

Synopsis

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Health Reform

There are now three main versions of a health reform bill floating around Capitol Hill: the House version; the Senate Finance Committee (Baucus) version; and the Republican version. The House version includes everything the most liberal politicians want, and faces a lot of opposition. The Baucus version comes closest to a compromise, with some of what the Republicans want and some of what the Democrats want. No one seems to like it, although it appears to be somewhat more palatable with the amendments made over the last two weeks.

This side-by-side is intended to present an overall comparison, and does not necessarily get into every single legal detail. Subscribers can request additional information on any aspect.

| Provision | House (HR 3200) | Republican (HR 3400) | Senate Finance |
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| Title | America's Affordable Health Choices Act of 2009 | Empowering Patients First Act of 2009 | America's Healthy Future Act of 2009 |
| | | | Items in green indicate amendments made during markup process. |
| Personal responsibility | All individuals are expected to ensure that they have acceptable health coverage. Tax of 2.5% of adjusted income imposed each year for not having coverage. Tax will not exceed the national average premium for that year. | No requirement to obtain coverage; plan aims to make it easier to obtain coverage. Tax deductions allowed for the purchase of health insurance, with limits as to how much of an individual's taxpayer liability may be reduced in this way. | All individuals will be required to carry health insurance. Excise tax for not having coverage: --\$750 per year for individuals with adjusted gross income between 100 & 300% of federal poverty level; family limit of \$1500 --\$950 per year for individuals with |

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| | | | <p>higher incomes; family limit of \$3800</p> <p>Penalty exemption provided for taxpayers who cannot find health care coverage at 8% of their adjusted gross incomes (down from 10% in original mark).</p> <p>Penalty eliminated in first year of HIE for any person not eligible for a waiver & who does not purchase health care. 50% penalty in second year; full penalty after that.</p> |
| Employer responsibility | <p>Employers expected to offer all employees coverage under a qualifying health benefit plan (QHBP), and to contribute towards that coverage.</p> <p>If an employee instead obtains coverage through an health insurance exchange (HIE) plan, the employer is to contribute towards that coverage.</p> <p>Employer is to provide at least 72.5% of the individual premium or 65% of the family premium for the lowest priced plan offered by the employer.</p> <p>Employers who fail to substantially comply with these requirements may be subject to additional employment or excise taxes, equal to up to 8% of their annual payroll.</p> | <p>Employers not required to provide health insurance to employees.</p> <p>Employees may choose to have their employer's contribution paid to a different insurer than the employer has chosen for the rest of the company. Excise tax imposed if the amount paid in that circumstance is less than what would have been paid for company coverage.</p> <p>Employers may auto-enroll employees into specific plans. Employees may refuse such coverage.</p> | <p>Employers would not be required to offer health insurance. All employers with more than 50 employees that do not offer coverage would have to pay a fee for each employee who receives a tax credit for health insurance through the state exchange. The fee would be the lesser of a flat dollar amount multiplied by the number of employees receiving a tax credit or \$400 per employee, based on the total number of employees.</p> |

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| Plan design | <p>QHBP's must conform to certain standards:</p> <ul style="list-style-type: none"> ○ No pre-existing condition exclusions or other limitations on coverage based on health status ○ Guaranteed renewal each year, except in cases of fraud ○ No discrimination in the provision of benefits ○ Parity in the provision of mental health and substance abuse disorder benefits ○ Provider networks must be adequate <p>Premiums limited in how widely they may vary, and based on what.</p> <p>QHBP's must meet a medical loss ratio each year. For any plan year in which the ratio is not met, enrollees must receive rebates sufficient to meet the ratio. This ensures that plans spend at least a minimum amount of premiums collected on the provision of services.</p> <p>No restrictions other than cost-sharing unrelated to clinical appropriateness.</p> <p>Minimum set of health care services laid out.</p> | | <p>Minimum set of health care services laid out.</p> <p>Four levels of plans set forth, depending upon how much the premium equals the actuarial value of the plan. Minimum creditable coverage set at 65%.</p> <p>“Young invincible” plan available for those 25 and younger, providing only catastrophic coverage.</p> |

