



**Comparison of Select Provisions of House and Senate Health Reform Legislation**

*\*This is not an exhaustive summary. Please contact your Ropes & Gray attorney for additional information.*

	House Affordable Health Choices Act, H.R. 3962 Adopted November 7, 2009	Senate Patient Protection and Affordable Health Care Act, H.R. 3590, Signed into Law by the President on March 23, 2010 Public Law No. 111-148	Senate Patient Protection Act and Affordable Health Care Act, H.R. 3590, Combined with the Health Care and Education Reconciliation Act of 2010 (H.R. 4872) Adopted by the House and Senate on March 25, 2010 (Changes made by H.R. 4872 to H.R. 3590 are noted in red)
<b>General</b>			
<b>Estimated Cost of Bill</b>	<ul style="list-style-type: none"> <li>\$1.1 trillion. Estimated to reduce deficits by \$109 billion/10 years.</li> </ul>	<ul style="list-style-type: none"> <li>\$871 billion. Estimated to reduce deficits by \$132 billion/10 years.</li> </ul>	<ul style="list-style-type: none"> <li>\$938 billion. Estimated to reduce deficits by \$143 billion/10 years.</li> </ul>
<b>Coverage Provisions</b>			
<b>% of People Covered</b>	<ul style="list-style-type: none"> <li>94% of all non-elderly residents</li> <li>96% of all non-elderly, excluding undocumented immigrants</li> <li>Reduces the number of uninsured by 36 million by 2019</li> <li>18 million people left uninsured in 2019</li> </ul>	<ul style="list-style-type: none"> <li>92% of all non-elderly residents</li> <li>94% of all non-elderly, excluding undocumented immigrants</li> <li>Reduces the number of uninsured by 31 million by 2019</li> <li>24 million people left uninsured in 2019</li> </ul>	<ul style="list-style-type: none"> <li>92% of all non-elderly residents</li> <li>94% of all non-elderly, excluding undocumented immigrants</li> <li>Reduces the number of uninsured by <b>32 million</b> by 2019</li> <li>23 million people left uninsured in 2019</li> </ul>
<b>Insurance Reforms</b>	<ul style="list-style-type: none"> <li>Prohibits individual and group health plans from applying lifetime limits on health benefits; imposing any preexisting condition exclusions; and from varying premiums by more than 2:1 for age.</li> <li>Imposes guaranteed issue</li> </ul>	<ul style="list-style-type: none"> <li>Prohibits individual and group health plans from: applying lifetime limits on required health benefits; imposing any preexisting condition exclusions; varying premiums by more than 3:1 for age and 1.5:1 for tobacco use (rating changes do not apply to</li> </ul>	<ul style="list-style-type: none"> <li>Prohibits individual and group health plans from: applying lifetime limits on required health benefits; imposing any preexisting condition exclusions; varying premiums by more than 3:1 for age and 1.5:1 for tobacco use (rating changes do not apply to</li> </ul>

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<p><b>Insurance Reforms</b></p>	<p>requirements on all insurers and extends mental health and substance abuse parity requirements to all individual and group health plans.</p> <ul style="list-style-type: none"> <li>Imposes a medical loss ratio of 85% on small and large group plans and on individual plans.</li> </ul>	<p>self-insured plans); imposing excessive waiting periods for coverage (does not apply to individual plans); and, imposing prior authorization for emergency and OB/GYN services. [As indicated below, only certain insurance reforms apply to “grandfathered health plans,” which are plans in effect as of the date of enactment.]</p> <ul style="list-style-type: none"> <li>Requires individual and group health plans to extend dependent care coverage to children up to 26 years of age.</li> <li>Requires individual and group plans to cover routine care provided during a clinical trial that would have been covered had it not been provided through a clinical trial.</li> <li>Imposes guaranteed issue requirements on insurers and mental health parity requirements to all individual and group health</li> </ul>	<p>self-insured plans); imposing excessive waiting periods for coverage (does not apply to individual plans); rescinding coverage for enrollees; and, imposing prior authorization for emergency and OB/GYN services. [As indicated below, only certain insurance reforms apply to “grandfathered health plans,” which are plans in effect as of the date of enactment.]</p> <ul style="list-style-type: none"> <li>Requires individual and group health plans to extend dependent care coverage to children up to 26 years of age. <b>Requires grandfathered health plans to similarly extend coverage.</b></li> <li>Requires individual and group health plans to cover routine care provided during a clinical trial that would have been covered had it not been provided through a clinical trial.</li> <li>Imposes guaranteed issue</li> </ul>

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<p><b>Insurance Reforms</b></p>		<p>plans.</p> <ul style="list-style-type: none"> <li>Imposes a medical loss ratio of 85% on all large group plans and 80% on small group and individual plans, including grandfathered health plans.</li> </ul>	<p>requirements on insurers and mental health parity requirements to all individual and group health plans.</p> <ul style="list-style-type: none"> <li>Imposes a medical loss ratio of 85% on all large group plans and 80% on small group and individual plans, including grandfathered health plans.</li> <li><b>Applies prohibitions on excessive waiting periods and lifetime limits to both individual and group grandfathered health plans</b> and requires these plans to comply with uniform explanation of coverage and cost accounting requirements. <b>Applies prohibitions on annual limits and preexisting conditions to grandfathered health plans that are group health plans.</b></li> </ul>
<p><b>Exchange</b></p>	<ul style="list-style-type: none"> <li>Establishes a national Exchange by 2013, which will be overseen</li> </ul>	<ul style="list-style-type: none"> <li>Requires each state to establish an American Health Benefit Exchange, including a small</li> </ul>	<ul style="list-style-type: none"> <li>Requires each state to establish an American Health Benefit Exchange, including a small</li> </ul>

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<p><b>Exchange</b></p>	<p>by an Exchange Commissioner.</p> <ul style="list-style-type: none"> <li>• Each plan participating in the Exchange must meet standardized affordability, essential benefit, and consumer protection requirements. Exchange plans must meet state benefits requirements.</li> <li>• Provides four plan levels: basic plan (70% actuarial value), enhanced plan (85% actuarial value), premium plan (95% actuarial value), and a premium-plus plan that provides benefits in addition to the essential benefits package.</li> <li>• Imposes \$5,000 and \$10,000 limits on cost sharing for individuals and families respectively.</li> <li>• In the first and second years of operation, only individuals and small employers (up to 50 employees) will be eligible to obtain coverage through the Exchange. Employers with</li> </ul>	<p>business exchange, by 2014. States may form regional exchanges.</p> <ul style="list-style-type: none"> <li>• Each plan participating in an Exchange must meet standardized affordability, essential benefit, and consumer protection requirements. Exchange plans must meet state benefits requirements; however, states must defray premium and cost-sharing costs related to additional benefits for subsidized individuals.</li> <li>• Provides four plan levels: bronze plan (60% actuarial value), silver plan (70% actuarial value), gold plan (80% actuarial value), and platinum plan (90% actuarial value). Permits the offering of catastrophic coverage only plans to individuals under 30 and those meeting the individual mandate hardship exception.</li> <li>• In 2014-2016, only individuals and employers in the small group</li> </ul>	<p>business exchange, by 2014. States may form regional exchanges.</p> <ul style="list-style-type: none"> <li>• Each plan participating in an Exchange must meet standardized affordability, essential benefit, and consumer protection requirements. Exchange plans must meet state benefits requirements; however, states must defray premium and cost-sharing costs related to additional benefits for subsidized individuals.</li> <li>• Provides four plan levels: bronze plan (60% actuarial value), silver plan (70% actuarial value), gold plan (80% actuarial value), and platinum plan (90% actuarial value). Permits the offering of catastrophic coverage only plans to individuals under 30 and those meeting the individual mandate hardship exception.</li> <li>• In 2014-2016, only individuals and employers in the small group</li> </ul>



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<b>Exchange</b>	between 50 and 100 employees and, at the Commissioner's discretion, employers with more than 100 employees will be permitted to participate in the third and subsequent years.	market are eligible to participate in the Exchange; beginning in 2017, states may permit employers in the large group market to participate.	market are eligible to participate in the Exchange; beginning in 2017, states may permit employers in the large group market to participate.  <ul style="list-style-type: none"> <li>Requires each Exchange to provide information to the Secretary of the Treasury and taxpayer regarding the level of coverage obtained through the Exchange, the period of coverage, the premium paid, identification of each individual covered, information provided to the Exchange regarding eligibility for credits, and information to determine whether any individual has received excess advance credits.</li> </ul>
<b>Public Plan/National Plan/CO-Ops</b>	<ul style="list-style-type: none"> <li>Authorizes the creation of a national public plan that would negotiate rates with providers and would be offered through the Exchange. Rates would be no less</li> </ul>	<ul style="list-style-type: none"> <li>No provision for a public plan.</li> <li>Instead, creates at least two Multi-State plans to be overseen and negotiated by the Office of Personnel Management. Plans</li> </ul>	<ul style="list-style-type: none"> <li>No provision for a public plan.</li> <li>Instead, creates at least two Multi-State plans to be overseen and negotiated by the Office of Personnel Management. Plans</li> </ul>

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<p><b>Public Plan/National Plan/CO-Ops</b></p>	<p>than Medicare and would not exceed average rates paid by Exchange plans. The public plan is subject to all Exchange plan requirements.</p> <ul style="list-style-type: none"> <li>• Authorizes \$5 billion to fund a Consumer Operated and Oriented Plan (CO-OP) to support the creation of non-profit, member-run health insurance companies that would be offered through the Exchange.</li> </ul>	<p>would comply with Exchange plan requirements and Federal Employees Health Benefits Plan requirements. At least one Multi-State plan must be not-for-profit. A Multi-State plan initially must be offered in at least 60% of states and in all states by the plan’s fourth year of operation.</p> <ul style="list-style-type: none"> <li>• Authorizes \$6 billion to fund a Consumer Operated and Oriented Plan (CO-OP) to support the creation of non-profit, member-run health insurance companies that would be offered through the Exchange.</li> <li>• Permits states to create a federally-funded, non-Medicaid state plan for non-elderly individuals with incomes between 133% and 200% FPL who are not eligible to receive affordable employer-sponsored insurance under which the employee contribution is equal to or less than 9.8% of income (as well as</li> </ul>	<p>would comply with Exchange plan requirements and Federal Employees Health Benefits Plan requirements. At least one Multi-State plan must be not-for-profit. A Multi-State plan initially must be offered in at least 60% of states and in all states by the plan’s fourth year of operation.</p> <ul style="list-style-type: none"> <li>• Authorizes \$6 billion to fund a Consumer Operated and Oriented Plan (CO-OP) to support the creation of non-profit, member-run health insurance companies that would be offered through the Exchange.</li> <li>• Permits states to create a federally-funded, non-Medicaid state plan for non-elderly individuals with incomes between 133% and 200% FPL who are not eligible to receive affordable employer-sponsored insurance under which the employee contribution is equal to or less than <b>9.5%</b> of income (as well as</li> </ul>

