credentialing of telehealth providers.* (sec. 1191)	
Extension of Outpatient Hold Harmless Provision	Extends the existing outpatient hold harmless provision through FY 2011. (sec. 1192) (-$.4 billion)	
Extension of Sec. 508 Hospital Reclassifications	Extends reclassifications under section 508 of the Medicare Modernization Act through FY 2011 (i.e., certain specific rural hospitals that were deemed by that Act to be reclassified to another area within the State. (sec. 1193) (-$.5 billion)	
Extension of Geographic Floor for Work	Extends a floor on geographic adjustments to the work portion of the fee schedule through the end of 2011, with the effect of increasing practitioner fees in rural areas. (sec. 1194) (-$1.3 billion)	
Extension of Payment for Technical Component of Certain Physician Pathology Services	Extends a provision that directly reimburses qualified rural hospitals for certain clinical laboratory services through the end of 2011. (sec. 1195) (-$.2 billion)	
Extension of Ambulance Add-ons	Extends bonus payments made by Medicare for ground and air ambulance services in rural and other areas through the end of 2011. (sec. 1196) (-$.1 billion)	
Ensuring Proportional Representation of Interests of Rural Areas on MedPAC	*E&C amendment offered by Rep. Walden (R-OR) to provide that the proportion of members of Medicare Payment Advisory Commission (MedPAC) who represent the interests of health care providers and beneficiaries located in rural areas shall be no less than the proportion of the total number of Medicare beneficiaries who reside in rural areas. Applies to appointments to MedPAC made after the date of enactment. (new sec. 1197)*	

G. Miscellaneous Medicare Provisions

Provision	House Tri-Committee Bill	Senate HELP
Miscellaneous Medicare Beneficiary Improvements for Low-Income Beneficiaries	Makes a number of changes to improve and simplify financial assistance for low-income Medicare beneficiaries, including increasing assets test for eligibility for the Part D low-income subsidy and Medicare Savings Programs to $17,000 for individuals and $34,000 for couples indexed annually by CPI. (secs. 1201-1207) (CBO estimates that the combined effect of these provisions is -$11.9 billion.)	
Extension of Therapy Caps Exceptions Process	Extends the process allowing exceptions to limitations on medically necessary therapy through 2011. (sec. 1231) (-$1.8 billion)	
Immunosuppressive Drugs for Kidney Transplant Patients	Lifts the current 36-month limitation on Medicare coverage of immunosuppressive drugs for kidney transplant patients who would otherwise lose this coverage on or after January 1, 2012 and makes technical changes to the bundled payment system for End Stage Renal Disease. (sec. 1232) (-$.4 billion)	
Advance Care Planning Consultation	Provides coverage for consultation between enrollees and practitioners to discuss advance care planning for end-of-life services including advance medical directives for life-sustaining treatment. Instructs CMS to modify 'Medicare & You' handbook to incorporate information on end-of-life planning resources and to incorporate measures on advance care planning into the physician's quality reporting initiative. (sec. 1233) (-$2.7 billion)	

H. Promoting Primary Care, Mental Health Services, and Coordinated Care

Provision	House Tri-Committee Bill	Senate HELP
Accountable Care Organization Pilot	Provides that the HHS Secretary shall conduct a pilot program to test specific payment incentive models (including a performance target model and a partial capitation model) within fee-for-service Medicare to reward physician-led accountable care organizations that reduce the growth of expenditures and improve health outcomes in the provision of items and services to their patient panel over time. Accountable Care Organizations (ACOs) can include groups of physicians organized around a common delivery system (including a hospital), an independent practice association, a group practice, or other common practice organizations. ACOs can include nurse practitioners and physician assistants and other providers as designated by the ACO. The pilot must begin no later than 1/01/2012 and may cover a period of 3-5 years. *Ways and Means Chairman's amendment in the nature of a*	

Provision	House Tri-Committee Bill	Senate HELP
	substitute clarifies that physicians from various specialties can be the primary point of care for beneficiaries in ACOs. *E&C Chairman's amendment in the nature of a substitute requires the HHS Secretary to set specific goals for the number of ACOs, participating practitioners, and patients served and to ensure that the pilot program includes urban, rural and underserved areas. Requires the Secretary to disseminate the pilot program rapidly on a national basis. Instructs the Secretary to implement this model on as large a geographic scale as practical and economical if it is found to be successful in improving quality while reducing costs.* *E&C en bloc amendment by Rep. Doyle (D-PA) directs the HHS Secretary to attempt to attract at least 10% of all eligible providers to act as ACOs and implement such mechanisms and reforms within 5 years of enactment. If successful, requires the Secretary to implement such mechanisms and reforms on as large a geographic scale as practical and economical.* (sec. 1301) (+$2.0 billion)	
Medical Home Pilot	Provides that the HHS Secretary shall conduct a medical home pilot program to assess the feasibility of reimbursing for qualified patient-centered medical homes. The pilot will test two models: (1) the "independent patient-centered medical home", structured around a provider, which is targeted at the top half of high-need Medicare beneficiaries with multiple chronic diseases. *(E&C amendment offered by Rep. Green (D-TX) adds "individuals with cognitive impairment that leads to functional impairment")*. The pilot of this model must begin 6 months after enactment. (2) The "community based medical home", is targeted at a broader population of Medicare beneficiaries with chronic diseases and allows for State-based or non-profit entities to provide care-management supervised by a beneficiary designated primary care provider. This model must begin no later than 2 years of enactment. Provides approximately $1.6 billion from the Trust Fund for the 5-year pilot programs. *Ways and Means Chairman's amendment in the nature of a substitute adds physician assistants to the definition of primary care for purposes of the Medical Home Pilot.* *E&C Chairman's amendment in the nature of a substitute requires the HHS Secretary to set specific goals for the number of practices, communities, and patients served under the pilot program and ensure that it includes urban, rural and underserved areas. Requires the Secretary to*	