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| High income tax | <p>Additional tax imposed on individuals with high incomes: --1% on income above \$350,000 but below \$500,000; --1.5% on income between \$500,000 and \$1 million; and --5.4% on income above \$1 million</p> <p>The first two percentages would double if federal health reform savings do not meet their targets after the first year.</p> <p>Income may not be sheltered from this tax.</p> | | |
| Pooling | <p>Health Insurance Exchange (HIE): A Health Choices Commissioner would run the exchange. Qualified health benefits plans could reach individuals through this market. Individuals may purchase through the HIE if they do not have employer-provided coverage or a federal program. Small employers could offer coverage through the HIE.</p> <p>Public option may be created if private insurers continue to be too expensive for many individuals.</p> | <p>States must create high-risk pools or other risk-adjustment mechanisms to ensure coverage of those who would otherwise find it difficult to obtain coverage. Block grants would be available for these purposes.</p> <p>Bonuses available for states ensuring global coverage of targeted populations, reversing premium trends, and similar activities.</p> | <p>States to establish pools for the individual and small group markets (they may be merged).</p> <p>Reinsurance required for these plans. All health insurance issuers would be required to contribute to a reinsurance program for individual policies.</p> <p>For those with pre-existing conditions, a high risk pool could be created. Individuals must be without health insurance for six months to gain access to this pool. The pool will exist until 2013. \$5 billion in funding will subsidize premiums.</p> <p>States could opt into a new federal health care plan for those between</p> |

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| | | | 133% & 200% of the federal poverty level who are not covered by Medicare. |
| Association offering of health insurance | No mention. | <p>Individual membership associations (IMAs): associations which have existed for at least five years and have been formed for non-health coverage purposes may offer health insurance to their members. Membership in the organization may not be conditional upon the person enrolling in that insurance plan.</p> <p>States may issue regulations governing IMAs, but this legislation does not.</p> <p>Organizations may include those made up of medical providers.</p> | <p>Consumer Operated & Oriented Plan (CO-OP) program to foster the creation of nonprofit, member-run health insurances companies to serve individuals.</p> <p>Organizations may enter into collective purchasing arrangements for services and items that increase administrative and other cost efficiencies. They may not set payment rates for health care facilities and providers.</p> |
| Interstate purchase of health insurance | No mention. | <p>Individuals may purchase insurance plans written in other states. The laws of the insurer's primary state govern the insurance plan even when the beneficiary lives in a secondary state. Issuer must warn that the plan might be cheaper than those in the home state because it does not have to follow all of the laws or consumer protections of the enrollee's home state. Any plan offered in a secondary state must also be offered in the primary state.</p> | <p>By 2013, the National Association of Insurance Commissioners (NAIC) will develop model rules for health care choice compacts. Starting in 2015, states can form these compacts between two or more states.</p> <p>Insurers would be allowed to sell policies participating in the compact. Policies will be subject to the laws and regulations of the state where the policy is written or issued. The state where the consumer lives retains authority to address market conduct, unfair</p> |

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| | | After two years, individuals may not buy secondary state insurance if the primary state premium exceeds the national premium by 10% or more. | trade practices, network adequacy and consumer protection standards. |
| National plans | No mention. | No mention. | Issuers would be allowed to create national plans. These would be plans licensed in every state in which the issuer operates, and will offer a uniform benefit package across all of the states. Premiums would be determined based on rating rules in each state and will reflect geographic variation among rating areas. |
| Current plans | | | Individuals and groups that want to keep their current coverage would be allowed to do so. No tax credits would be offered for these plans. |
| Assistance with premiums | <p>Eligible individuals can receive affordability credits towards HIE-participating plan premiums and cost-sharing requirements. Amounts paid directly to the insurers.</p> <p>In the first two years, credits can only be used towards the basic plan. After that, they can be applied towards the enhanced or premium plan. However, that individual must pay the difference in the premium between the lower and higher level plans.</p> | <p>Tax credits available for small employers who either contribute to employees' insurance or auto-enroll employees, for two years.</p> <p>Low-income individuals can receive tax credits towards the purchase of health insurance, up to \$2,000 per year (\$4,000 for joint filers), and \$500 for the each of the first two dependents. Tax credit reduced by 1% for each thousand dollars the person's adjust gross income exceeds the income threshold (initially set at 200% of the federal poverty</p> | <p>Includes a refundable tax credit for eligible individuals and families who purchase health insurance through state exchanges, payable directly to insurers. Available for individuals with modified adjusted gross incomes up to 300% of the federal poverty level.</p> <p>Small employers could receive tax credits to purchase health insurance. Qualifying employers would be those with no more than 25 fulltime equivalents (FTEs). Phase-in provided depending number of employees and</p> |