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<b>Public Plan/National Plan/CO-OP</b>		lawfully present immigrants with incomes below 133% FPL who are ineligible for Medicaid due to the 5 year bar to eligibility). Eligible individuals would enroll in such a state plan instead of obtaining coverage through the Exchange and would not be permitted to enroll in an Exchange plan.	lawfully present immigrants with incomes below 133% FPL who are ineligible for Medicaid due to the 5 year bar to eligibility). Eligible individuals would enroll in such a state plan instead of obtaining coverage through the Exchange and would not be permitted to enroll in an Exchange plan.
<b>Individual and Employer Requirements</b>	<ul style="list-style-type: none"> <li>Imposes a 2.5% surtax on the modified adjusted gross income of individuals who do not obtain coverage by 2013. Authorizes the Secretary of the Treasury and Exchange Commissioner to create a hardship exemption.</li> <li>Employers must offer qualified coverage to their employees or contribute to the Exchange for employees who obtain coverage through the Exchange by 2013. Assesses a fee equal to 8% of average wages paid by the employer on those not meeting these requirements. Special rules</li> </ul>	<ul style="list-style-type: none"> <li>Imposes a tax penalty on each uninsured adult who does not obtain coverage by 2014. The tax penalty is the greater of a flat penalty of \$750 or 2% of income. Penalties are gradually phased in between 2014 and 2016. Provides a hardship exemption for individuals for whom the lowest cost premium exceeds 8% of income.</li> <li>Employers with more than 50 employees that do not offer coverage and that have at least one full time employee who receives a premium tax credit, must pay a fee</li> </ul>	<ul style="list-style-type: none"> <li>Imposes tax penalty on each uninsured adult who does not obtain coverage by 2014. The tax penalty is the greater of a flat penalty of \$695 or 2.5% of the excess of household income over the threshold amount requiring a tax return to be filed. Penalties are gradually phased in between 2014 and 2016. Provides hardship exemption for individuals for whom lowest cost premium exceeds 8% of income.</li> <li>Employers with more than 50 employees that do not offer coverage and that have at least one</li> </ul>

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<p><b>Individual and Employer Requirements</b></p>	<p>apply to employers with payrolls less than \$750,000.</p> <ul style="list-style-type: none"> <li>Requires employers to extend the availability of COBRA to individuals who are eligible for COBRA on or after the date of enactment until coverage is available through the Exchange.</li> <li>Provides a 50% health insurance tax credit to small businesses with ten or fewer employees and \$20,000 or less in average wages. The credit, which is available on a rolling basis for the first two years that an employer offers coverage, fully phases out for firms with average wages equal or greater to \$40,000. The credit is not available for highly compensated employees (\$80,000 or more in aggregate compensation).</li> </ul>	<p>of \$750 per year (\$62.50 per month) per full time employee.</p> <ul style="list-style-type: none"> <li>Employers with more than 50 employees that offer coverage must pay a fee of \$3000 per year (\$250 per month) per employee for each full time employee who receives a premium tax credit.</li> <li>Requires employers that provide employer-sponsored coverage to offer free choice vouchers to assist employees for whom the required contribution to the employer's plan is between 8 and 9.8% of their income to purchase Exchange coverage instead. The voucher amount would equal the employer's contribution to its own plan.</li> <li>From 2010-2013, provides a health insurance tax credit of up to 35% (25% for tax-exempt small employers) to small employers with 25 or fewer "full-time equivalent" employees and</li> </ul>	<p>full time employee who receives a premium tax credit, must pay a fee of <b>\$2,000 per year (\$166.67 per month)</b> per full time employee, <b>excluding the first 30 full time employees.</b></p> <ul style="list-style-type: none"> <li>Employers with more than 50 employees that offer coverage must pay a fee of \$3000 per year (\$250 per month) per employee for each full time employee who receives a premium tax credit, <b>excluding the first 30 full time employees.</b></li> <li>Requires employers that provide employer-sponsored coverage to offer free choice vouchers to assist employees for whom required contribution to employer's plan is between 8 and 9.8% of their income to purchase Exchange coverage instead. Voucher amount would equal employer's contribution to its own plan.</li> <li>From 2010-2013, provides health</li> </ul>

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<p><b>Individual and Employer Requirements</b></p>		<p>average annual wages of no more than \$50,000 of the employer's contribution to the cost of providing health insurance to their employees so long as the employer contribution meets or exceeds 50% of the total cost of coverage. The full credit is available to employers with 10 or fewer employees and wages less than \$25,000, and is phased out based on the number of employees and average wages. In 2014, the tax credit rises to up to 50% for-profit small businesses (35% to tax-exempt small businesses) with 25 or fewer employees and average wages up to \$25,000. After 2014, the credit is available for two consecutive years, and fully phases out for firms with average wages equal to or greater than \$50,000.</p>	<p>insurance tax credit of up to 35% (25% for tax-exempt small employers) to small employers with 25 or fewer "full-time equivalent" employees and average annual wages of no more than \$50,000 of the employer's contribution to the cost of providing health insurance to employees so long as the employer contribution meets or exceeds 50% of the total cost of coverage. Full credit is available to employers with 10 or fewer employees and wages less than \$25,000, and is phased out based on the number of employees and average wages. In 2014, tax credit rises to up to 50% for-profit small businesses (35% to tax-exempt small businesses) with 25 or fewer employees and average wages up to \$25,000. After 2014, the credit is available for two consecutive years, and fully phases out for firms with average wages equal to or greater than \$50,000.</p>

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<p><b>Affordability Credits</b></p>	<ul style="list-style-type: none"> <li>• Provides affordability premium credits and cost-sharing credits to non-Medicaid eligible individuals and individuals not enrolled in an employer-sponsored plan with incomes between 133-400% FPL. Credits are based on the average premium of the three basic plans:               <ul style="list-style-type: none"> <li>○ Premium credits are set on a sliding scale based on income, with individuals' premium contributions limited to the following percentages:                   <ul style="list-style-type: none"> <li>▪ 133-150% FPL: 1.5 – 3% of income</li> <li>▪ 150-200% FPL: 3 – 5.5% of income</li> <li>▪ 200-250% FPL: 5.5 – 8% of income</li> <li>▪ 250-300% FPL: 8 – 10% of income</li> <li>▪ 300-350% FPL: 10 – 11% of income</li> <li>▪ 350-400% FPL: 11 – 12% of income</li> </ul> </li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Provides affordability premium credits and cost-sharing credits to non-Medicaid eligible individuals and individuals not enrolled in an affordable employer-sponsored plan with incomes between 100-400% FPL. Credits are based on the second lowest cost silver plan.               <ul style="list-style-type: none"> <li>○ Premium credits are set on a sliding scale based on the premium amounts that an individual is required to pay. The lowest income individuals (incomes between 100-133% FPL) would pay premium amounts that do not exceed 2% of their income. Individuals with incomes between 134-400% FPL would pay premium amounts equal to 2 to 9.8% of their income, with lower income individuals paying closer to 2% and higher income individuals paying closer to 9.8%.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Provides affordability premium credits and cost-sharing credits to non-Medicaid eligible individuals and individuals not enrolled in an affordable employer-sponsored plan with incomes between 100-400% FPL. Credits are based on the second lowest cost silver plan.               <ul style="list-style-type: none"> <li>○ Premium credits are set on a sliding scale based on income, with individuals' premium contributions limited to the following percentages:                   <ul style="list-style-type: none"> <li>▪ Up to 133% FPL: 2% of income</li> <li>▪ 133 to 150% FPL: 3 – 4% of income</li> <li>▪ 150 to 200% FPL: 4 – 6.3% of income</li> <li>▪ 200 to 250% FPL: 6.3 – 8.05% of income</li> <li>▪ 250 to 300% FPL: 8.05% - 9.5% of income</li> <li>▪ 300 to 400% FPL: 9.5% of income</li> </ul> </li> </ul> </li> </ul>

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<b>Affordability Credits</b>	<ul style="list-style-type: none"> <li>○ Cost sharing credits will be determined by the Exchange Commissioner, subject to out-of-pocket limit based on the percentages established for premium credits.</li> </ul>	<ul style="list-style-type: none"> <li>○ Cost-sharing credits equal an amount necessary to reduce cost-sharing as follows:               <ul style="list-style-type: none"> <li>▪ 100 to 150% FPL: 90%</li> <li>▪ 150 to 200% FPL: 80%</li> <li>▪ 200 to 400% FPL: 70%</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>○ Premium credits will be increased annually based on the excess of premium growth over income growth.</li> <li>○ Cost-sharing credits equal an amount necessary to reduce cost-sharing as follows:               <ul style="list-style-type: none"> <li>▪ 100 to 150% FPL: 94%</li> <li>▪ 150 to 150% FPL: 87%</li> <li>▪ 200 to 250% FPL: 73%</li> <li>▪ 250 to 400% FPL: 70%</li> </ul> </li> </ul>
<b>Medicaid Expansion</b>	<ul style="list-style-type: none"> <li>• Effective 2013, expands Medicaid to all non-elderly individuals under 150% of federal poverty.</li> <li>• The federal government would pay 100% of costs of new eligible for the first two years, and 91% of such costs from 2015 on.</li> <li>• Extends the enhanced FMAP provided under the American Reinvestment and Recovery Act, which is slated to expire on December 31, 2010, for an additional six months (through</li> </ul>	<ul style="list-style-type: none"> <li>• Effective 2014, requires states to expand Medicaid to all non-elderly individuals up to 133% FPL. States may voluntarily expand coverage up to this level beginning on April 1, 2010.</li> <li>• For most states, the federal government would pay 100% of costs for the first three years, and a lower percentage of the costs for later years that in part would vary based on a state's Medicaid eligibility levels at the time of enactment. For 2019 and beyond,</li> </ul>	<ul style="list-style-type: none"> <li>• Effective 2014, requires states to expand Medicaid to all non-elderly individuals up to 133% FPL. States may voluntarily expand coverage up to this level beginning on April 1, 2010.</li> <li>• For most states, the federal government would pay 100% of costs related to newly eligible individuals for the first three years (2014-2016), 95% for 2017, 94% for 2018, 93% for 2019, and 90% for years 2020 and beyond. [Note this cap is lower than the 95% cap</li> </ul>

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<b>Medicaid Expansion</b>	June 30, 2011). This provision is estimated to provide \$23 billion to states.	all states would receive a 32.3 percentage point increase in their FMAP for newly eligible (with no FMAP exceeding 95%). <ul style="list-style-type: none"> <li>o For Nebraska, the federal government would continue to pay 100% of costs of the newly eligible after the first three years. Vermont and Massachusetts would also receive additional federal assistance for their existing programs, and Louisiana would receive a limited extension of federal assistance from the Recovery Act.</li> </ul>	under the Senate bill prior to reconciliation.] <ul style="list-style-type: none"> <li>• Provides increased assistance to “expansion states” as compared with the Senate bill. States that have already expanded coverage to both parents and childless adults with incomes up to 100% FPL will receive a phased-in increase to their FMAP for non-pregnant childless adults so that by 2020 they receive the same 90% federal funding as other states for these populations.</li> <li>• Louisiana would receive a limited extension of federal assistance from the Recovery Act. Removes the Nebraska and Massachusetts provisions, and limits special assistance to Vermont to two years.</li> </ul>
<b>CHIP</b>	<ul style="list-style-type: none"> <li>• Eliminates the CHIP program in 2014, and requires all states to either enroll CHIP beneficiaries into the Exchange as of January 1,</li> </ul>	<ul style="list-style-type: none"> <li>• Preserves the CHIP program and requires states to maintain children’s eligibility levels until 2019. Increases the federal</li> </ul>	<ul style="list-style-type: none"> <li>• Preserves the CHIP program and requires states to maintain children’s eligibility levels until 2019. Increases the federal</li> </ul>