Provision	House Tri-Committee Bill	Senate HELP
	disseminate the pilot program rapidly on a national basis. Instructs the Secretary to implement this model on as large a geographic scale as practical and economical if it is found to be successful in improving quality while reducing costs. (sec. 1302) (-$1.8 billion)	
Payment Incentive for Primary Care Services	Increases the Medicare payment rate for primary care services of physicians specializing in primary care by 5% (10% in the case of practitioners predominating furnishing services in an area designed as a primary care health professional shortage area). Physicians specializing in primary care are defined both by specialty (e.g., family practitioners, internists, and others) and by share of a practice in primary care (at least 50% of allowed charges are for primary care services). Effective for services furnished on or after 1/01/2011. *Ways and Means Chairman's amendment in the nature of a substitute clarifies that a physician supervises physician assistants. (E&C substitute makes a similar clarification.)* (sec. 1303) (-$6.4 billion)	
Independence at Home Pilot	*E&C amendment by Rep. Markey (D-MA) creates a pilot program to test a payment incentive and service delivery model that utilizes physician and nurse practitioner directed home-based primary care teams. Tests whether this model reduces preventable hospitalizations, prevents hospital readmissions, reduces ER visits, and other quality objectives. A 'qualifying independence at home medical practice' means a physician or nurse practitioner or group of such providers who have experience and training in providing home-based primary care services to high cost chronically ill patients; care is provided by a team of providers with experience in home-based primary care, who make in-home visits, and carry out plans of care that are tailored to the individual patient. Grants a home medical practice 80% of the savings in excess of 5% if expenditures for patients in the pilot program are at least 5% less than a target spending level or rate of growth. Requires the pilot program to begin no later than January 1, 2012. (new sec. 103)*	
Increased Reimbursement for Certified Nurse-Midwives	Increases the payment rate for nurse-midwives for covered services from 65% of the rate that would be paid were a physician performing a service to the full rate. Effective for services furnished on or after 1/01/2011. (sec. 1304) (-$.1 billion)	
Coverage and Waiver of Cost-Sharing for Preventive Services	Waives all Medicare cost-sharing (both co-insurance and deductibles) for a specific list of screening and preventive services. Effective for services furnished on or after	

Provision	House Tri-Committee Bill	Senate HELP
	1/01/2011. (sec. 1305) (-$2.8 billion) *E&C amendment offered by Rep. Green (D-TX) adds a requirement for the HHS Secretary to report to Congress within 12 months of enactment on barriers to preventive services (including abdominal aortic aneurysm screening).*	
Waiver of Deductible for Colorectal Cancer Screening Tests	Clarifies that the deductible is waived for a screening colonoscopy even if a diagnosis is established as a result of a test or tissue is removed during the procedure. Effective for services furnished on or after 1/01/2011. *Ways and Means Chairman's amendment in the nature of a substitute adds reference to waiving co-payments and deductibles for beneficiaries undergoing screening colonoscopy and ancillary tissue removal.* (sec. 1306)	
Exclude Clinical Social Worker Services from Coverage Under Medicare SNF PPS and Consolidated Payment	Removes clinical social worker services from coverage under the SNF PPS, which allows clinical social workers to bill separately for their services in the SNF setting. Effective for services furnished on or after 7/01/2010. (sec. 1307)	
Coverage of Certain Therapy Services	Adds State-licensed or certified marriage and family therapists and mental health counselors as Medicare providers and pays them at the same rate as social workers. (sec. 1308) Effective for services furnished on or after 1/01/2011. (-$.5 billion)	
Extension of Physician Fee Schedule Mental Health Add-on	Extends the 5% add-on payment rate for psychiatric services two years, through the end of 2011. (sec. 1309) (-$.1 billion)	
Expanding Access to Vaccines	Transfers coverage from Medicare Part D to Medicare Part B for all Medicare-covered vaccines. Vaccines other than for influenza will be paid for according to the average sales price methodology. Effective for vaccines administered on or after 1/01/2011. (sec. 1310) (-$1.5 billion)	
Expansion of Medicare-Covered Preventive Services at Federally-Qualified Health Centers (FQHCs)	*Ways and Means Chairman's amendment in the nature of a substitute expands the number of preventive services reimbursed by Medicare when furnished by FQHCs. (new sec. 1311)*	
Certified Diabetes Educators	*E&C amendment by Rep. DeGette (D-CO) adds "Certified Diabetes Educators" as certified providers for purposes of Medicare diabetes outpatient self-management training services. Outlines process for such providers to be certified. (new sec. 1311)*	

I. Quality Provisions

Provision	House Tri-Committee Bill	Senate HELP
Comparative Effectiveness Research	Establishes a Center for Comparative Effectiveness Research (CCER) within the Agency for Healthcare Research and Quality (AHRQ) to conduct, support and synthesize research with respect to the comparative effectiveness of the full spectrum of health care items, services, and systems, including pharmaceuticals, medical devises, medical and surgical procedures and other medical interventions. Establishes an independent Comparative Effectiveness Research Commission to oversee and evaluate the activities of the Center. The 17-member Commission will be appointed by the HHS Secretary with input from the Comptroller General and the Institute of Medicine and will include the director of AHRQ, the Chief Medical Officer of CMS and additional members representing stakeholders such as clinicians, patients, researchers, third-party payers and consumers. Clinical perspective advisory panels will provide advice on specific research questions, methods and gaps in evidence in terms of clinical outcomes for priorities identified by the Commission in order to ensure that the research is clinically relevant. Duties of the Commission include: • determining national priorities for research and in making such determinations consult with a broad array of public and private stakeholders, including patients, health care providers and payers; • monitoring the appropriateness and use of Comparative Effectiveness Research Trust Fund (see sec. 1802 below); • identifying highly credible research methods and standards of evidence for such research considered by CCER; • reviewing methodologies developed by CCER; • entering into an arrangement under which the Institute of Medicine of the National Academy of Sciences shall conduct an evaluation and report on standards of evidence for such research not later than 1 year after the date of enactment; • supporting forums to increase stakeholder awareness and permit stakeholder feedback on the efforts of the AHRC; • making recommendations for policies that would allow for public access of data; • appointing a clinical perspective advisory panel for each research priority to ensure that the information	

Provision	House Tri-Committee Bill	Senate HELP
	produced from such research is clinically relevant to decisions made by clinicians and patients at the point of care; • making recommendations for the priority for periodic reviews of previous comparative effectiveness research and studies conducted by CCER; • routinely reviewing processes of CCER regarding research to confirm that the information produced is objective, credible, consistent with standards of evidences and developed through a transparent process; and • making recommendations the CCER for the broad dissemination of the findings. The Commission and the advisory panels it appoints will be subject to strict conflict of interest requirements. The CCER and the Commission are prohibited from mandating coverage, reimbursement or other policies to any public or private payer. Effective on enactment. (sec. 1401) (CBO estimates reduced Medicare outlays of +$.1 billion).	
Comparative Effectiveness Research Trust Fund; Financing	The CCER and the research it conducts would be funded out of a Comparative Effectiveness Research Trust Fund (CERTF) funded initially by transfers from general revenues: • FY 2010: $90 million • FY 2011: $100 million • FY 2012: $110 million (sec. 1401) (-$1.2 billion) The fund would also be financed by a tax on health insurance policies and self-funded health plans on the basis of the number of insured individuals. The total amount of aggregate taxes to be paid by all insurers is capped at $375 million. (sec. 1802) (+$2.0 billion)	
SNF and Nursing Facility (NF) Transparency	Imposes a number of new transparency and accountability requirements on SNFs and NFs, including: • Requires SNFs and NFs to disclose information on ownership and facility organizational structure and requires the Secretary to develop a standardized format for such information within two years of date of enactment. (sec. 1411) • Requires SNFs and NFs to operate compliance and ethics programs on or after the date that is 36 months after enactment. Directs the Secretary to develop a quality assurance and improvement program for SNFs and NFs no later than December 31, 2011. (sec. 1412) • Directs the Secretary to include additional information on the Nursing Home Compare Medicare website, include staffing data based on information collected	