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| | <p>Eligible individuals are those in the country legally, not enrolled in the QHBP as an employee (or dependent), have a family income below 400% of the federal poverty level, and are not Medicaid eligible.</p> <p>Some employees may still be eligible, as in the case of divorce or separation, or if the employer-provided insurance exceeds 11% of the family income.</p> | <p>guideline).</p> | <p>average wages.</p> |
| Abortion | Not covered. | Specifically not covered. | Specifically not covered. |
| Illegal aliens | Not eligible for tax credits and other protections. | Specifically not covered. | <p>Specifically not covered.</p> <p>Amendment failed that would have required legal immigrants to reside in the US for 5 years to be eligible for tax credits.</p> |
| Medicaid | <p>Expands coverage, to include, among others, all children born in the US not otherwise covered by health insurance. Increases the income level under which individuals qualify for coverage. Requires coverage for list of preventive care services.</p> | <p>Savings achieved through greater health efficiency in Medicaid. The level of those savings would depend upon whether and how much national uninsured rates increase or decrease.</p> | <p>Expands coverage, and provides additional federal financial assistance to help states. Individuals offered employer-sponsored coverage would be eligible for wrap-around benefits.</p> <p>Additional services and sites of care included in the Medicaid program.</p> |
| Medicare | <p>Long list of adjustments to the Medicare program, aimed at controlling cost increases. Include, but not limited to:</p> <ul style="list-style-type: none"> ○ Re-evaluation of disproportionate share | <p>Reference made to finding money through increasing efficiency within Medicare. Other than the disproportionate share program, no specifics given.</p> | <p>A number of adjustments to Medicare made:</p> <ul style="list-style-type: none"> ○ Rebased physician payment schedule ○ Action required on mis-valued codes under the Physician |

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| | <ul style="list-style-type: none"> hospital (DSH) payments ○ Rebasing of physician payments ○ Action required on mis-valued codes under the Physician Fee Schedule ○ Additional 5% incentive payment for physician services furnished in “efficient areas” ○ Adjustments to hospital payments aimed to reduce potentially avoidable readmissions ○ Bundling post-acute care services ○ Medicare Advantage program changes ○ Elimination of the coverage gap within Part D’s prescription program ○ Payment to health care providers for advance care planning discussions ○ Development of accountable care organizations (ACOs) | | <ul style="list-style-type: none"> Fee Schedule ○ Discount program for beneficiaries in the Part D coverage gap ○ Medicare Advantage program changes ○ Various areas of the Medicare program rebased, including home health agencies, hospice, hospital wage indexes, and others ○ Some classes of providers have payments cut, in order to sustain the program <p>Independent Medicare Commission created to establish payment policies and proposals to reduce Medicare spending by targeted amounts each year.</p> <p>Medicare commission may not propose certain changes to beneficiary premiums.</p> |
| Medical liability reform | No provision. | Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2009: Lawsuits must commence within three years of the injury. Non-economic damages limited to \$250,000. Each party’s share of liability is limited. Attorney contingency fees are limited depending upon the size of the | Sense of the Senate calling upon Congress to establish a state demonstration program to evaluate alternatives to the current civil litigation system. |

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| | | <p>award.</p> <p>High burden of proof implemented to obtain punitive damages. None are allowed when the product complies with FDA standards. Provider liability is not permitted in product liability lawsuits.</p> <p>These provisions do not apply to vaccine injury laws.</p> <p>Affirmative defense is created when the provider follows best practice guidelines, to be selected by HHS.</p> | |
| Comparative effectiveness research | <p>Center for Comparative Effectiveness Research would be created within the Agency for Healthcare Research and Quality. It would conduct, support and synthesize research concerning the comparative effectiveness of a wide array of medical interventions.</p> <p>A related commission would oversee the center and would disseminate the center's findings.</p> | <p>HHS may not use data from comparative effectiveness research to deny coverage of any item or service in a federal health plan. This does not appear to affect any DoD or VA health plans, and specifically does not affect the FDA or Public Health Service.</p> <p>Research results can only be released by the government after approval of relevant physician specialty organizations.</p> | <p>Renamed "patient-centered outcomes research". Institute created to oversee national efforts in this area, and provides grants. Results would be reviewed, and findings would be distributed.</p> <p>Legislation specifically prohibits the Institute from using the findings to mandate coverage, reimbursement or any other policy for a public or private payer.</p> |
| Quality reform | <p>Establishes national priorities for quality improvement. HHS Secretary to publish, within 3 years, a list of such priorities.</p> <p>In cooperation with "qualified entities," Secretary will develop</p> | <p>By Jan. 1, 2010, HHS to submit a proposal for a formal proposal to develop performance-based quality measures to be applied to physician services under Medicare.</p> | <p>Hospital value-based purchasing (VBP) program within Medicare pays hospitals for actual performance on quality measures beginning in FY13. Inpatient payments decreased to fund incentive payments.</p> |