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<b>CHIP</b>	2014 or to enroll them in Medicaid.	<p>matching rate.</p> <ul style="list-style-type: none"> <li>• Extends the current reauthorization period of CHIP for two years, through September 30, 2015.</li> <li>• Provides states a 23% increase in their CHIP federal match rates for fiscal years 2016 through 2019.</li> </ul>	<p>matching rate.</p> <ul style="list-style-type: none"> <li>• Extends the current reauthorization period of CHIP for two years, through September 30, 2015.</li> <li>• Provides states a 23% increase in their CHIP federal match rates for fiscal years 2016 through 2019.</li> </ul>
<b>Undocumented Immigrants</b>	<ul style="list-style-type: none"> <li>• Undocumented immigrants are not eligible for affordability credits, but are permitted to obtain coverage through the Exchange.</li> </ul>	<ul style="list-style-type: none"> <li>• Undocumented immigrants are not eligible to receive affordability credits or to enroll in an Exchange.</li> </ul>	<ul style="list-style-type: none"> <li>• Undocumented immigrants are not eligible to receive affordability credits or to enroll in an Exchange.</li> </ul>
<b>Abortion Coverage</b>	<ul style="list-style-type: none"> <li>• Individuals who receive federal subsidies to buy exchange plans cannot choose a plan that covers abortions for which funding is prohibited under federal law.</li> <li>• The public plan would not provide</li> </ul>	<ul style="list-style-type: none"> <li>• States may prohibit coverage of abortion services through an Exchange.</li> <li>• Federal funds for the public plan and for Exchange subsidies must be segregated and cannot be used</li> </ul>	<ul style="list-style-type: none"> <li>• States may prohibit coverage of abortion services through an Exchange.</li> <li>• Federal funds for the public plan and for Exchange subsidies must be segregated and cannot be used</li> </ul>

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<b>Abortion Coverage</b>	abortion coverage.	toward the cost of abortion services for which funding is prohibited under federal law.  • At least one Multi-State plan must not cover abortion services.	toward the cost of abortion services for which funding is prohibited under federal law.  • At least one Multi-State plan must not cover abortion services.
<b>Long-Term Care Program</b>	<ul style="list-style-type: none"> <li>Creates a long-term care insurance program, the “Community Living Assistance Services and Support” (CLASS) program, to be financed by voluntary payroll deductions that would cover the full cost of the program. To be eligible to draw on coverage, an individual must be enrolled in the program for at least five years, including two consecutive years, and meet certain earnings requirements.</li> </ul>	<ul style="list-style-type: none"> <li>Creates a long-term care insurance program, the CLASS program, to be financed by voluntary payroll deductions that would cover the full cost of the program. To be eligible to draw on coverage, an individual must be enrolled in the program for at least five years, including two consecutive years, and meet certain earnings requirements.</li> </ul>	<ul style="list-style-type: none"> <li>Creates a long-term care insurance program, the CLASS program, to be financed by voluntary payroll deductions that would cover the full cost of the program. To be eligible to draw on coverage, an individual must be enrolled in the program for at least five years, including two consecutive years, and meet certain earnings requirements.</li> </ul>
<b>Delivery System Reforms</b>			
<b>Value-Based Purchasing</b>	<ul style="list-style-type: none"> <li>Does not establish any value-based purchasing programs for providers, but requires the Institute of Medicine (IOM) to consider the adoption of a value</li> </ul>	<ul style="list-style-type: none"> <li>Implements a budget neutral value-based purchasing program for hospitals, under which Medicare inpatient prospective payment system (IPPS) payments</li> </ul>	<ul style="list-style-type: none"> <li>Implements a budget neutral value-based purchasing program for hospitals, under which Medicare inpatient prospective payment system (IPPS) payments</li> </ul>

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<p><b>Value-Based Purchasing</b></p>	<p>index based on a composite of quality and cost measures that would adjust Medicare provider payments on a regional or provider-level basis.</p>	<p>would be reduced by 1% in fiscal year FY 2013, 1.25% in FY 2014, 1.5% in FY 2015, 1.75% in FY 2016, and 2% in FY 2017 and thereafter to fund incentive payments to hospitals achieving certain quality-based performance scores.</p> <ul style="list-style-type: none"> <li>• Requires the Secretary of HHS to issue a plan by October 1, 2011, to develop value-based purchasing programs for skilled nursing facilities and home health agencies.</li> <li>• Requires the Secretary of HHS to issue a plan by January 1, 2011 to develop a value-based purchasing program for ambulatory surgical centers.</li> <li>• Requires the Secretary of HHS to establish and apply a value-based payment modifier to the physician fee schedule (PFS), separate from geographic adjustment factors.</li> </ul>	<p>would be reduced by 1% in fiscal year FY 2013, 1.25% in FY 2014, 1.5% in FY 2015, 1.75% in FY 2016, and 2% in FY 2017 and thereafter to fund incentive payments to hospitals achieving certain quality-based performance scores.</p> <ul style="list-style-type: none"> <li>• Requires the Secretary of HHS to issue a plan by October 1, 2011, to develop value-based purchasing programs for skilled nursing facilities and home health agencies.</li> <li>• Requires the Secretary of HHS to issue a plan by January 1, 2011 to develop a value-based purchasing program for ambulatory surgical centers.</li> <li>• Requires the Secretary of HHS to establish and apply a value-based payment modifier to the physician fee schedule (PFS), separate from geographic adjustment factors.</li> </ul>

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<b>Hospital Readmissions</b>	<ul style="list-style-type: none"> <li>Reduces hospital payments under Medicare, for hospital discharges on or after October 1, 2011, to account for “excess readmissions” for a limited number of conditions. Payment reductions would apply to all admissions, and planned readmissions would be exempt. Hospitals with a disproportionate patient percentage of 30% would be eligible to receive funding to assist with activities related to readmissions.</li> </ul>	<ul style="list-style-type: none"> <li>Reduces hospital payments under Medicare, for hospital discharges on or after October 1, 2012, to account for “excess readmissions” for a limited number of conditions. Payment reductions would apply to all admissions. Planned readmissions would be exempt. Hospitals’ readmission rates would be publicly available on the CMS Hospital Compare website.</li> </ul>	<ul style="list-style-type: none"> <li>Reduces hospital payments under Medicare, for hospital discharges on or after October 1, 2012, to account for “excess readmissions” for a limited number of conditions. Payment reductions would apply to all admissions. Planned readmissions would be exempt. Hospitals’ readmission rates would be publicly available on the CMS Hospital Compare website.</li> </ul>
<b>Hospital-Acquired Conditions (HACs)</b>	<p><u>Medicare</u></p> <ul style="list-style-type: none"> <li>Does not contain Medicare payment provisions related to HACs, but does require hospitals and ambulatory surgery centers to report on health-care associated infections to participate in Medicare and Medicaid.</li> </ul>	<p><u>Medicare</u></p> <ul style="list-style-type: none"> <li>Beginning in FY 2015, hospitals in the top quartile of national, risk-adjusted HAC rates in a year would receive only 99% of their otherwise applicable Medicare payments the next year.</li> </ul>	<p><u>Medicare</u></p> <ul style="list-style-type: none"> <li>Beginning in FY 2015, hospitals in the top quartile of national, risk-adjusted HAC rates in a year would receive only 99% of their otherwise applicable Medicare payments the next year.</li> </ul>



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<p><b>Hospital-Acquired Conditions (HACs)</b></p>	<p><u>Medicaid</u></p> <ul style="list-style-type: none"> <li>Effective for discharges on or after January 1, 2010, prohibits Medicaid payments for HACs determined to be a non-covered service.</li> </ul>	<p><u>Medicaid</u></p> <ul style="list-style-type: none"> <li>Requires the Secretary of HHS to adopt regulations effective July 1, 2011 to prohibit federal payments to states for services related to health-care acquired conditions.</li> </ul>	<p><u>Medicaid</u></p> <ul style="list-style-type: none"> <li>Requires the Secretary of HHS to adopt regulations effective July 1, 2011 to prohibit federal payments to states for services related to health-care acquired conditions.</li> </ul>

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<p><b>Payment Bundling</b></p>	<p><u>Medicare</u></p> <ul style="list-style-type: none"> <li>Requires the Secretary of HHS to issue a plan to establish Medicare bundled payments for post-acute services no later than three years after enactment.</li> <li>To further promote bundled payments, requires the Secretary to convert the Medicare acute care episode demonstration program into a voluntary pilot program and to expand the program to include post-acute care services by January 1, 2011.</li> </ul> <p><u>Medicaid</u></p> <ul style="list-style-type: none"> <li>Does not contain Medicaid bundling provisions.</li> </ul>	<p><u>Medicare</u></p> <ul style="list-style-type: none"> <li>Requires the Secretary of HHS to establish a Medicare pilot program no later than January 1, 2013 to evaluate alternative payment methodologies that promote care coordination, including bundled payments, for 10 conditions to be selected by the Secretary. Authorizes the Secretary to expand the pilot if it reduces spending without decreasing quality.</li> </ul> <p><u>Medicaid</u></p> <ul style="list-style-type: none"> <li>Creates a Medicaid bundled payment demonstration, to begin on January 1, 2012 in up to 8 states, under which hospitals would receive bundled payments for a hospitalization and physician services provided during the hospitalization.</li> </ul>	<p><u>Medicare</u></p> <ul style="list-style-type: none"> <li>Requires the Secretary of HHS to establish a Medicare pilot program no later than January 1, 2013 to evaluate alternative payment methodologies that promote care coordination, including bundled payments, for 10 conditions to be selected by the Secretary. Authorizes the Secretary to expand the pilot if it reduces spending without decreasing quality.</li> </ul> <p><u>Medicaid</u></p> <ul style="list-style-type: none"> <li>Creates a Medicaid bundled payment demonstration, to begin on January 1, 2012 in up to 8 states, under which hospitals would receive bundled payments for a hospitalization and physician services provided during the hospitalization.</li> </ul>

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<p><b>Accountable Care Organizations (ACOs)</b></p>	<p><u>Medicare</u></p> <ul style="list-style-type: none"> <li>Establishes a Medicare ACO pilot program beginning no later than January 1, 2012 to test different ACO payment incentive models designed to constrain expenditure growth and improve quality, including a partial capitation model or other payment models that improve quality and efficiency. To participate, an ACO would have to include a physician group and could include hospitals and other providers, although hospitals would be excluded from ACO leadership.</li> </ul> <p><u>Medicaid</u></p> <ul style="list-style-type: none"> <li>Establishes a Medicaid ACO program. Sstates would apply to the Secretary for approval of an ACO pilot and would receive an enhanced administrative match of 90% for the first two years of the pilot program and 75% for the next three years of the pilot.</li> </ul>	<p><u>Medicare</u></p> <ul style="list-style-type: none"> <li>Beginning January 1, 2012, permits qualifying groups of providers, including physicians and hospitals, to be recognized as Medicare ACOs and to share in Medicare cost savings above a certain threshold, provided that certain quality standards are satisfied. The Secretary may pay ACOs using a partial capitation model or other payment models that improve quality and efficiency.</li> </ul> <p><u>Medicaid</u></p> <ul style="list-style-type: none"> <li>Creates a pediatric Medicaid ACO demonstration beginning January 1, 2010, under which certain pediatric medical providers would be eligible for incentive payments based on quality and cost savings.</li> </ul>	<p><u>Medicare</u></p> <ul style="list-style-type: none"> <li>Beginning January 1, 2012, permits qualifying groups of providers, including physicians and hospitals, to be recognized as Medicare ACOs and to share in Medicare cost savings above a certain threshold, provided that certain quality standards are satisfied. The Secretary may pay ACOs using a partial capitation model or other payment models that improve quality and efficiency.</li> </ul> <p><u>Medicaid</u></p> <ul style="list-style-type: none"> <li>Creates a pediatric Medicaid ACO demonstration beginning January 1, 2010, under which certain pediatric medical providers would be eligible for incentive payments based on quality and cost savings</li> </ul>