Provision	House Tri-Committee Bill	Senate HELP
	under sec. 1416 below and summary information on complaints filed for SNFs and NFs. (sec. 1413) • Requires SNFs to separately report expenditures for direct care services, indirect care services, capital assets, and administrative costs on cost reports for cost reporting periods beginning on or after two years after date of enactment. (sec. 1414) • Directs the Secretary to create a standardized complaint form and requires States to establish complaint resolution processes. Provides whistleblower protection for employees who complain in good faith about the quality of care or services at a facility. (sec. 1415) • Requires the Secretary to develop a program for facilities to report staffing information in a uniform format based on payroll data, including information on agency or contract staff. Effective two years after date of enactment. (sec. 1416)	
SNF and NF Enforcement Provisions	Establishes mechanisms to target enforcement with respect to SNFs and NFs, including: • Authorizes the HHS Secretary to impose civil monetary penalties on SNFs for a deficiency that results in the direct proximate cause of death of a resident, and authorizes States to impose similar civil monetary penalties on NFs. Effective 1 year after date of enactment. (sec. 1421) • Directs the HHS Secretary to establish, in consultation with the HHS Inspector General, a 2-year pilot program to develop, test and implement use of an independent monitor to oversee interstate and large intrastate chains of SNFs and NFs. The Inspector General must submit a report to the Secretary and Congress not later than 180 days after completion of the pilot, which must begin no later than 1 year after enactment. (sec. 1422) • Requires the administrator of a facility that is preparing to close to provide written notification to residents and other parties and to prepare a plan for closing that ensures safe transfer of residents to new facilities. Effective 1 year after date of enactment. (sec. 1433)	
Improved SNF and NF Staff Training	Requires SNFs and NFs to conduct dementia management and abuse prevention training of employees prior to employment and, if the Secretary determines appropriate, as part of ongoing training. Effective 1 year after date of enactment. (sec. 1431)	

Provision	House Tri-Committee Bill	Senate HELP
Study and Report on Training Required for SNF and NF Certified Nurse Aides and Supervisory Staff	Requires the Secretary to study the content of training requirements for certified nurse aides and supervisory staff of SNFs and NFs and to submit a report with recommendations on content and length of training to Congress within two years of date of enactment. (sec. 1432)	
Establishment of National Priorities for Quality Improvement	Directs the Secretary to establish national priorities for performance improvement, incorporating recommendations from outside entities. These priorities should reflect areas that contribute to a large burden of disease, have high potential to decrease morbidity and mortality and improve performance, address health disparities, and have the potential to produce the most rapid change based on current evidence. (sec. 1441)	Directs the HHS Secretary to establish a national strategy to improve the delivery of health care services, patient health outcomes, and population health. The Secretary will identify national priorities including: • addressing the health care provided to patients with high-cost chronic diseases; • improving the design, development, demonstration, dissemination, and adoption of infrastructure and innovative methodologies for quality improvement in the delivery of care; • have the greatest potential for improving health outcomes. (new sec. 399HH of the PHSA added by bill sec. 201)
Development of New Quality Measures	The HHS Secretary shall develop, test and update new patient-centered and population-based quality measures for the assessment of health care services. Provides $25 million for this section. Instructs GAO to periodically evaluate the program to determine the effectiveness of the quality measures and the extent to which these measures can result in quality improvement and cost savings, and report to Congress. (sec. 1442) (-$.3 billion)	Requires the Director of the Agency for Healthcare Research and Quality (AHRQ) to identify gaps where no exist, or existing quality measures need improvement, and award grants, contracts or intergovernmental agreements to eligible entities ('qualified consensus-based entities') for purposes of developing, improving, updating or expanding quality measures. (new sec. 299D of the PHSA added by bill sec. 203)
Multi-stakeholder Pre-rulemaking Input	Provides for stakeholder input into the use of quality measures for purposes of payment. Each year, the Secretary shall make public a list of measures being considered for usage for payment systems. Under a transparent process, a consensus-based entity shall convene a multi-stakeholder group to provide recommendations for the usage of measures in a timely fashion, and the Secretary shall consider these recommendations. (sec. 1443)	Similar to House bill. (new sec. 399JJ of the PHSA added by bill sec. 201)
Application of Quality Measures	Ensures that quality measures selected by the Secretary are endorsed by a consensus-based entity with a contract with the Secretary under section 1890, except in certain circumstances; e.g., the measure has not been evaluated and no comparable endorsed measure exists. If the Secretary chooses to use a measure that the entity considers but does not endorse, the Secretary shall include the rationale for continued use in rulemaking. Applies this standard to inpatient hospitals, physician services, and renal dialysis services. (sec. 1444)	Similar to House bill. (new sec. 399JJ of the PHSA added by bill sec. 201)

Provision	House Tri-Committee Bill	Senate HELP
Consensus-based Entity Funding	The contract amount for the consensus-based entity with a contract under section 1890(d) of the Social Security Act, is increased to $12 million for years 2010-2012. (sec. 1445)	Similar to House bill. (new sec. 399JJ of the PHSA added by bill sec. 201)
Physician Payments Sunshine Provisions	Requires manufacturers or distributors of covered drugs, devices, biologicals, or medical supplies under Medicare, Medicaid, or CHIP and physicians and other health care entities to electronically report to HHS Inspector General any payments or transfers of value (other than drug samples) made to a 'covered recipient'. The term `payment or other transfer of value' means a transfer of anything of value for or of any of the following: gifts, food, or entertainment; travel or trips; honoraria; research funding or grants; education or conference funding; consulting fees, ownership or investment interest and royalties or license fees. The term `covered recipient' means: physicians; physician group practices; any other prescriber of a covered drug, device, biological, or medical supply; pharmacies or pharmacists; health insurance issuers, group health plans, or other entities offering health benefits plans, including any employee of such an issuer, plan, or entity; pharmacy benefit managers, including any employee of such a manager; hospitals; medical schools; sponsors of continuing medical education programs; patient advocacy or disease specific groups; organizations of health care professionals; biomedical researchers; and group purchasing organizations. Requires hospitals or entities that bill Medicare to report any ownership share by a physician. The HHS Secretary shall establish procedures to ensure that, not later than 9/30/2011, and on June 30 of each year thereafter, the information submitted under subsections (a) and (b), other than information regarding drug samples, with respect to the preceding calendar year is made available through an Internet website that is searchable and clear and understandable. This information will include, among other things, the name of the applicable manufacturer or distributor, the name of the covered recipient, the business address of the covered recipient, the specialty (if applicable) of the covered recipient, the value of the payment or other transfer of value, the date on which the payment or other transfer of value was provided to the covered recipient, the form of the payment or other transfer of value. Failure to report is subject to civil monetary penalties. Effective 3/31/2011 and annually thereafter. (sec. 1451)	No provision.

