HOUSE-SENATE COMPARISON OF KEY PROVISIONS

The House- and Senate-passed health reform bills are based on the plan set out by President Obama in his campaign and shaped during the legislative process. As a result, they have substantial similarities that will greatly facilitate the final step of developing an agreement on a bill for the President's signature. Both bills:

- Provide a comprehensive set of "early deliverables," starting in 2010, which include (1) initial insurance reforms and consumer protections, (2) a new insurance pool to make coverage available to individuals with pre-existing conditions or chronic illnesses who can't get coverage today, and (3) disclosure, review and justification of insurance rate increases. Both bills also contain additional early investments in community health centers and the workforce, which are essential both to ensure access when the coverage reforms are implemented go into place and to begin to improve both personal and community health and wellness immediately. Additional Medicare improvements, including beginning to close the donut hole, also begin in 2010.

- Improve insurance coverage by implementing major coverage reforms (2013 in House bill, 2014 in Senate) and providing financial assistance to lower- and middle-income families and small businesses. Those provisions include:
  - Insurance reforms, minimum benefit standards, and creation of a new health insurance marketplace called an "exchange" where health plans compete based on price and quality for individual and small employer business.
  - Increases in Medicaid eligibility levels for those with the lowest income, and new funding for critical safety net services through community health centers.
  - Sliding scale financial credits to ensure affordable premiums and cost-sharing assistance for households with income above new Medicaid income levels but below 400 percent of the federal poverty level.
  - Individual responsibility to purchase insurance within this new framework.
  - Employer responsibility to offer coverage or provide financial contributions to help pay for coverage.

- Improve Medicare coverage for prescription drugs and preventive services, and implement major Medicare delivery system and payment reforms to make Medicare more efficient and restrain future spending growth. Both bills institute numerous long-term reforms that experts have called for to enhance quality and value for Medicare beneficiaries and the entire health care system.

- Provide revenues that, coupled with the program savings above, meet the commitment of the President, the Speaker and the leaders of the House and Senate that the bill be fully paid for. In fact, both bills actually reduce the deficit by more than $100 billion over the first 10 years, and are projected to yield savings in the second 10 years.

These similarities provide a strong platform for discussions to lead to a final agreement. However, especially on a topic as historic and sweeping as health reform, there are differences between the chambers that will need to be resolved. A brief look at some of the top-line differences follows. Additional and more detailed information will be available as it is developed.

Prepared by Tri-Committee House staff; budget and coverage data from the Congressional Budget Office or the Joint Committee on Taxation.

ISSUE	HOUSE	SENATE
COVERAGE		
Exchange subsidy levels	The House provides sliding scale affordability credits, the Senate tax credits, for those above the new Medicaid income levels but with income less than 400% of the federal poverty level (FPL). *(400% of the poverty level in 2009 is $43,320 for an individual and $88,200 for a family of four.)* Those credits help make premiums more affordable and reduce the cost-sharing and maximum out-of-pocket spending by income level. The credits provide greater support at lower income levels and phase out at 400% of the FPL. Key differences include: • The House provides much greater financial support for premiums and for reduced cost-sharing for families with income at or below 300 percent of the FPL. • The Senate provides greater financial support for premiums for families with income between 300-400 percent of the FPL, and similar protections for cost-sharing at those income levels. Attachment A provides a more detailed comparison; additional analyses are forthcoming.	
Payments and reductions in uninsured	Affordability credits, 2013-2019: $602 billion Reduction in uninsured, 2019: 36 million	Tax credits, 2014-2019: $436 billion Reduction in uninsured, 2019: 31 million
Employer financial requirements (for employers above the small employer exception thresholds)	Employers that do not offer qualified coverage pay an 8% payroll tax on wages for all employees (including full-time, part-time and temporary). Total employer payment in lieu of providing coverage: $135 billion	Employers that do not offer any coverage pay $750 per employee if even one employee receives a tax credit in the Exchange. (This flat dollar amount equals about 1.5% of payroll for a firm with an average payroll of $50,000.) The requirement applies only to full-time workers (30 hours or more a week). Employers that do offer some coverage pay a penalty for employees who go to Exchange and get tax credits where the employee share of the employer premium is more than 9.8% of income and/or the employer does not offer minimal coverage. The penalty is $3,000 per employee going into Exchange and getting a credit, but with a maximum penalty of $750 times the number of full-time employees in workforce. Employers also pay a penalty if they have a waiting period for coverage. Total employer payment in lieu of providing coverage: $28 billion