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<p><b>Graduate Medical Education</b></p>	<p><u>Medicare</u></p> <ul style="list-style-type: none"> <li>• Redistributes 90% of unused residency positions to be used for primary care training, providing preference to hospitals with programs that place greater emphasis on training in FQHCs, provider-based outpatient departments, and hospitals with positions in excess of the applicable resident limit.</li> <li>• Counts time spent on certain training activities toward DGME and IME payments, effective retroactively for unsettled cost reports or those under appeal.</li> <li>• Amends Medicare DGME and IME payment rules to encourage training in “non-provider” settings, and requires an OIG report on the impact of changes.</li> <li>• Creates a Medicare demonstration program for the operation of primary care residency programs by approved “teaching health</li> </ul>	<p><u>Medicare</u></p> <ul style="list-style-type: none"> <li>• Redistributes 65% of unused residency slots to increase primary care and general surgery residencies. Of the pool of redistributed slots, 70% would be reserved for hospitals in states with resident to population ratios in the lowest quartile.</li> <li>• Counts time spent on certain training activities toward DGME and IME payments, effective for cost reporting periods beginning on or after July 1, 2009 for DGME and October 1, 2001 for IME, although settled cost reports would not be reopened unless under appeal.</li> <li>• Provides flexibility in counting time spent by residents in non-hospital settings toward Medicare DGME and IME payments effective July 1, 2010.</li> <li>• Makes qualified teaching health centers (including FQHCs, among</li> </ul>	<p><u>Medicare</u></p> <ul style="list-style-type: none"> <li>• Redistributes 65% of unused residency slots to increase primary care and general surgery residencies. Of the pool of redistributed slots, 70% would be reserved for hospitals in states with resident to population ratios in the lowest quartile.</li> <li>• Counts time spent on certain training activities toward DGME and IME payments, effective for cost reporting periods beginning on or after July 1, 2009 for DGME and October 1, 2001 for IME, although settled cost reports would not be reopened unless under appeal.</li> <li>• Provides flexibility in counting time spent by residents in non-hospital settings toward Medicare DGME and IME payments effective July 1, 2010.</li> <li>• Makes qualified teaching health centers (including FQHCs, among</li> </ul>

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<p><b>Graduate Medical Education</b></p>	<p>centers” (including FQHCs or rural health centers) in cooperation with a teaching hospital, in which the health center would be eligible for payment for its own DGME costs and those of its contracting hospital.</p> <p><u>Medicaid</u></p> <ul style="list-style-type: none"> <li>Provides explicit authority for payment of the costs of graduate medical education “whether provided in or outside of a hospital” as part of medical assistance under the Medicaid statute, undermining CMS’ reasoning for elimination of Medicaid GME payments in its 2007 proposed rule. Requires states to submit to CMS on an annual basis information on how payments are being used to fund GME. Requires CMS to publish a rule by December 31, 2011, outlining program goals for the use of Medicaid GME funds.</li> </ul>	<p>other designated clinics) eligible for DGME and IME payments for operating primary care residency programs.</p> <ul style="list-style-type: none"> <li>Creates a graduate nurse education demonstration program in Medicare for advance practice nurses. Eligible hospitals would receive Medicare reimbursement for the clinical training costs attributable to the training of advance practice nurses.</li> <li>Creates a demonstration through which grants would be available to FQHCs and nurse-managed health clinics training family nurse practitioners.</li> </ul> <p><u>Medicaid</u> No provisions.</p>	<p>other designated clinics) eligible for DGME and IME payments for operating primary care residency programs.</p> <ul style="list-style-type: none"> <li>Creates a graduate nurse education demonstration program in Medicare for advance practice nurses. Eligible hospitals would receive Medicare reimbursement for the clinical training costs attributable to the training of advance practice nurses.</li> <li>Creates a demonstration through which grants would be available to FQHCs and nurse-managed health clinics training family nurse practitioners.</li> </ul> <p><u>Medicaid</u> No provisions.</p>

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<p><b>Primary Care Reimbursement</b></p>	<p><u>Medicare</u></p> <ul style="list-style-type: none"> <li>Provides a Medicare payment bonus of 5% for primary care services furnished by primary care providers (10% for providers in Health Professional Shortage Areas (HPSAs)) after January 1, 2011.</li> </ul> <p><u>Medicaid</u></p> <ul style="list-style-type: none"> <li>Increases fee-for-service and managed care payments for primary care services provided by primary care providers to no less than 80% of the adjusted payment Medicare Part B rates in 2010, 90% in 2011, and 100% in 2012 (which are increased by five percent, or by ten percent for physicians practicing in HPSAs). The federal government would pay 100% of the costs of the amount of the increased payments before FY 2015, and 91% of the costs from FYs 2015 to 2019.</li> </ul>	<p><u>Medicare</u></p> <ul style="list-style-type: none"> <li>Establishes a five-year, 10% Medicare bonus for select E&amp;M codes furnished by physicians and other primary care providers (e.g., nurse practitioners, clinical nurse specialists, or physician assistants) and major surgical procedures furnished by general surgeons in a health professional shortage area, beginning January 1, 2011.</li> </ul> <p><u>Medicaid</u></p> <ul style="list-style-type: none"> <li>No provision.</li> </ul>	<p><u>Medicare</u></p> <ul style="list-style-type: none"> <li>Establishes five-year, 10% Medicare bonus for select E&amp;M codes furnished by physicians and other primary care providers (e.g., nurse practitioners, clinical nurse specialists, or physician assistants) and major surgical procedures furnished by general surgeons in a health professional shortage area, beginning January 1, 2011.</li> </ul> <p><u>Medicaid</u></p> <ul style="list-style-type: none"> <li><b>Increases fee-for-service and managed care payments for primary care services from physicians in family medicine, general internal medicine, and internal medicine to no less than 100% of the adjusted Medicare Part B rates in 2013 and 2014. Federal government will pay 100% of the costs of the amount of the increased payments during these two years.</b></li> </ul>

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<p><b>Community Health Centers</b></p>	<ul style="list-style-type: none"> <li>• Authorizes an additional \$12 billion in funding from FY 2011-2015 for community health centers (these funds would be available only to CHCs receiving Section 330 grants and not to FQHC look-alikes). These funds would be provided out of funds that are appropriated to the Public Health Investment Fund that is created under the Act.</li> </ul>	<ul style="list-style-type: none"> <li>• Authorizes the establishment of a Community Health Center Fund and appropriates to the fund:               <ul style="list-style-type: none"> <li>○ \$7 billion from 2011 to 2015 for the Community Health Center (CHC) Program</li> <li>○ \$1.5 billion available from 2011 to 2015 for construction and renovation of CHCs</li> <li>○ \$1.5 billion from 2011 to 2015 for the National Health Service Corp.</li> </ul> </li> <li>• Authorizes an additional \$34 billion in funding from FY 2010 to FY 2015 for Section 330 grants to CHCs. CHC funding for FY 2016 and beyond would be based on the prior year's appropriated funds, which would be increased to account for increases in costs per patient and increases in the number of patients served.</li> <li>• These funds would be available only to Section 330 grantees and not to FQHC look-alikes.</li> </ul>	<ul style="list-style-type: none"> <li>• Authorizes the establishment of a Community Health Center Fund and appropriates to the fund:               <ul style="list-style-type: none"> <li>○ <b>\$9.5 billion</b> from 2011 to 2015 for the Community Health Center (CHC) Program</li> <li>○ \$1.5 billion available from 2011 to 2015 for construction and renovation of CHCs</li> <li>○ \$1.5 billion from 2011 to 2015 for the National Health Service Corp.</li> </ul> </li> <li>• Authorizes an additional \$34 billion in funding from FY 2010 to FY 2015 for Section 330 grants to CHCs. CHC funding for FY 2016 and beyond would be based on the prior year's appropriated funds, which would be increased to account for increases in costs per patient and increases in the number of patients served.</li> <li>• These funds would be available only to Section 330 grantees and</li> </ul>

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<b>Community Health Centers</b>		<ul style="list-style-type: none"> <li>Establishes a prospective payment system beginning October 1, 2014 for Medicare-covered services furnished by FQHCs. Payment rates under the PPS would be based on 100% of the estimated reasonable costs that would have been incurred in the first year had the PPS not been implemented.</li> </ul>	<p>not to FQHC look-alikes.</p> <ul style="list-style-type: none"> <li>Establishes a prospective payment system beginning October 1, 2014 for Medicare-covered services furnished by FQHCs. Payment rates under the PPS would be based on 100% of the estimated reasonable costs that would have been incurred in the first year had the PPS not been implemented.</li> </ul>
<b>340B Program</b>	<ul style="list-style-type: none"> <li>Expands existing program (outpatient drug discounts) to children’s hospitals, critical access hospitals, maternal and child health programs, comprehensive mental health services programs, substance abuse treatment programs, Medicare-dependent small rural hospitals, sole community hospitals and rural referral centers.</li> <li>Adds new program integrity requirements for manufacturers and covered entities.</li> <li>Effective on date of enactment.</li> </ul>	<ul style="list-style-type: none"> <li>Extends 340B discounts to inpatient drugs.</li> <li>Expands the program to children’s hospitals, critical access hospitals, and rural referral centers.</li> <li>Adds new program integrity requirements for manufacturers and covered entities.</li> <li>These provisions are effective beginning January 1, 2010.</li> </ul>	<ul style="list-style-type: none"> <li><b>Removes the Senate bill’s extension of 340B discounts to inpatient drugs.</b></li> <li>Expands the program to children’s hospitals, critical access hospitals, and rural referral centers. <b>These entities will not receive discounts on orphan drugs.</b></li> <li>Adds new program integrity requirements for manufacturers and covered entities.</li> <li>These provisions are effective beginning January 1, 2010.</li> </ul>



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Provider Payment Changes			
<p><b>Medicare Market Basket Updates</b></p>	<ul style="list-style-type: none"> <li>Freezes the market basket update applicable to skilled nursing facilities (SNFs) for the second, third, and fourth quarters of FY 2010.</li> <li>Extends the market basket freeze applicable to inpatient rehabilitation facilities (IRFs) through FY 2010.</li> </ul>	<ul style="list-style-type: none"> <li>Implements a market basket reduction of 0.25% in 2010 and 2011, 0.1% in 2012 and 2013, and 0.2% from 2014 through 2019 for inpatient and outpatient hospitals, IRFs, and psychiatric hospitals.</li> <li>For long-term care hospitals (LTCHs), implements a market basket reduction of 0.25% in 2010, 0.5% in 2011, 0.1% in 2012 and 2013, and 0.2% from 2014 through 2019.</li> <li>Planned reductions for 2014 through 2019 would be eliminated if the total percentage of the insured population for the applicable year is more than five percentage points below CBO projections.</li> <li>Implements a 0.1% market basket reduction for home health agencies in 2011, 2012, and 2013.</li> <li>Implements a 0.3% market basket</li> </ul>	<ul style="list-style-type: none"> <li>Implements a market basket reduction of 0.25% in 2010 and 2011, 0.1% in 2012 and 2013, <b>0.3% in 2014, 0.2% in 2015 and 2016, and 0.75% in 2017 through 2019</b> for inpatient and outpatient hospitals, inpatient rehabilitation facilities, and psychiatric hospitals.</li> <li>For long-term care hospitals (LTCHs), implements a market basket reduction of 0.25% in 2010, 0.5% in 2011, 0.1% in 2012 and 2013, <b>0.3% in 2014, 0.2% in 2015 and 2016, and 0.75% in 2017 through 2019.</b></li> <li><b>For the above providers, removes language that would have eliminated planned reductions for 2014 through 2019 if the total percentage of the insured population for the applicable year had been more than five percentage points below CBO</b></li> </ul>