Provision	House Tri-Committee Bill	Senate HELP
Reporting by Hospitals and Ambulatory Surgical Centers on Infections	Requires hospitals and ambulatory surgical centers to report public health information on healthcare-associated infections to the Centers for Disease Control and Prevention. (sec. 1461)	

J. Medicare Graduate Medical Education

Provision	House Tri-Committee Bill	Senate HELP
Distribution of Unused Residency Provisions	Directs the HHS Secretary to redistribute residency positions that have been unfilled for the prior 3 cost reports and direct those slots for training of primary care physicians. Preference will be given to programs that saw a reduction in their slots under this section, have formal arrangements to train residents in ambulatory settings or shortage areas, operate 3-year primary care residency programs, currently operate residency programs over their cap, or are located in States with a low physician resident to general population ratio. The Secretary shall distribute the increase in primary care residency positions to qualifying hospitals no later than 7/01/2011. (sec. 1501)	
Increasing Training in Non-provider Settings	Modifies rules governing when hospitals can receive indirect medical education (IME) and direct graduate medical education (DGME) funding for residents who train in a non-provider setting so that any time spent by the resident in a non-provider setting shall be counted toward DGME and IME if the hospital incurs the costs of the stipends and fringe benefits. Directs the HHS Inspector General to study the level of training in non-provider setting and report to Congress not later than 4 years after date of enactment. Establishes a demonstration project whereby approved teaching health centers (which may be non-provider settings such as rural health clinics and Federally-qualified health centers) may become a primary care training program and receive DGME and the DGME of its contracting hospitals for such residents. (sec. 1502)	
Rules for Counting Resident Time	Modifies current law to allow hospitals to count resident time spent in didactic conferences toward IME costs in the provider (i.e., hospital) setting and toward DGME in the non-provider (i.e., non-hospital) setting. (sec. 1503)	
Preservation of Resident Cap Positions from Closed Hospitals	Directs the HHS Secretary to redistribute medical residency slots from a hospital that closes on or after the date that is 2 years before the enactment of this clause to other hospitals in the same State, taking into account recommendations by the senior health official in the State. Such recommendations shall be submitted not later than 180 days after the date of	

Provision	House Tri-Committee Bill	Senate HELP
	the hospital closure involved, or in the case of a hospital that closed within two years of date of enactment, not later than 180 days after enactment. (sec. 1504)	
Improving Accountability for Approved Medical Residency Training	Sets goals for approved medical residency training programs, including: (1) training to work in non-acute traditional settings; (2) coordination of care within and across settings; (3) understanding cost and value of diagnostic and treatment options; (4) working in multi-disciplinary teams; (5) participating in quality improvement projects; and, (6) demonstrating meaningful use of electronic health records in improving quality of patient care. Directs the GAO to evaluate the extent to which residency training programs are meeting the goals cited. (sec. 1505) (CBO estimates that the combined effect of secs. 1501-1505 is -$1.5 billion)	

K. Medicare Waste, Fraud and Abuse; Program Integrity

Provision	House Tri-Committee Bill	Senate HELP
Increased Funding to Fight Fraud and Abuse	Provides an additional $100 million annually in funding for the Health Care Fraud and Abuse Control Fund. Allows expanded use of funds by the CMS Medicare Integrity Program. (sec. 1601)	
Enhanced Penalties for Fraud and Abuse	The bill contains a number of enhanced penalties designed to combat fraud and abuse in the Medicare program, including: • Establishes civil monetary penalties of $50,000 per violation for providers, suppliers, MA, or Part D plans that knowingly make false Statements or misrepresentation of material fact on enrollment applications for any Federal health care program. (sec. 1611) • Establishes civil monetary penalties of $50,000 per violation for knowing submission of false statements or misrepresentation of material facts in information submitted to support a claim for payment. (sec. 1612) • Establishes civil monetary penalties of $15,000 per day for delaying or refusing to grant timely access to the HHS OIG for audits, investigations, or evaluations. (sec. 1613) • Requires the HSS Secretary to take immediate action to remedy any violation in a hospice facility that jeopardizes the health and safety of patients. Allows intermediate sanctions (e.g., civil monetary penalties, suspension or partial payments, etc.) for violations that do not endanger patients. (sec. 1614)	

Provision	House Tri-Committee Bill	Senate HELP
	• Establishes civil monetary penalties of $50,000 per violation for any person who orders or prescribes an item or service while excluded from a Federal health care program if that person knows or should know that the program from which they are excluded will be billed for the item or service. (sec. 1615) • Establishes civil monetary penalties for misrepresentations or false information provided by an MA or Part D plan of up to three times the payment made to the plan or plan sponsor based on the misrepresentation or false information. (sec. 1616) • Establishes new criteria for determining marketing violations, and provides greater discretion to the Secretary or the CMS Administrator to impose penalties on MA and Part D plans that violate marketing requirements. (sec. 1617) • Allows for permissive exclusion of individuals or entities found to have obstructed an investigation into or audit of fraud. (sec. 1618) • Clarifies definition of exclusion of Medicare and Medicaid entities under section 1128 to mean exclusion from all Federal health care programs. (sec. 1619) (CBO estimates the savings from all waste, fraud and abuse, and program integrity changes is $+1.3 billion)	
Enhanced CMS Program Protection Authority	Allows HHS Secretary to designate program areas of 'significant risk' requiring enhanced oversight to prohibit waste, fraud, and abuse. Directs the Secretary to establish screening procedures for new providers (e.g., licensing board checks, screening lists for those excluded from other health programs, background checks, unannounced pre-enrollment or other site visits). Allows for enhanced oversight periods (to include site visits, prepayment review, enhanced claims review) for new providers or suppliers in high risk areas, and allows for a moratorium on enrollment of new suppliers or service providers in high risk areas if the Secretary determines that there would be no adverse impact on beneficiaries. (sec. 1631)	
Enhanced Medicare, Medicaid and CHIP Disclosures	Requires new suppliers or providers of services to disclose affiliations within the past 10 years with any provider or supplier that has uncollected debt or has been suspended from Medicare, Medicaid, or CHIP. (sec. 1632)	
Requires Providers and Suppliers to Fight Fraud and Abuse	Requires all providers and suppliers (other than physicians) to adopt compliance programs and authorizes the Secretary to disenroll a supplier or impose civil monetary penalties or other intermediate sanctions for failure to establish such a program. (sec. 1635)	