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| | <p>new quality measures through which provider performance can be judged.</p> | | <p>Physician VBP incentive payments available to professionals who voluntarily complete certain quality requirements. CMS required to provide timely feedback on their performance, and appeals process to be established.</p> <p>VBPs also created for home health agencies and skilled nursing facilities.</p> <p>Payment adjusted implemented for reducing hospital acquired conditions (HACs).</p> <p>Secretary to establish a national quality reform system to govern the health care system in general.</p> |
| <p>Workforce measures</p> | <p>Public Health Investment Fund to finance public health initiatives, including loan repayment and scholarship programs for health care providers.</p> <p>Participants in the NHS Corps could fulfill their service requirement through half-time service, over a longer period of time.</p> <p>Frontline Health Providers Loan Repayment Program created to promote primary care.. this would</p> | <p>Federally supported student loan funds created for medical students. Student would have to finish training and to practice medicine until the loan is repaid. Loan forgiveness available for those who practice primary care for at least five years, up to \$50,000.</p> | <p>Establish 10% bonus on select E&M codes in Medicare for five years. Primary care physicians who practice in health professional shortage areas could also receive a bonus for hospital visits. General surgeons in HPSAs also eligible for 10% bonus on major procedure codes for five years.</p> <p>Unused residency slots will be redistributed to other hospitals willing to train primary care and generalist physicians.</p> |

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| | <p>apply to primary care providers working in areas or facilities designated as Health Professional Needs Areas.</p> <p>Primary care student loans also created. Additional support provided to training programs to increase their capacity.</p> <p>Medical residents can be trained in non-hospital settings.</p> <p>Similar activities undertaken in dentistry and nursing areas.</p> <p>A number of other programs implemented to increase numbers of primary care providers and the diversity of the overall workforce.</p> <p>Special grants authorized to ease the education of potential nurses. These grants will also create a career ladder from Certified Nurse Assistant to Registered Nurse, with several steps along the way. These grants will help provide education and training as well as recruit additional personnel into the nursing field.</p> | | <p>Medicare reimbursement allowed for residency activities in non-hospital settings.</p> <p>Workforce Advisory Committee created to develop a national workforce strategy to set the nation on a path toward recruiting, training and retaining a health care workforce to meet current & future health care needs.</p> |
| Prevention and wellness | HHS Secretary to create, within a year, a national prevention and wellness strategy. The strategy is to identify national goals and priorities, disparities among the | Group health plans may vary premiums and cost-sharing up to 50% based on individuals' participation in a standards-based wellness program. | Eligible health plans required to cover specified preventive services with no cost sharing or deductible. |

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| | <p>population, and a plan to address these issues.</p> <p>Research grants would be available for identified areas.</p> <p>All federal health programs to actively implement this strategy.</p> <p>Health Empowerment Zones would be created to implement multiple community preventive and wellness services.</p> <p>QHBP's required to provide specified preventive services with no cost sharing or deductible.</p> <p>Wellness grants may be awarded to qualified employers equal to 50% of the employer's costs in connection with a qualified wellness program during that plan year. The grant cannot exceed \$200 per employee for the first 200 employees and \$100 per employee over that. Overall, grants can be up to three years and up to \$50,000.</p> | | |
| Executive compensation | | | Deductions for executive compensation for health insurance providers limited to \$500,000 if at least 25% of the firm's gross income is derived from legislation's mandates. |

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| Revenue items | | <p>Unused stimulus act funds are repealed.</p> <p>Other savings to come from increasing health efficiency in Medicare and Medicaid. The amount of these changes would depend upon whether and how much national uninsured rates increase or decrease.</p> <p>OIG to receive additional funding to root out additional fraudulent and wasteful spending.</p> | <p>Excise tax on high cost premiums if aggregate value of employer-sponsored health coverage for an employee exceeds a threshold amount. Tax would be equal to 35% of the aggregate value that exceeds a threshold amount, initially set at \$8,000 for an individual and \$21,000 for family coverage. The threshold can rise for inflation.</p> <p>The definition of medical expense for the purposes of employer-provided health coverage is conformed to the definition used for purposes of the itemized deduction of medical expenses.</p> <p>Tax on distributions from a Health Savings Account that are not used for qualified medical expenses is increased to 20% of the disbursed amount.</p> <p>Manufacturers and importers of branded drugs would be responsible for a sector-wide fee of \$2.3 billion per year, allocated on the basis of each organization's market share.</p> <p>Manufacturers and importers of medical devices would be responsible for a sector-wide fee of \$4 billion per year, allocated on</p> |

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| | | | <p>the basis of market share.</p> <p>US health insurance providers would be responsible for a sector-wide fee of \$6 billion, allocated on the basis of market share.</p> <p>Clinical laboratories would be responsible for a \$750 million annual aggregate fee, allocated on the basis of market share.</p> <p>These aggregate fees will be applied to the SMI Trust Fund.</p> |
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