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<b>Medicare Market Basket Updates</b>		reduction for hospice providers from 2013 through 2019, except no reduction would occur from 2014 through 2019 if the total percentage of the insured population for the applicable year is more than five percentage points below CBO projections.	<p>projections.</p> <ul style="list-style-type: none"> <li>• Implements a 0.1% market basket reduction for home health agencies in 2011, 2012, and 2013.</li> <li>• Implements a 0.3% market basket reduction for hospice providers from 2013 through 2019, except no reduction would occur from 2014 through 2019 if the total percentage of the insured population for the applicable year is more than five percentage points below CBO projections.</li> </ul>
<b>Medicare Productivity Adjustments</b>	<ul style="list-style-type: none"> <li>• Adjusts downward (but not below zero) the annual market basket increase for inpatient and outpatient hospital services, SNFs, LTCHs, IRFs, psychiatric hospitals, hospice, ambulatory surgical centers (ASCs), home health, and other services (e.g., ambulance, laboratory, DME) to account for economy-wide</li> </ul>	<ul style="list-style-type: none"> <li>• To account for economy-wide productivity gains, adjusts downward the annual market basket increase for inpatient and outpatient hospital services, SNFs, LTCHs, IRFs, home health, psychiatric hospitals, hospice, ASCs, and other services (e.g., ambulance, laboratory, DME, dialysis, and prosthetics). Most</li> </ul>	<ul style="list-style-type: none"> <li>• To account for economy-wide productivity gains, adjusts downward the annual market basket increase for inpatient and outpatient hospital services, SNFs, LTCHs, IRFs, home health, psychiatric hospitals, hospice, ASCs, and other services (e.g., ambulance, laboratory, DME, dialysis, and prosthetics). Most</li> </ul>

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<b>Medicare Productivity Adjustments</b>	productivity gains. Reductions would take effect in FY 2010 for hospitals (including LTCHs), hospice, and ASCs and in FY 2011 for other providers.	reductions would begin in FY 2012. Provides that productivity adjustments could result in negative market basket changes and a reduction in payment rates from the preceding fiscal year.	reductions would begin in FY 2012. Provides that productivity adjustments could result in negative market basket changes and a reduction in payment rates from the preceding fiscal year.
<b>Medicare Fast- Tracked Payment Reform Initiatives</b>	<ul style="list-style-type: none"> <li>Require the Institute of Medicine (IOM) to consider the adoption of a value index based on a composite of quality and cost measures that would adjust Medicare provider payments on a regional or provider-level basis. Recommendations regarding the adoption of such an index would be submitted by the IOM in a report to Congress by April 15, 2011, and would be implemented by the Secretary of HHS if the House and Senate fail to adopt a resolution of disapproval within a specified timeframe.</li> </ul>	<ul style="list-style-type: none"> <li>Establishes an independent, fifteen member Independent Payment Advisory Board required to submit proposals aimed at reducing excess Medicare cost growth by targeted amounts to MedPAC, the President, and Congress annually beginning January 15, 2014, unless the Chief Actuary of CMS makes certain findings related to cost growth.</li> <li>For certain providers, including Medicare Advantage and Part D Plans, the Advisory Board's proposals automatically would be implemented by the Secretary of HHS if Congress, using fast-track procedures, fails to pass an alternative package that meets the</li> </ul>	<ul style="list-style-type: none"> <li>Although H.R. 4872 does not make any policy changes to the Senate bill's Independent Payment Advisory Board (IPAB), in light of H.R. 4872's increased market basket reductions, the CBO has estimated that the IPAB will result in \$15.5 billion in provider reductions over ten years—\$12.6 billion less than anticipated under the unamended Senate bill.</li> </ul>

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<p><b>Medicare Fast- Tracked Payment Reform Initiatives</b></p>		<p>same savings targets.</p> <ul style="list-style-type: none"> <li>• For hospitals and other providers scheduled to receive a reduction to inflationary payment updates in excess of a productivity adjustment through 2019 (e.g., LTCHs, IRFs, psychiatric hospitals, and hospice), the Advisory Board's recommendations would be non-binding until 2020.</li> <li>• Requires the Board to submit, no less than biennially, non-binding recommendations to Congress, the President, and the public on constraining costs and improving quality in the private sector.</li> </ul>	
<p><b>Medicare Geographic Payment Disparities</b></p>	<ul style="list-style-type: none"> <li>• Requires the IOM to issue a report one year after enactment recommending modifications to Medicare's geographic adjustment factors for inpatient hospital and physician payments. Taking into account the IOM report, the Secretary of HHS would be</li> </ul>	<ul style="list-style-type: none"> <li>• Extends the 1.00 floor on the geographic index for physician work under the Medicare PFS through December 2012. Also directs the Secretary of HHS to adjust the practice expense geographic practice cost indices in 2010 by .25%, in 2011 by .5% and</li> </ul>	<ul style="list-style-type: none"> <li>• Extends the 1.00 floor on the geographic index for physician work under the Medicare PFS through December 2012. Also directs the Secretary of HHS to adjust the practice expense geographic practice cost indices in 2010 and 2011 by .5%</li> </ul>

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<b>Medicare Geographic Payment Disparities</b>	required to include proposals for revising the geographic adjustment factor in the next annual IPPS and PFS rules. No reductions in the geographic adjustment factors could be made until 2014, and any reductions after 2014 would have to be budget neutral.	thereafter to ensure accurate geographic adjustments across fee schedule areas. <ul style="list-style-type: none"> <li>Provides for a permanent wage index floor of 1.00 for “frontier states.”</li> </ul>	(accelerating the adjustment in 2010 by an additional .25% compared to the Senate bill) and thereafter to ensure accurate geographic adjustments across fee schedule areas. <ul style="list-style-type: none"> <li>Provides for a permanent wage index floor of 1.00 for “frontier states.”</li> <li>Provides \$400 million in supplemental payments under the inpatient prospective payment system for hospitals located in counties in the bottom quartile of counties as ranked by risk adjusted spending per Medicare enrollee.</li> </ul>
<b>Medicare &amp; Medicaid DSH</b>	<ul style="list-style-type: none"> <li>Reduces federal spending for payments under the Medicaid disproportionate share hospital (DSH) payment program by \$10 billion over ten years—\$1.5 billion for 2017, \$2.5 billion for 2018, and \$6 billion for 2019. The Secretary will determine the</li> </ul>	<ul style="list-style-type: none"> <li>Reduces federal spending for Medicaid DSH payments by an estimated \$19 billion over 10 years, with the cuts linked to a state-level trigger based on a decrease in the uninsured and the amount of cuts varying among certain categories of states.</li> </ul>	<ul style="list-style-type: none"> <li>Adopts an approach closer to that in the House bill, reducing Medicaid DSH payments by an aggregate \$500m for 2014, \$600m for 2015, \$600m for 2016, \$1.8 billion in 2017, \$5 billion in 2018, \$5.6 billion in 2019, and \$4 billion in 2020. The Secretary will</li> </ul>

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<b>Medicare &amp; Medicaid DSH</b>	<p>amount of cuts imposed on each state based on a defined methodology. These reductions are meant to reflect expected decreases in services provided to the uninsured after coverage expansions take effect.</p> <ul style="list-style-type: none"> <li>Reduces Medicare DSH payments by an estimated \$10 billion over ten years, and targets a large portion of remaining funds to hospitals with high uncompensated care.</li> </ul>	<ul style="list-style-type: none"> <li>Reduces Medicare DSH payments by an estimated \$24 billion over 10 years beginning in 2015, redistributes a portion of the funds that otherwise would have been paid to hospitals with high uncompensated care.</li> </ul>	<p>determine the amount of cuts imposed on each state based on a defined methodology (to which the reconciliation bill adds the requirements (1) that the Secretary impose a smaller percentage reduction on low DSH states and (2) that the methodology take into account the extent to which DSH allotments have been used for coverage expansion).</p> <ul style="list-style-type: none"> <li>Reduces Medicare DSH payments by an estimated \$22 billion over 10 years beginning in 2014, and redistributes a slightly greater portion of the funds that otherwise would have been paid to hospitals with high uncompensated care.</li> </ul>
<b>Medicare Advantage</b>	<ul style="list-style-type: none"> <li>Aligns Medicare Advantage plan payments with Medicare fee-for-service rates and reduces total payments to the plans by \$170 billion over ten years.</li> <li>Extends the authority for MA special needs plans through 2013</li> </ul>	<ul style="list-style-type: none"> <li>Applies a competitive benchmark amount to Medicare Advantage plans and reduces total payments to the plans by \$118 billion over ten years.</li> <li>Grandfathers MA local plans and provides transitional rebates for</li> </ul>	<ul style="list-style-type: none"> <li>Freezes Medicare Advantage payments in 2011. Transitions payments to a benchmark that will vary from 95% of fee-for-service payment levels in high-spending states to 115% in low-spending states. Beginning in 2012, benchmarks will be phased in over</li> </ul>

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<p><b>Medicare Advantage</b></p>	<p>(2016 for certain designated plans).</p>	<p>extra benefits provided by plans in certain designated areas, including the two largest metropolitan statistical areas.</p> <ul style="list-style-type: none"> <li>• Extends the authority for MA special needs plans through 2014.</li> </ul>	<p>3 years in most plan areas; some areas will be given 4 to 6 years, depending on the initial difference between current MA payments and the benchmark.</p> <ul style="list-style-type: none"> <li>• Awards additional payments of 1.5% in 2012 and up to 5% after 2014 for Medicare Advantage plans with quality rankings of 4 stars or better (out of 5); some plans in qualifying areas may receive double bonuses.</li> <li>• Ties rebate system to quality of plans: those with 4.5 stars may offer rebates of up to 70% of the difference between the benchmark and their bid, those with 3.5-4.5 stars may offer 60% rebates, and those with less than 3.5 stars may offer 50% rebates.</li> <li>• Adjusts payments to plans indefinitely for coding adjustments relating to the health status of MA enrollees.</li> <li>• Repeals comparative cost</li> </ul>



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Medicare Advantage			<p>adjustment program that was part of the Medicare Modernization Act of 2003.</p> <ul style="list-style-type: none"> <li>Removes language from Senate bill that would have applied a competitive benchmark amount to MA plans.</li> <li>Requires Medicare Advantage plans to have a medical loss ratio of at least 85% beginning in 2014, and imposes penalties on plans that fail to achieve this goal.</li> <li>Extends the authority for MA special needs plans through 2014.</li> </ul>
<b>Other Financing</b>			
Drug Rebates	<p><u>Medicare</u></p> <ul style="list-style-type: none"> <li>Medicare: Establishes a manufacturer rebate for Part D drugs used by dual eligibles, as well as low-income subsidy eligibles beginning in 2015.</li> <li>Provides for discounts to</li> </ul>	<p><u>Medicare</u></p> <ul style="list-style-type: none"> <li>Provides for discounts to beneficiaries in the Part D coverage gap. See Medicare Part D below.</li> </ul>	<p><u>Medicare</u></p> <ul style="list-style-type: none"> <li>Provides for discounts to beneficiaries in the Part D coverage gap. See Medicare Part D below.</li> </ul>