Provision	House Tri-Committee Bill	Senate HELP
Maximum Submission Period for Medicare Claims	Reduces the period for Medicare claims submission to not more than 12 months in order to reduce "gaming" of payment systems. (sec. 1636)	
Durable Medical Equipment and Home Health Services Requirements	• Requires that physicians ordering durable medical equipment or home health services billable to Medicare must be Medicare-enrolled physicians. Allows the Secretary discretion to expand this requirement to other areas if such an extension would help reduce waste, fraud, and abuse. (sec. 1637) • Requires physician or supplier to maintain and provide upon request of the Secretary, documentation related to the ordering of durable medical equipment, home health services, or other areas of high risk. (sec. 1638) • Requires face-to-face (or telemedicine) encounter with a patient before a physician may certify home health services or durable medical equipment. Allows the Secretary discretion to expand this requirement to other areas if such an extension would help reduce waste, fraud, and abuse. (sec. 1639)	
Other Program Integrity Provisions	• Extends testimonial subpoena authority to program exclusion investigations. (sec. 1640) • Clarifies that when a provider or supplier, MA or Part D plan (but not a beneficiary) becomes aware of a Medicare or Medicaid overpayment, it must be reported and returned within 60 days. (sec. 1641) • Provides authority for the OIG to access ownership or compensation agreements between renal dialysis facilities and physicians. (sec. 1643) • Requires billing agents, clearinghouses, or other alternate payees required to be registered under Medicare and Medicaid in a form and manner to be specified by the Secretary. (sec. 1644)	

II. Medicaid, CHIP, Prevention, Access and Financing Provisions

A. Medicaid and CHIP

Provision	House Tri-Committee Bill	Senate HELP
Expand Medicaid Eligibility for Individuals with Incomes up to 133-1/3% of Federal Poverty Level	Requires State Medicaid programs to cover non-disabled, childless adults under age 65 with income at or below 133% of FPL ($14,400 per year for an individual). The additional expenditures would be subject to a 100% Federal Medical Assistance Percentage ("FMAP") for the costs of Medicaid coverage for this population. Effective 1/1/2013. (b) Requires State Medicaid programs to cover parents and individuals with disabilities under age 65 with income at or below 133% of FPL ($29,300 per year for a family of 4). Federal government would pay 100% of the costs of Medicaid coverage for individuals in these categories with incomes between the levels in effect in the State as of June 16, 2009 and 133% of FPL. Effective 1/1/2013. (c) Requires State Medicaid programs to cover newborns up to the first 60 days of life who do not otherwise have acceptable coverage upon birth. Federal government will pay 100% of the costs of Medicaid coverage for these newborns. Effective 1/1/2013. *E&C en bloc amendment offered by Rep. Ross (D-AR) and others ("Blue Dog" amendment) changes the FMAP from 100% to 90% in all of the sections noted above.* (CBO estimates the combined cost of all of the Medicaid and CHIP coverage expansions is -$438 billion, not including the effects of the Blue Dog amendment noted above.) (sec. 1701)	
Enrollment of Medicaid Eligible Individuals	Requires State Medicaid programs to enter into a memorandum of understanding with the Health Choices Commissioner to coordinate enrollment of low-income individuals into the Exchange or Medicaid as appropriate. (sec. 1702)	
CHIP and Medicaid Maintenance of Effort	Prohibits States from adopting eligibility standards, methodologies, or procedures in their CHIP programs that are more restrictive than those in effect as of June 16, 2009. Maintenance of effort ends with the opening of the Exchange in 2013 or, if later, the date on which (1) the HCC determines that the Exchange has the capacity to support CHIP enrollees and (2) the HHS Secretary determines that procedures are in effect to ensure timely transition without interruption of coverage. Prohibits States from adopting eligibility standards, methodologies, or procedures in their Medicaid programs more restrictive than those in effect on 6/16/2009. The HHS Secretary shall extend any Medicaid waiver for such a period as may be required for a State to	

Provision	House Tri-Committee Bill	Senate HELP
	meet the maintenance of effort requirements. Provides that a State is not eligible for Medicaid payments if it applies any asset or resource test in determining the eligibility of certain non-disabled populations. Effective January 1, 2013, requires any Medicaid benchmark benefit package to meet the EBP and cost-sharing requirements of a basic plan offered through an Exchange. *E&C Chairman's amendment in the nature of a substitute changes 'Effort' to 'Eligibility.'* *E&C en bloc amendment by Rep. Doyle (D-PA) adds a new provision: For purposes of establishing the CHIP maintenance of effort termination date, the HHS Secretary is to first determine that comparable coverage (as specified in section 202(g)) is available through the Exchange and that procedures have been established for transferring CHIP enrollees into acceptable coverage without interruption of coverage or a written plan or treatment.* *E&C amendment offered by Rep. Welch (D-VT) provides an exception for a certain State waiver in effect on June 16, 2009, to allow the State to apply more restrictive eligibility standards, methodologies or procedures under the waiver.* (sec. 1703)	
Reduction in Medicaid DSH	Requires the HHS Secretary to report to Congress by January 1, 2016 on the continuing role of Medicaid DSH as health reform is implemented. Directs the Secretary to reduce Medicaid DSH payments to States by a total of $10 billion ($1.5 billion in FY 2017, $2.5 billion in FY 2018, and $6.0 billion in FY 2019) using a methodology that focuses on the uninsurance rate in each State and the amount of uncompensated care provided by hospitals. *E&C en bloc amendment by Rep. Doyle (D-PA) requires the Secretary's report to also take into account the ratio of the amount of DSH funds allocated to a State to the number of uninsured individuals in such State.* (sec. 1704) (+$6.4 billion)	
Expanded Outstationing	Requires State Medicaid programs to allow adults to apply for Medicaid coverage at DSH hospitals, FQHCs, and other locations than welfare offices (requirement already applies to pregnant women and children). Effective July 1, 2010. (sec. 1705)	

B. Prevention

Provision	House Tri-Committee Bill	Senate HELP
Required Coverage of Preventive Services	Requires State Medicaid programs to cover preventive services not otherwise covered that the HHS Secretary determines are recommended by the U.S. Preventive Services Task Force and appropriate for Medicaid beneficiaries. Effective 7/1/2010. *E&C amendment by Rep. Capps (D-CA) prohibits a State from imposing deductibles, cost-sharing, or similar beneficiary charges on the "preventive services described in section 1905(z)."* (sec. 1711) (-$7.1 billion)	
Tobacco Cessation	Prohibits State Medicaid programs from excluding tobacco cessation products from coverage. Effective 7/1/2010. (sec. 1712) (-$.1 billion)	
Optional Coverage of Nurse Home Visitation Services	Allows State Medicaid programs to cover home visits by trained nurses to families with a first-time pregnant woman or child under 2 eligible for Medicaid. Effective 1/1/ 2010. (sec. 1713) (-$.8 billion)	
State Eligibility Option for Family Planning Services	Allows State Medicaid programs to cover low-income women who are not pregnant for family planning services and supplies without obtaining a waiver. Effective on enactment. (sec. 1714)	
Requiring Medicaid Coverage of Optometrists	*E&C amendment offered by Reps. Engel (D-NY) and Schakowsky (D-IL) to require Medicaid coverage of medical and other health services furnished by an optometrist to the extent such services may be performed under State law. Effective for services performed on or after 90 days after the date of enactment. (new sec. 1715)*	

C. Access and Coverage Provisions

Provision	House Tri-Committee Bill	Senate HELP
Payments to Primary Care Practitioners	Requires that State Medicaid programs reimburse for primary care services furnished by physicians and other practitioners at no less than 80% of Medicare rates in 2010, 90% in 2011, and 100% in 2012 and thereafter. Maintains the Medicare payment differentials between physicians and other practitioners. The Federal government would pay 100% of the incremental costs attributable to this requirement. (sec. 1721) (CBO estimate of cost included in Medicaid coverage estimate noted above in sec. 1701.)	