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<b>Drug Rebates</b>	<p>beneficiaries in the Part D coverage gap. See Medicare Part D below.</p> <p><u>Medicaid</u></p> <ul style="list-style-type: none"> <li>Effective January 1, 2010, increases the minimum percentage rebate on brand-name drugs to 23.1 percent of average manufacturer price in January 2010.</li> <li>Establishes an additional rebate for new drug formulations in 2010.</li> <li>Extends rebate requirement to drugs prescribed by Medicaid managed care organizations.</li> </ul>	<p><u>Medicaid</u></p> <ul style="list-style-type: none"> <li>Increases the minimum percentage rebate on brand-name drugs to 23.1 percent of average manufacturer price in January 2010 (although the minimum rebate percentage for certain clotting factors and drugs approved for pediatric medications would be 17.1%).</li> <li>Increases the rebate for other drugs to 13 percent in 2010.</li> <li>Establishes an additional rebate for new formulations of brand-name drugs, but exempts new formulations of orphan drugs.</li> <li>Extends rebate requirement to drugs prescribed by Medicaid managed care organizations.</li> </ul>	<p><u>Medicaid</u></p> <ul style="list-style-type: none"> <li>Increases the minimum percentage rebate on brand-name drugs to 23.1 percent of average manufacturer price in January 2010 (although the minimum rebate percentage for certain clotting factors and drugs approved for pediatric medications would be 17.1%).</li> <li>Increases the rebate for other drugs to 13 percent in 2010.</li> <li>Establishes an additional rebate for new formulations of brand-name drugs effective as of the date of enactment. <b>Strikes exemption for new formulations of orphan drugs.</b></li> <li>Extends rebate requirement to drugs prescribed by Medicaid managed care organizations.</li> </ul>
<b>Pharmaceutical Industry Fees</b>	No provision.	<ul style="list-style-type: none"> <li>Imposes a \$2.3 billion annual excise tax on branded pharmaceutical manufacturers and</li> </ul>	<ul style="list-style-type: none"> <li>Imposes an annual fee on branded pharmaceutical manufacturers and importers equal to the following:</li> </ul>

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<b>Pharmaceutical Industry Fees</b>		importers, which applies to any sales after December 31, 2008. The fee will be assessed based on a company's branded pharmaceutical sales to certain government programs, including Medicare and Medicaid, with the exception of orphan drug sales.	<ul style="list-style-type: none"> <li>○ \$2.5 billion in 2011;</li> <li>○ \$2.8 billion in 2012 and 2013;</li> <li>○ \$3 billion in 2014 through 2016;</li> <li>○ \$4 billion in 2017;</li> <li>○ \$4.1 billion in 2018; and</li> <li>○ \$2.8 billion in 2019 and thereafter.</li> </ul> <ul style="list-style-type: none"> <li>• The fee will be assessed based on a company's branded pharmaceutical sales to certain government programs, including Medicare and Medicaid, with the exception of orphan drug sales.</li> <li>• This revised fee is estimated to raise \$27 billion in revenues in contrast to the \$22.2 billion that was estimated to be raised under the Senate bill.</li> </ul>
<b>Medical Device Industry Fees</b>	<ul style="list-style-type: none"> <li>• Imposes a 2.5% excise tax on medical devices at the point-of-sale. The tax applies to domestic</li> </ul>	<ul style="list-style-type: none"> <li>• Imposes a \$2 billion annual excise tax (rising to \$3 billion a year after 2017) on medical device</li> </ul>	<ul style="list-style-type: none"> <li>• Imposes a 2.3% excise tax on all taxable medical devices, excluding eyeglasses, contact</li> </ul>

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<b>Medical Device Industry Fees</b>	sales after December 31, 2012. Revenues of \$20 billion are estimated over ten years.	manufacturers and importers, which applies to any domestic sales after December 31, 2009. The fee will be assessed based on a company's medical device sales, with the exception of Class II devices that retail for \$100 or less and all Class I devices.	<p>lenses, and hearing aids effective for all sales after December 31, 2012.</p> <ul style="list-style-type: none"> <li>This revised excise tax is estimated to raise \$27 billion in revenues in contrast to the \$19.2 billion that was estimated to be raised under the Senate bill.</li> </ul>
<b>Insurance Industry Fees</b>	<ul style="list-style-type: none"> <li>Imposes a per enrollee fee (amount to be determined by the Secretary) on insurers, including self-insured employer plans, to finance the bill's comparative effectiveness research fund. The calculation of the fee does not include government program enrollees.</li> </ul>	<ul style="list-style-type: none"> <li>Imposes a \$2 per enrollee fee on insurers, including self-insured employer plans, to finance the bill's comparative effectiveness research fund. The calculation of the fee does not include government program enrollees.</li> <li>Imposes an annual fee on health insurance plans (estimated to raise \$59.6 billion in revenue over ten years) beginning January 1, 2010. The initial annual tax will be \$2 billion and by 2017 will equal \$10 billion. <ul style="list-style-type: none"> <li>2011 .....\$2,000,000,000</li> <li>2012 .....\$4,000,000,000</li> <li>2013 .....\$7,000,000,000</li> <li>2014, 2015 and 2016 .....\$9,000,000,000</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Imposes a \$2 per enrollee fee on insurers, including self-insured employer plans, to finance the bill's comparative effectiveness research fund. The calculation of the fee does not include government program enrollees.</li> <li>Imposes an annual fee on health insurance plans (estimated to raise \$60.1 billion in revenue over ten years) beginning January 1, 2014, as follows: <ul style="list-style-type: none"> <li>2014 .....\$8,000,000,000</li> <li>2015-2016.....\$11,300,000,000</li> <li>2017.....\$13,900,000,000</li> <li>2018.....\$14,300,000,000</li> <li>Each year thereafter will equal the applicable amount for the previous year</li> </ul> </li> </ul>

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<p><b>Insurance Industry Fees</b></p>		<p>2017 and thereafter .....\$10,000,000,000</p> <ul style="list-style-type: none"> <li>• The fee would be apportioned based on an insurer’s net premiums. Exempts:               <ul style="list-style-type: none"> <li>○ Governmental entities,</li> <li>○ self-insured employer plans,</li> <li>○ non-profit entities for which premium increases are regulated by states and for which the medical loss ratio is 100%,</li> <li>○ non-profit entities for which the medical loss ratio is 90% in the individual and small and large group markets and 92% in all other markets,</li> <li>○ certain mutual insurance plans;</li> <li>○ all long-term care plans,</li> <li>○ Medicare supplemental plans, and</li> <li>○ other insurance, such as accident and disability coverage.</li> </ul> </li> </ul>	<p>increased by the rate of premium growth.</p> <ul style="list-style-type: none"> <li>• The fee would be apportioned based on an insurer’s net premiums. <b>Only 50% of tax-exempt insurers premiums are included in the calculation of the fee.</b></li> <li>• Exempts:               <ul style="list-style-type: none"> <li>○ Governmental entities,</li> <li>○ self-insured employer plans,</li> <li>○ <b>any entity that is a non-profit corporation under state law, which does not pay dividends to any shareholder or individual and does not engage in lobbying activities (except as permitted under section 501(h) of the Internal Revenue Code) or participate in political campaigns, and for which 80% of gross revenues are received from Medicare, Medicaid or CHIP;</b></li> <li>○ <b>and voluntary employee benefit associations.</b></li> </ul> </li> </ul>

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<b>Tax on High-Cost Health Plans</b>	No provision.	<ul style="list-style-type: none"> <li>Effective for plan years occurring after December 31, 2012, imposes a 40% excise tax on the value of any employer-sponsored plan that exceeds \$8,500 in the case of individual coverage and \$23,000 in the case of family coverage</li> <li>This provision is estimated to raise \$148.9 billion in revenue over ten years.</li> </ul>	<ul style="list-style-type: none"> <li>Effective for plan years occurring after <b>December 31, 2017</b>, in the case of individual coverage, imposes a 40% excise tax on the value of any employer-sponsored plan that exceeds <b>\$10,200 multiplied by the health cost adjustment percentage</b>. In the case of family coverage, imposes a 40% excise tax on the value of any employer-sponsored coverage that exceeds <b>\$27,500 multiplied by the health cost adjustment percentage</b>.</li> <li><b>The health cost adjustment percentage is based on the increase in cost of health insurance for federal employees from 2010 to 2018.</b></li> <li>This provision estimated to raise <b>\$32 billion</b> in revenue over ten years.</li> </ul>
<b>Tax on High-Income Individuals</b>	<ul style="list-style-type: none"> <li>Imposes a 5.4% surtax on income over \$500,000 for individuals and \$1 million for families.</li> </ul>	<ul style="list-style-type: none"> <li>Imposes an additional 0.9% hospital insurance tax on wages or self-employment income above</li> </ul>	<ul style="list-style-type: none"> <li>Imposes an additional 0.9% hospital insurance tax on wages or self-employment income above</li> </ul>

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<b>Tax on High-Income Individuals</b>		\$200,000 for individual filers, and \$250,000 for joint filers effective as of January 1, 2013.	\$200,000 for individual filers, <b>\$125,000 for married filing separate filers</b> , and \$250,000 for joint filers effective as of January 1, 2013.  <ul style="list-style-type: none"> <li>Imposes a 3.8% surtax on the lesser of net investment income or the excess of the modified adjusted gross income over \$200,000 for individual filers, \$125,000 for married filing separate filers, and \$250,000 for joint filers effective as of January 1, 2013. Net investment income includes income from interest, dividends, annuities, royalties, rents, and capital gains.</li> </ul>
<b>Tax on Indoor Tanning</b>	No provision.	<ul style="list-style-type: none"> <li>Imposes a 10% service tax on indoor tanning effective July 1, 2010.</li> </ul>	<ul style="list-style-type: none"> <li>Imposes a 10% service tax on indoor tanning effective July 1, 2010.</li> </ul>
<b>Cafeteria Plans</b>	<ul style="list-style-type: none"> <li>Effective January 1, 2013, limits annual salary contributions to health flexible spending arrangements. Limits distributions for medicines to</li> </ul>	<ul style="list-style-type: none"> <li>Effective January 1, 2011, limits annual salary contributions to health flexible spending arrangements to \$2,500 a year and indexes the limit by CPI-U</li> </ul>	<ul style="list-style-type: none"> <li>Effective <b>January 1, 2013</b>, limits annual salary contributions to health flexible spending arrangements to \$2,500 a year and indexes the limit by CPI-U</li> </ul>

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<b>Cafeteria Plans</b>	<p>prescribed drugs and insulin only.</p> <ul style="list-style-type: none"> <li>Increases the penalty from 10 to 20% for nonqualified Health Savings Account (HSA) payments effective January 1, 2010.</li> </ul>	<p>beginning in 2012.</p> <ul style="list-style-type: none"> <li>Effective January 1, 2011, limits distributions for medicines to prescribed drugs and insulin only.</li> <li>Increases the penalty from 10 to 20% for nonqualified Health Savings Account (HSA) payments effective January 1, 2011.</li> </ul>	<p>beginning in 2014.</p> <ul style="list-style-type: none"> <li>Effective January 1, 2011, limits distributions for medicines to prescribed drugs and insulin only.</li> <li>Increases the penalty from 10 to 20% for nonqualified Health Savings Account (HSA) payments effective January 1, 2011.</li> </ul>
<b>Itemized Deduction of Medical Expenses</b>	No provision.	<ul style="list-style-type: none"> <li>Increases the threshold for itemized deductions for medical expenses from 7.5% to 10% of adjusted gross income effective January 1, 2012. The threshold is not increased until January 1, 2017, for individuals over the age of 65.</li> </ul>	<ul style="list-style-type: none"> <li>Increases the threshold for itemized deductions for medical expenses from 7.5% to 10% of adjusted gross income effective January 1, 2012. The threshold is not increased until January 1, 2017, for individuals over the age of 65.</li> </ul>
<b>Compliance &amp; Transparency</b>			
<b>Expansion of False Claims Act</b>	<ul style="list-style-type: none"> <li>Requires the Secretary of HHS to promulgate regulations identifying fraud and abuse provisions, such as the False Claims Act, that will apply to the public health insurance option. Does not extend</li> </ul>	<ul style="list-style-type: none"> <li>Applies the False Claims Act to payments made by, through, or in connection with the Exchange if payments include any federal funds.</li> </ul>	<ul style="list-style-type: none"> <li>Applies the False Claims Act to payments made by, through, or in connection with the Exchange if payments include any federal funds.</li> </ul>