Provision	House Tri-Committee Bill	Senate HELP
Medical Home Pilot	Establishes a 5-year pilot program to test the medical home concept with high-need Medicaid beneficiaries, including medically fragile children and high-risk pregnant women. Federal government would match costs of community care workers at 90% for the first two years and 75% for the next 3 years, up to a total of $1.235 billion. (sec. 1722) (-$.5 billion)	
Translation Services	Provides a 75% FMAP for cost of translation or interpretation services for Medicaid-eligible adults for whom English is not primary language. Effective 1/1/2010. (sec. 1723) (-$.2 billion)	
Optional Coverage for Birth Centers	Allows State Medicaid programs to cover services provided by birth centers that are not hospitals. Effective on enactment. (sec. 1724)	
Vaccines	Allows children who do not have insurance coverage for immunizations to receive vaccines through the Vaccines for Children program at a public health clinic. Effective upon enactment. (sec. 1725) (-$1.0 billion)	
Accountable Care Organization Pilot Program	*E&C en bloc amendment offered by Rep. Baldwin (D-WI) and others (the "Progressives" amendment) provides that the Secretary shall establish an accountable care program under which a State may apply to the Secretary for approval of an ACO pilot program, applying one or more of the ACO models as added by sec. 1301, described above). (new sec. 1726)*	
Coverage of Therapeutic Foster Care	*E&C amendment offered by Rep. Baldwin (D-WI) to allow States to cover therapeutic foster care for eligible children in out-of-home placements. Defines 'therapeutic foster care' to include structured daily activities, crisis intervention and support services, medication monitoring, counseling, case management services, and specialized training for the foster parent on the management of children with mental illnesses and related conditions. (new sec. 1726)*	
Incarcerated Medicaid Enrollees	*E&C amendment by Rep. Tim Murphy (D-PA) establishes processes for States to follow in cases where a Medicaid enrollee who is age 18 or younger becomes incarcerated. Requires States to ensure such persons are enrolled in Medicaid on or before their date of release. (new sec. 1726)*	
Quality Measures for Maternity and Adult Health Services under Medicaid and CHIP	*E&C amendment offered by Reps. Engel (D-NY) and Capps (D-CA) to amend title XI of the Social Security Act to add a new sec. 1139B. Requires the HHS Secretary to develop a proposed set of quality measures for maternity care and adult health care under Medicaid and CHIP. Sets forth a time line and process for developing the measures, including pre-rulemaking input from multi-stakeholders. It also requires the Secretary to develop and publish standardized reporting formats for the quality measures for use by State*	

Provision	House Tri-Committee Bill	Senate HELP
	programs to collect data from providers who participate in Medicaid and CHIP, and to provide an annual report to Congress beginning 1/01/2013 regarding the quality measures data and recommendations for improving the quality of care furnished under State plans. (new sec. 1726)	
Optional Medicaid Coverage of Low-income HIV Patients	Allows State Medicaid programs to cover individuals with HIV with incomes and resources below State eligibility levels for individuals with disabilities. The costs of coverage of such individuals would be matched at an enhanced rate. Effective on enactment; sunsets on 1/1/2013. (sec. 1731) (-$1.0 billion)	
Extending Transitional Medicaid Assistance	Extends the 1-year transitional Medicaid coverage for families leaving cash assistance to work from 12/31/2010 through 12/31/2012. (sec. 1732) (-$2.4 billion)	
12-Month Continuous Coverage under Certain CHIP Programs	Requires stand-alone CHIP programs to provide 12-month continuous eligibility for all enrollees with incomes below 200% of FPL. Effective 1/1/2010. (sec. 1733) (CBO estimate of cost is included in Medicaid coverage estimate above in sec. 1701.)	
Requirement of Medicaid Coverage of Non-Emergency Transportation to Medically Necessary Services	*E&C amendment offered by Rep. Engel (D-NY) to amend section 1902(a)(10) of the Social Security Act to add a requirement to provide non-emergency transportation to medically necessary services. Effective on the date of enactment. (new sec. 1734)*	
State Option to Provide Medicaid Coverage for Certain Individuals with High Prescription Drug Costs	*E&C amendment by Rep. Barton (R-TX) provides that in redetermining the eligibility of a Medicaid individual with extremely high prescription drug costs, the State has the option of disregarding family income to the extent specified by the State (up to $200,000), or if it exceeds that amount, the income is equal to the cost of the orphan drugs taken by the individual provided the family income does not exceed 75% of the amount incurred for such drugs. (new sec. 1734)*	
No Waiting Period for CHIP Coverage	*E&C amendment by Rep. McNerney (D-CA) prohibits the application of a waiting period for coverage under CHIP for a child under the following conditions:* • *the child is under the age of two;* • *the child (through a parent) had previous health insurance coverage through a group or employer health plan and lost coverage due to termination of employment, loss of eligibility due to reduced hours, elimination of retiree health benefits, or termination of the group or employer health plan; or* • *the family demonstrates that the cost of health insurance coverage for such family exceeds 10 percent of income.* *Effective 90 days after enactment. (new sec. 1734)*	

D. Miscellaneous Provisions

Provision	House Tri-Committee Bill	Senate HELP
Puerto Rico and Territories	Provides additional Federal Medicaid matching payments to Puerto Rico and the territories totaling $10.350 billion over the period 2011 through 2019. (sec. 1771) (-$10.4 billion)	
Extension of QI Program	Eliminates the funding limitation and extends for two years (through December 2012) the 'qualified individuals' program to assist low-income Medicare beneficiaries with paying Medicare premiums. (sec. 1782) (-$1.4 billion)	
Extension of Delay in Managed Care Organization Provider Tax Elimination	*E&C amendment offered by Rep. Matsui (D-CA) to extend the delay in managed care organization provider tax elimination from 10/01/2009 to 10/01/2010. (new sec. 1783)*	
Prohibition on Federal Medicaid and CHIP for Undocumented Aliens	*E&C amendment offered by Rep. Space (D-OH) to provide that nothing in the bill shall change current prohibitions against Federal Medicaid and CHIP payments on behalf of individuals who are not lawfully present in the U.S. (new sec. 1783)*	
Repeal of Trigger Provision	Repeals Subtitle A of Title VIII of the Medicare Prescription Drug, Improvement and Modernization act, commonly referred to as the '45% trigger'. The 45% trigger is a mechanism to recoup excess general revenue funding for the Part D drug benefit. The Medicare Trustees are required to include as part of their annual report a section reviewing the impact on general revenues for both the Medicare Part A and Part B Trust Funds (including the Part D drug account), beginning with the report in 2005. The report includes a determination of trust fund balances, and whether the projected general revenue Medicare funding exceeds 45% for that fiscal year or for any of the succeeding six fiscal years. A Medicare funding warning is made if 2 years in a row, general revenues were expected to exceed 45% of total Medicare spending in any of the 7 fiscal years in the reporting period. If there is a Medicare funding warning, the President is required to submit to Congress proposed legislation to respond to such warning. Such proposed legislation should be designed to eliminate excess general revenue Medicare funding for the 7 fiscal-year period that begins in a given fiscal year. The trigger also includes a mechanism requiring both bodies of Congress to introduce legislative proposals submitted by the President in response to the warning by the Medicare Trustees. (sec. 1901)	

Provision	House Tri-Committee Bill	Senate HELP
Repeal of Comparative Cost Adjustment (CCA) Program	Repeals section 1860-1 of the Social Security Act, as added by section 241(a) of the Medicare, Prescription Drug, Improvement and Modernization Act of 2003, commonly referred to as the 'premium support demonstration project.' (sec. 1902)	
Extension of Gainsharing Demonstration	Extends Gainsharing Demonstration enacted in the Deficit Reduction Act of 2005 from December 31, 2009 to September 30, 2011. (sec. 1903)	
Grants to States for Quality Home Visitation Programs	Provides grants to States to support voluntary, evidence-based home visitation programs for pregnant women and for families with pre-school age children in order to improve the well-being, health and development of children. (sec. 1904)	
Improved Coordination and Protection for Dual Eligibles	Requires CMS to establish a dedicated office to improve coordination of benefits and other policies for beneficiaries dually eligible for Medicare and Medicaid. (sec. 1905)	
Assessment of Medicare Cost-Intensive Diseases and Conditions	*Ways and Means Chairman's amendment in the nature of a substitute directs the CMS Administrator to conduct an assessment of the diseases and conditions that are the most cost-intensive for the Medicare program, directs the Administrator to review and update that assessment and creates a fund for research into such diseases and conditions.* (new sec. 1906)	
Establishment of Center for Medicare and Medicaid Payment Innovation Within CMS	*E&C en bloc amendment offered by Rep. Ross (D-AR) and others ("Blue Dog" amendment) would create a Center for Medicare and Medicaid Payment Innovation which would have responsibility for testing of alternative Medicare and Medicaid payment models designed to improve the quality of patient care (as determined by CMS) without increasing spending, or reduce spending without reducing the quality of patient care, or both. Among other things, the amendment sets forth criteria for the selection of models to be tested, requires the HHS Secretary to conduct an evaluation of each model tested, provides funding for testing items and services and administrative costs and requires an annual report to Congress beginning in 2012 describing the models tested, the results of evaluations of the models, and recommendations for legislative changes that the Secretary believes are appropriate to facilitate the development and expansion of successful payment models. (new sec. 1906)*	
Background Checks for Long-Term Care Facility Employees	*E&C en bloc amendment by Rep. Doyle (D-PA) requires the HHS Secretary to establish a program for long-term care facilities or providers to conduct background checks on prospective direct patient access employees on a nationwide basis. Requires the Secretary to enter into agreements with each state regarding background checks under the nationwide program. Requires the background check to*	

Provision	House Tri-Committee Bill	Senate HELP
	include a fingerprint check. States are required to monitor compliance with the program, establish procedures to conduct screening and criminal background checks, monitor compliance by facilities and providers, and allow a provisional period of employment, among other functions.	
Medicaid Demonstration Project for Reimbursements to Non-Publicly Owned Mental Institutions	*E&C en bloc amendment by Rep. Doyle (D-PA) requires the HHS Secretary to create a 3-year demonstration project for eligible State Medicaid plans to reimburse non-publicly owned mental institutions that provide stabilizing medical assistance for an emergency medical condition to a Medicaid eligible individual between 21 and 65 years of age. Requires the Secretary to create an in-stay review that determines whether a patient is stabilized. Directs the Secretary to submit annual reports on the demonstration project's progress and a final report evaluating the project's impact on the health and mental health service system for individuals enrolled in Medicaid. Appropriates $75 million available from FY 2010 through December 31, 2012. (new sec. 1906)*	

E. Medicaid Financing Provisions

Provision	House Tri-Committee Bill	Senate HELP
Payments to Pharmacists	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. (sec. 1741) (CBO estimated that the combined savings from secs. 1741-1744, including Medicaid interactions with 340B provisions in sec. 2501-02 and Part D provisions in sec. 1182 as +$18.3 billion.)	
Prescription Drug Rebates	Increases the minimum manufacturer rebate for brand-name drugs purchased by State Medicaid programs from 15.1% of AMP to 22.1% of AMP, and applies the additional Medicaid rebate to new formulations of brand-name drugs. Effective 1/1/2010. (sec. 1742)	
Extension of Prescription Drug Discounts to Medicaid Managed Care Plan Enrollees	Requires manufacturers to pay rebates to State Medicaid programs for drugs dispensed to program beneficiaries enrolled in Medicaid managed care organizations. Effective 7/1/2010). (sec. 1743)	

Provision	House Tri-Committee Bill	Senate HELP
Payments for Graduate Medical Education	Clarifies that State Medicaid programs may receive Federal matching payments for the costs of graduate medical education. Directs the Secretary to specify program goals for the use of such funds based on workforce needs. Effective upon enactment. (sec. 1744)	

Division C – Public Health and Workforce Development

Miscellaneous Provisions

Provision	House Tri-Committee Bill	Senate HELP
Expanded Participation in 340B Program	Amends Section 340B(a)(4) of the PHSA to include the following to the list of covered entities receiving discounted prescription drug prices, for inpatient as well as outpatient drugs: • Certain children's hospitals. • Critical access hospitals (as determined under section 1820(c)(2) of the Social Security Act). • Entities receiving funds under title V of the Social Security Act (relating to maternal and child health) for the provision of health services. • Entities receiving funds under subpart I of part B of title XIX of the Public Health Service Act (relating to comprehensive mental health services) for the provision of community mental health services. • Entities receiving funds under subpart II of such part B (relating to the prevention and treatment of substance abuse) for the provision of treatment services for substance abuse. • Medicare-dependent, small rural hospitals. • Sole community hospitals. • Rural referral centers. (The 340B Drug Pricing Program requires prescription drug manufacturers to provide outpatient drugs to certain covered entities at a reduced price. The 340B price is a 'ceiling price', meaning it is the highest price the covered entity would have to pay for select outpatient and over-the-counter drugs and minimum savings the manufacturer must provide. Effective for drugs dispensed on or after 7/01/2010. (sec. 2501)	Amends Section 340B of the PHSA to expand the list of covered entities eligible to receive discounted prices under the 340B program to include: • certain children's hospitals excluded from the Medicare prospective payment system; • critical access hospitals; • rural referral centers; and • sole community hospitals with disproportionate share adjustment greater than 8 percent. Extends the discount to include inpatient and outpatient drugs. Prohibits group purchasing arrangements on outpatient drugs with certain exceptions for administrative burdens, generic substitution, and drug shortages. (sec. 611) Requires the HHS Secretary to develop compliance improvements for manufacturers including a system and oversight to verify of accuracy of ceiling prices and the provision of refunds for overcharges. HHS will provide a secure website for covered entities with applicable ceiling prices for covered drugs. The Secretary shall conduct selective auditing of manufacturers and wholesalers to ensure integrity of program. Civil monetary penalties may be assessed not exceeding $5000 for each instance of knowingly overcharging a covered entity. The Secretary will develop a system for using a standard identifier for covered entities. Creates sanctions for covered entities for violations. Creates an alternative dispute resolution system for covered entities overcharged for drug purchases and manufacturers for claims resulting from audit results. (sec. 612)