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<b>Expansion of False Claims Act</b>	fraud and abuse provisions to the entire Exchange.	<ul style="list-style-type: none"> <li>Narrows application of the public disclosure bar to permit an individual who has independent knowledge that materially adds to the publicly disclosed allegations can serve as an original source.</li> </ul>	<ul style="list-style-type: none"> <li>Narrows application of the public disclosure bar to permit an individual who has independent knowledge that materially adds to the publicly disclosed allegations can serve as an original source.</li> </ul>
<b>Enhanced Penalties for Federal Health Care Offenses</b>	No provision.	<ul style="list-style-type: none"> <li>Expands the crimes that constitute a “Federal health care offense” to include violations of the anti-kickback statute and the Federal Food, Drug, and Cosmetic Act. Mandates increased sentences for defendants convicted of Federal health care offenses.</li> </ul>	<ul style="list-style-type: none"> <li>Expands the crimes that constitute a “Federal health care offense” to include violations of the anti-kickback statute and the Federal Food, Drug, and Cosmetic Act. Mandates increased sentences for defendants convicted of Federal health care offenses.</li> </ul>
<b>Anti-Kickback Statute Intent Standard</b>	No provision.	<ul style="list-style-type: none"> <li>Amends the anti-kickback statute intent standard to provide that a person may violate the anti-kickback statute without actual knowledge of or specific intent to violate the statute, making prosecution under the anti-kickback statute easier in some jurisdictions.</li> </ul>	<ul style="list-style-type: none"> <li>Amends the anti-kickback statute intent standard to provide that a person may violate the anti-kickback statute without actual knowledge of or specific intent to violate the statute, making prosecution under the anti-kickback statute easier in some jurisdictions.</li> </ul>

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<b>Physician Payment Sunshine</b>	<ul style="list-style-type: none"> <li>Effective March 31, 2011, requires drug and device manufacturers to report annually to the Secretary of HHS all payments or other transfers of value greater than \$5 to a broad range of providers and other entities including physicians, hospitals, pharmacy benefit managers (PBMs), group purchasing organizations (GPOs), and clinical medical education (CME) sponsors.</li> <li>Also requires drug and device manufacturers, GPOs, hospitals, and other providers to report physician ownership and investment data annually.</li> </ul>	<ul style="list-style-type: none"> <li>Effective March 31, 2013, requires drug and device manufacturers to report annually to the Secretary of HHS all payments or other transfers of value greater than \$10 (and any payments less than \$10 if they exceed \$100 in the aggregate in a particular year) to physicians and teaching hospitals.</li> <li>Also requires drug and device manufacturers and GPOs to report physician ownership and investment data annually.</li> </ul>	<ul style="list-style-type: none"> <li>Effective March 31, 2013, requires drug and device manufacturers to report annually to the Secretary of HHS all payments or other transfers of value greater than \$10 (and any payments less than \$10 if they exceed \$100 in the aggregate in a particular year) to physicians and teaching hospitals.</li> <li>Also requires drug and device manufacturers and GPOs to report physician ownership and investment data annually.</li> </ul>
<b>Physician-Owned Hospitals</b>	<ul style="list-style-type: none"> <li>Limits the availability of the Stark law's whole-hospital exception to existing specialty hospitals.</li> </ul>	<ul style="list-style-type: none"> <li>Limits the availability of the Stark law's whole-hospital exception to existing hospitals and new hospitals that obtain a Medicare provider agreement by August 1, 2010.</li> <li>Physician-owned hospitals cannot</li> </ul>	<ul style="list-style-type: none"> <li>Limits the availability of the Stark law's whole-hospital exception to existing hospitals and new hospitals that obtain a Medicare provider agreement by <b>December 31, 2010</b>.</li> <li>Physician-owned hospitals cannot</li> </ul>

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<b>Physician-Owned Hospitals</b>		expand licensed facility capacity at any time on or after the date of enactment (or after the effective date of its provider agreement, if such is granted after the date of enactment but before August 1, 2010) unless granted an exception under a process to be developed by the Secretary of HHS by July 1, 2011.	expand licensed facility capacity at any time on or after March 23, 2010 (or after the effective date of its provider agreement, if such is granted after March 23, 2010 but before December 31, 2010) unless granted an exception under a process to be developed by the Secretary of HHS by <b>February 1, 2012</b> .  <ul style="list-style-type: none"> <li>Permits “High Medicaid” facilities, which are those hospitals that are not the sole hospital in the county and whose Medicaid inpatient admissions percentage exceeds the percentage of any other hospital located in the same county, to apply for an exception.</li> </ul>
<b>PBM Transparency</b>	<ul style="list-style-type: none"> <li>Requires PBMs that contract with an Exchange plan to report various claims data to the plan and the Exchange Commissioner. These data include aggregate average payments made under a contract, per prescription, made to</li> </ul>	<ul style="list-style-type: none"> <li>Requires PBMs that manage Medicare Part D and Exchange plan prescription drug coverage to disclose certain information to the Secretary, including number of prescriptions filled by mail order compared to retail pharmacies and</li> </ul>	<ul style="list-style-type: none"> <li>Requires PBMs that manage Medicare Part D and Exchange plan prescription drug coverage to disclose certain information to the Secretary, including number of prescriptions filled by mail order compared to retail pharmacies and</li> </ul>

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<b>PBM Transparency</b>	mail order and retail pharmacies, and an estimate of the aggregate average payment per prescription received from pharmaceutical manufacturers, including all rebates, discounts, and price concessions.	the aggregate amount and type of price concessions received, including rebates.	the aggregate amount and type of price concessions received, including rebates.
<b>Mandatory Compliance Programs</b>	<ul style="list-style-type: none"> <li>Prohibits the Secretary from enrolling a provider or supplier in Medicare or Medicaid unless the provider or supplier has established a compliance program that meets requirements to be established by the Secretary of HHS, in consultation with the Inspector General of HHS.</li> </ul>	<ul style="list-style-type: none"> <li>Requires providers and suppliers to establish and maintain compliance programs that satisfy requirements to be established by the Secretary of HHS, in consultation with the Inspector General of HHS, as a condition of enrollment in Medicare, Medicaid, and CHIP.</li> </ul>	<ul style="list-style-type: none"> <li>Requires providers and suppliers to establish and maintain compliance programs that satisfy requirements to be established by the Secretary of HHS, in consultation with the Inspector General of HHS, as a condition of enrollment in Medicare, Medicaid, and CHIP.</li> </ul>
<b>Stark Self-Disclosure Protocol</b>	<ul style="list-style-type: none"> <li>Requires the Secretary of HHS, in cooperation with the Inspector General of HHS, to establish a self-referral disclosure protocol no later than six months after enactment.</li> </ul>	<ul style="list-style-type: none"> <li>Requires the Secretary of HHS, in cooperation with the Inspector General of HHS, to establish a self-referral disclosure protocol no later than six months after enactment.</li> </ul>	<ul style="list-style-type: none"> <li>Requires the Secretary of HHS, in cooperation with the Inspector General of HHS, to establish a self-referral disclosure protocol no later than six months after enactment.</li> </ul>

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<b>Antitrust Exemption for Health Insurers</b>	<ul style="list-style-type: none"> <li>Ends blanket exemption from antitrust laws.</li> </ul>	No provision.	No provision. The House passed a separate bill, H.R. 4626, on February 24, 2010, to repeal the health insurer antitrust exemption. The Senate has not acted on this bill.
<b>Recovery Audit Contractor Program Expansion</b>	No provision.	<ul style="list-style-type: none"> <li>Expands the program to Medicare Parts C &amp; D, and Medicaid.</li> </ul>	<ul style="list-style-type: none"> <li>Expands the program to Medicare Parts C &amp; D, and Medicaid.</li> </ul>
<b>Medicare Prepayment Medical Review</b>	No provision.	No provision.	<ul style="list-style-type: none"> <li>Eliminates statutory limitations on Medicare prepayment medical review.</li> </ul>
<b>Durable Medical Equipment Supplier Oversight</b>	<ul style="list-style-type: none"> <li>Beginning January 1, 2011, the Secretary may withhold payment for a period of 90 days from any durable medical equipment supplier if the Secretary determines there is a significant risk of fraudulent activity among DME suppliers in the same category or geographic area.</li> </ul>	No provision.	<ul style="list-style-type: none"> <li>Beginning January 1, 2011, the Secretary may withhold payment from any durable medical equipment supplier for a period of 90 days if the Secretary determines there is a significant risk of fraudulent activity among DME suppliers in the same category or geographic area.</li> </ul>

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<b>Funding to Combat Health Care Fraud and Abuse</b>	<ul style="list-style-type: none"> <li>Provides an additional \$100 million per year in funding for the Health Care Fraud and Abuse and Control Fund.</li> </ul>	No provision.	<ul style="list-style-type: none"> <li>Provides additional funding for the Health Care Fraud Abuse and Control Fund in the following amounts: \$95 million in FY 2011; \$55 million in FY 2012; \$30 million in FY 2014; and \$20 million for each of FY 2015 and FY 2016.</li> <li>Provides additional funding for the Medicaid Integrity Program by increasing the prior year's appropriated amount by the percent increase in the CPI.</li> </ul>
<b>Study on Possible New Causes of Action</b>	No provision.	<ul style="list-style-type: none"> <li>Directs the General Accountability Office to study, within two years of enactment, whether implementation of health reform legislation would result in the establishment of any new causes of action or claims.</li> </ul>	<ul style="list-style-type: none"> <li>Directs the General Accountability Office to study, within two years of enactment, whether implementation of health reform legislation would result in the establishment of any new causes of action or claims.</li> </ul>

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Other Provisions			
<p><b>Disclosure of Hospital Charges and Specific Requirements for Tax-Exempt Hospitals</b></p>	<p>Requires states to adopt laws requiring hospitals to disclose information on hospital charges to the public and the Secretary, including information on charges for the most common inpatient and outpatient hospital services.</p>	<ul style="list-style-type: none"> <li>• All hospitals operating within the United States must annually establish, update, and make public (in accordance with guidelines developed by the Secretary) a list of the hospital’s standard charges for items and services provided by the hospital, including for Medicare DRGs.</li> <li>• Limits the amount that a tax-exempt hospital can charge individuals eligible for assistance under the hospital’s financial assistance policy for emergency or medically necessary care to “the amount generally billed” to individuals who have insurance.</li> <li>• Each tax-exempt hospital must conduct a community health needs assessment at least once every three years and adopt an implementation strategy that must be disclosed on the hospital’s 990. Failure to do so will result in a</li> </ul>	<ul style="list-style-type: none"> <li>• All hospitals operating within the United States must annually establish, update, and make public (in accordance with guidelines developed by the Secretary) a list of the hospital’s standard charges for items and services provided by the hospital, including for Medicare DRGs.</li> <li>• Limits the amount that a tax-exempt hospital can charge individuals eligible for assistance under the hospital’s financial assistance policy for emergency or medically necessary care to “the amount generally billed” to individuals who have insurance.</li> <li>• Each tax-exempt hospital must conduct a community health needs assessment at least once every three years and adopt an implementation strategy that must be disclosed on the hospital’s 990. Failure to do so will result in a</li> </ul>