Provision	House Tri-Committee Bill	Senate HELP
Extension of Discounts to Inpatient Drugs	Requires participating hospitals to credit State Medicaid programs with estimated annual cost savings resulting from the expanded 340B discounts, and establishes mechanisms for the calculation of such credits, payments deadlines, and a waiver of the credit requirement if hospitals can demonstrate to the State that it will lose reimbursements under the State plan and that the loss will exceed the amount of the credit otherwise owed by the hospital. Effective 7/01/2010. (sec. 2502)	Requires participating hospitals to issue a credit to State Medicaid programs for inpatient drugs as determined by the HHS Secretary within 90 days of filing Medicare cost reports. (sec. 611)
National Medical Device Registry	Amends sec. 519 of the Federal Food, Drug, and Cosmetic Act to establish a national medical device registry to facilitate analysis of postmarket safety and outcomes data one each device that: (1) is or has been used on a patient; and (2) is a class III device, or a class II device that is implantable, life-supporting, or life-sustaining. Not later than 36 months after the date of enactment, the HHS Secretary shall publish regulations for the establishment and operation of the registry requiring, among others things: • for device manufacturers to submit information to the registry, including the type, model and serial number of the device; • shall establish procedures to permit linkage of information submitted to patient safety and outcomes data, and permit analyses of linked data; • shall establish requirements for regular and timely reports to the Secretary for inclusion in the registry concerning adverse event trends or patterns, incidence and prevalence of adverse events, and other information the Sectary determines appropriate; • includes procedures to permit public access to the information in the registry. (sec. 2521)	No provision.
Employer-Based Wellness Programs	*Ed & Labor Chairman's amendment in the nature of a substitute requires the Labor Secretary to award grants to employers that have enacted a certified wellness program that includes health awareness, employee engagement, behavioral change, and supportive employee components. The size of the grant can be no more than 50% of the costs incurred directly from instituting the wellness program.*	Provides more flexibility under HIPAA and expands the amount that is allowed for employers to reward employees for participating in wellness programs from 20% (current law) to 30% premium discount. It also allows the Secretaries of Health and Human Services, Department of Labor and Department of Treasury to increase this reward to 50% if deemed appropriate. Amends Title III of the PHSA to add the following: Directs the Director of the Centers for Disease Control and Prevention (CDC Director), in coordination with relevant worksite health promotion organizations, State and local health departments, and academic institutions, to conduct targeted educational campaigns to: • make employers, employer groups, and other

Provision	House Tri-Committee Bill	Senate HELP
		interested parties aware of the benefits of employer-based wellness programs; • establish a culture of health by emphasizing health promotion and disease prevention; • emphasize an integrated and coordinated approach to workplace wellness; and • ensure informed decisions through high quality information to organizational leaders. The CDC Director is also directed to: • provide employers (including small, medium, and large employers, as determined by the Director) with technical assistance, consultation, tools, and other resources in evaluating such employers' employer-based wellness programs, including: (1) measuring the participation and methods to increase participation of employees in such programs; (2) developing standardized measures that assess policy, environmental and systems changes necessary to have a positive health impact on employees' health behaviors, health outcomes, and health care expenditures; and (3) evaluating such programs as they relate to changes in the health status of employees, the absenteeism of employees, the productivity of employees, the rate of workplace injury, and the medical costs incurred by employees; and • build evaluation capacity among workplace staff by training employers on how to evaluate employer-based wellness programs by ensuring evaluation resources, technical assistance, and consultation are available to workplace staff as needed through such mechanisms as web portals, call centers, or other means; Not later than 2 years after date of enactment, and at regular intervals (to be determined by the Director) thereafter, the CDC Director shall conduct a national worksite health policies and programs survey to assess employer-based health policies and programs. Upon the completion of each study, the CDC Director must submit a report to Congress that includes the Director's recommendations for the implementation of effective employer-based health policies and programs. The CDC Director, in collaboration with academic institutions and employers, must also institute workplace demonstration projects across small, medium, and large employers designed to determine how best to transform

Provision	House Tri-Committee Bill	Senate HELP
		the work environment for health, safety, and wellness, how to create a strong, sustainable, coordinated, and integrated workplace health promotion and wellness program, and how to create innovative and sustainable policy and environmental strategies to improve employee health and wellness. Upon completion of the demonstration projects, the Director must submit a report to Congress with recommendations for the implementation of effective employer-based health policies and programs. (sec. 334)
Licensure Pathway for Biosimilar Biological Products	*E&C amendment by Rep. Eshoo (D-CA) and others would amend Sec. 235 of PHSA, similar to the Senate bill, to provide a licensure pathway for biosimilar biological products. In general, the amendment authorizes the Food and Drug Administration to approve generic versions of biologic drugs. The amendment also grants biologics manufacturers 12 years of exclusive use of their drug before generic manufacturers could begin developing competitors.*	*The HELP Committee adopted a compromise biologics amendment to provide a licensure pathway for biosimilar biological products. In general, the amendment authorizes the Food and Drug Administration to approve generic versions of biologic drugs. The amendment also grants biologics manufacturers 12 years of exclusive use of their drug before generic manufacturers could begin developing competitors.*
Protecting Consumer Access to Generic Drugs	*E&C amendment offered by Rep. Rush (D-IL) to amend the Food, Drug, and Cosmetic Act to prohibit brand-name drug companies from settling patent litigation with generic competitors by paying them to delay marketing their products. Requires a GAO Study on litigation in U.S. courts during the period beginning [*] years prior to the date of enactment of this Act relating to patent infringement claims involving generic drugs. Requires a report to Congress of the findings of such a study and an analysis of the effect of the amendment on such litigation, whether such amendments have had an effect on the number and frequency of claims settled, and whether such amendments resulted in earlier or delayed entry of generic drugs to market, including whether any harm or benefits to consumers has resulted. (*not included in the language of the amendment posted on the E&C Committee's website)*	No provision.