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<p><b>Disclosure of Hospital Charges and Specific Requirements for Tax-Exempt Hospitals</b></p>		<p>penalty of \$50,000. These provisions take effect in the first taxable year after enactment.</p> <ul style="list-style-type: none"> <li>Each hospital must adopt and widely publicize a written financial assistance policy and may bill patients who qualify for financial assistance no more than the amounts generally billed. Hospitals must follow current Medicare policies regarding collection of debt and are prohibited from undertaking extraordinary collection actions without first making reasonable attempts to inform the patient about the hospital's financial assistance policy.</li> <li>HHS must report annually to Congress on the levels of charity care, bad debt expenses, and unreimbursed costs of means tested government programs incurred by private tax-exempt, taxable, and governmental hospitals, as well as the cost of</li> </ul>	<p>penalty of \$50,000. These provisions take effect in the first taxable year after enactment.</p> <ul style="list-style-type: none"> <li>Each hospital must adopt and widely publicize a written financial assistance policy and may bill patients who qualify for financial assistance no more than the amounts generally billed. Hospitals must follow current Medicare policies regarding collection of debt and are prohibited from undertaking extraordinary collection actions without first making reasonable attempts to inform the patient about the hospital's financial assistance policy.</li> <li>HHS must report annually to Congress on the levels of charity care, bad debt expenses, and unreimbursed costs of means tested government programs incurred by private tax-exempt, taxable, and governmental hospitals, as well as the cost of</li> </ul>

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<b>Disclosure of Hospital Charges and Specific Requirements for Tax-Exempt Hospitals</b>		community benefit activities incurred by private tax-exempt hospitals.	community benefit activities incurred by private tax-exempt hospitals.
<b>Follow-on Biologics</b>	<ul style="list-style-type: none"> <li>Establishes a pathway for FDA approval of follow-on biologics and a follow-on biologics user fee. Provides 12 years exclusivity to reference products and an additional six months exclusivity period if pediatric studies are conducted.</li> <li>Provides a period of exclusivity of at least one year to the first follow-on biologic approved for a particular reference product.</li> </ul>	<ul style="list-style-type: none"> <li>Establishes a pathway for FDA approval of follow-on biologics and a follow-on biologics user fee. Provides 12 years exclusivity to reference products and an additional six months exclusivity period if pediatric studies are conducted.</li> <li>Provides a period of exclusivity of at least one year to the first follow-on biologic approved for a particular reference product.</li> </ul>	<ul style="list-style-type: none"> <li>Establishes a pathway for FDA approval of follow-on biologics and a follow-on biologics user fee. Provides 12 years exclusivity to reference products and an additional six months exclusivity period if pediatric studies are conducted.</li> <li>Provides a period of exclusivity of at least one year to the first follow-on biologic approved for a particular reference product.</li> </ul>

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<b>Medicare Part D</b>	<ul style="list-style-type: none"> <li>Reduces the donut hole by \$500 and institutes a 50% discount for brand-name drugs in the donut hole, effective 2010. Counts the discounted amount toward the calculation of true out-of-pocket (TrOOP) costs.</li> <li>Phases out the donut hole by 2019.</li> <li>Requires the Secretary to negotiate lower drug prices with manufacturers.</li> </ul>	<ul style="list-style-type: none"> <li>Reduces the donut hole by \$500 and institutes a 50% discount for brand-name drugs in the donut hole, effective 2010. Counts the discounted amount toward the calculation of TrOOP costs.</li> <li>Eliminates the tax deduction for employers who receive Medicare Part D retiree drug subsidy payments effective January 1, 2013.</li> </ul>	<ul style="list-style-type: none"> <li>Closes the donut hole by lowering the beneficiary coinsurance from 100% to 25% over ten years. For generic drugs, the coinsurance will drop to 93% in 2011, and will continue to be reduced annually until reaching 25% in 2020. For brand-name drugs, manufacturers will provide a 50% discount starting in 2011, in addition to federal subsidies that will phase in beginning in 2013.</li> <li>Provides a one-time rebate of \$250 for Part D beneficiaries who reach the donut hole in 2010.</li> <li>Eliminates the tax deduction for employers who receive Medicare Part D retiree drug subsidy payments effective January 1, 2013.</li> </ul>
<b>Prevention &amp; Wellness</b>	<ul style="list-style-type: none"> <li>Requires Exchange and Medicaid plans to cover all preventive services recommended with a grade of A or B by the U.S. Preventive Services Task Force</li> </ul>	<ul style="list-style-type: none"> <li>Requires Exchange plans and Medicare to cover all preventive services recommended with a grade of A or B by the U.S. Preventive Services Task Force</li> </ul>	<ul style="list-style-type: none"> <li>Requires Exchange plans and Medicare to cover all preventive services recommended with a grade of A or B by the U.S. Preventive Services Task Force</li> </ul>

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<p><b>Prevention &amp; Wellness</b></p>	<p>without any cost sharing. Similarly, expands Medicare coverage of preventive services and eliminates cost sharing for such services.</p> <ul style="list-style-type: none"> <li>Establishes an employer wellness grant program to assist employers with 50 employees or less to implement employee wellness programs.</li> <li>Establishes a \$15.4 billion Prevention and Wellness Trust to fund prevention and wellness initiatives between FY 2010 and 2015. These initiatives include community-based prevention and wellness research and wellness services grants, as well as core public health infrastructure activities.</li> <li>Requires the Secretary of HHS to develop a national wellness and prevention strategy within one year of enactment and every two years thereafter.</li> </ul>	<p>without any cost sharing. Exchange plans also must cover (without imposing cost sharing) immunizations recommended by the CDC, with respect to infants, children, and adolescents, evidence-informed preventive care and screenings recommended by HRSA, and, with respect to women, additional preventive care and screenings recommended by HRSA.</p> <ul style="list-style-type: none"> <li>Effective January 1, 2011, Medicare beneficiaries would be eligible to receive an annual visit for personalized prevention plan services, including a comprehensive health risk assessment.</li> <li>Establishes an employer wellness grant program to assist employers with 100 employees or less to implement wellness programs.</li> <li>Provides a one percentage point FMAP increase to states that</li> </ul>	<p>without any cost sharing. Exchange plans also must cover (without imposing cost sharing) immunizations recommended by the CDC, with respect to infants, children, and adolescents, evidence-informed preventive care and screenings recommended by HRSA, and, with respect to women, additional preventive care and screenings recommended by HRSA.</p> <ul style="list-style-type: none"> <li>Effective January 1, 2011, Medicare beneficiaries would be eligible to receive an annual visit for personalized prevention plan services, including a comprehensive health risk assessment.</li> <li>Establishes an employer wellness grant program to assist employers with 100 employees or less to implement wellness programs.</li> <li>Provides a one percentage point FMAP increase to states that</li> </ul>

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<p><b>Prevention &amp; Wellness</b></p>		<p>provide Medicaid coverage for all services recommended by the U.S. Preventive Services Task Force and prohibits cost-sharing for such services.</p> <ul style="list-style-type: none"> <li>Creates a \$100 million program to provide incentives to Medicaid beneficiaries who successfully complete programs to lower or control cholesterol and/or blood pressure, lose weight, quit smoking and/or manage or prevent diabetes, and to address co-morbidities, such as depression, associated with these conditions.</li> <li>Permits employers to provide premium discounts, rebates or other rewards equal to up to 30% of the cost of employee-only coverage to employees who participate in wellness programs and satisfy standards that are related to health status factors. The Secretary of the Treasury may increase the allowable amount to 50%.</li> </ul>	<p>provide Medicaid coverage for all services recommended by the U.S. Preventive Services Task Force and prohibits cost-sharing for such services.</p> <ul style="list-style-type: none"> <li>Creates a \$100 million program to provide incentives to Medicaid beneficiaries who successfully complete programs to lower or control cholesterol and/or blood pressure, lose weight, quit smoking and/or manage or prevent diabetes, and to address co-morbidities, such as depression, associated with these conditions.</li> <li>Permits employers to provide premium discounts, rebates or other rewards equal to up to 30% of the cost of employee-only coverage to employees who participate in wellness programs and satisfy standards that are related to health status factors. The Secretary of the Treasury may increase the allowable amount to 50%.</li> </ul>

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<p><b>Prevention &amp; Wellness</b></p>		<ul style="list-style-type: none"> <li>Establishes a wellness program demonstration project under which states may permit individual health insurance plans to offer similar wellness programs.</li> <li>Establishes a \$15 billion Prevention and Public Health Fund to fund prevention, wellness, and public health activities, including prevention research and health screenings between FY 2010-2019. In particular, these funds will finance the newly-established Community Transformation grant program to implement, evaluate, and disseminate evidence-based community preventive health activities and Healthy Aging, Living Well pilot program to provide public health intervention services to individuals aged 55 to 64.</li> <li>Establishes a demonstration program to award grants to states</li> </ul>	<ul style="list-style-type: none"> <li>Establishes a wellness program demonstration project under which states may permit individual health insurance plans to offer similar wellness programs.</li> <li>Establishes a \$15 billion Prevention and Public Health Fund to fund prevention, wellness, and public health activities, including prevention research and health screenings between FY 2010-2019. In particular, these funds will finance the newly-established Community Transformation grant program to implement, evaluate, and disseminate evidence-based community preventive health activities and Healthy Aging, Living Well pilot program to provide public health intervention services to individuals aged 55 to 64.</li> <li>Establishes a demonstration program to award grants to states</li> </ul>

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<b>Prevention &amp; Wellness</b>		<p>to improve the provision of recommended immunizations for children, adolescents, and adults.</p> <ul style="list-style-type: none"> <li>Establishes a national diabetes prevention program at the CDC to carryout community-based prevention activities, training, outreach, and evaluation.</li> <li>Establishes the National Prevention, Health Promotion and Public Health Council, which is tasked with developing a national wellness and prevention strategy within one year of enactment.</li> </ul>	<p>to improve the provision of recommended immunizations for children, adolescents, and adults.</p> <ul style="list-style-type: none"> <li>Establishes a national diabetes prevention program at the CDC to carryout community-based prevention activities, training, outreach, and evaluation.</li> <li>Establishes the National Prevention, Health Promotion and Public Health Council, which is tasked with developing a national wellness and prevention strategy within one year of enactment.</li> </ul>
<b>Medical Malpractice Reform</b>	No provision.	<ul style="list-style-type: none"> <li>Establishes a state demonstration program to evaluate alternatives to current tort litigation for resolving medical malpractice disputes. States will receive 5 year grants to develop tort litigation alternatives that allow for dispute resolution and promote reduction in health care errors. Demonstration programs must permit patients to opt out and pursue remedies</li> </ul>	<ul style="list-style-type: none"> <li>Establishes a state demonstration program to evaluate alternatives to current tort litigation for resolving medical malpractice disputes. States will receive 5 year grants to develop tort litigation alternatives that allow for dispute resolution and promote reduction in health care errors. Demonstration programs must permit patients to opt out and pursue remedies</li> </ul>

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<p><b>Medical Malpractice Reform</b></p>		<p>through the courts.</p> <ul style="list-style-type: none"> <li>Requires MedPAC and MACPAC to study the impact of these alternatives on the Medicare and Medicaid programs and must report to Congress by December 31, 2016 on the efficiency and effectiveness of the programs. Appropriates \$50 million for the five-year period beginning with FY 2011.</li> <li>Extends federal medical malpractice coverage to free clinics.</li> </ul>	<p>through the courts.</p> <ul style="list-style-type: none"> <li>Requires MedPAC and MACPAC to study the impact of these alternatives on the Medicare and Medicaid programs and must report to Congress by December 31, 2016 on the efficiency and effectiveness of the programs. Appropriates \$50 million for the five-year period beginning with FY 2011.</li> <li>Extends federal medical malpractice coverage to free clinics.</li> </ul>