ISSUE	HOUSE	SENATE
Employer contribution and benefit standards	Employers are required to meet financial contribution level (72.5% of premium for individuals; 65% for families), benefit standards, and consumer protection standards. Contributions can be made on a pro rata basis for employees who work less than full-time.	No affirmative requirement, but employers pay a penalty (see above) if employer contributions don't make the insurance affordable to full-time employees and employees then seek exchange coverage, and if they don't meet some benefit standards. In addition, employees with an employer offer that is deemed "unaffordable," i.e. their share of premiums fall between 8 percent and 9.8 percent of their income, can convert their employer contribution into a "free choice voucher," which can be used to shop in the Exchange.
Employer grandfather provisions	Provides five-year grace period for employers offering coverage to meet some of the requirements.	Permanently grandfathers existing employer plans offering any level of coverage. With few exceptions, these plans are not required to adopt insurance reforms or quality standards.
Minimum benefit standard	Sets minimum standard of 70% of actuarial value (AV) – which means that, on average, the plan covers about 70 % of expected costs and the individual covers 30 % percent.	Sets minimum standard of 60% AV, which results in a lower premium than under the House bill because of reduced benefits (e.g., plan covers less).
Insurance reforms, plan standards	No "Young Invincibles" policy Sets age rating band at 2:1, meaning that rates can vary by no more than 2-1 between oldest and youngest adults. No tobacco rating. Contains numerous consumer protections, including requiring adequate network providers, transparency and plan disclosure provisions, standard rules for the coordination and subrogation of benefits and a clear grievance and appeals process.	Creates a high-deductible "Young Invincibles" policy for young adults (<age 30), with an initial $5,950 deductible (indexed over time). Sets age rating band at 3:1. Sets tobacco rating of 1.5:1, meaning that rates can be increased by 50% for smokers. Subsidies do not cover the tobacco rate-up difference. (This disproportionately affects lower-income individuals both because of more prevalent tobacco use and the subsidy policy.) Requires all insurers to implement internal claims denial appeals and States to make available external appeals processes.

ISSUE	HOUSE	SENATE
Exchanges	National Exchange with State option to operate Exchange if it meets the federal standards. Health plan bidding based on local market areas. Combines individual and small group markets into one insurance pool and one Exchange.	State Exchange with federal back-up. Health plan bidding based on local market areas. Maintains separate insurance pools for individual and small group market, and separate individual and small group Exchanges in each State. Permits States to set up additional Exchanges within the State. States can also apply for a block grant to provide health insurance for families with income below 200% of the federal poverty level rather than permitting those individuals to qualify for their federal tax credits and coverage in the Exchange.
Public option	National public option administered by HHS and using negotiated rates to pay providers.	No public option.
Office of Personnel Management plans	National exchange has responsibility for overseeing plan availability and has authority to negotiate with budding plans; no provision for OPM involvement.	In lieu of a public option, Office of Personnel Management has obligation to make sure that there are two multi-State qualified plans (at least one of which is non-profit) in each State Exchange.
Individual mandate requirement	Uninsured contribute 2.5% of income above filing threshold (e.g., ~$20k), capped at the amount of the average premium. Exemption for those for whom the contribution would constitute financial hardship.	Uninsured contribute fixed dollar amounts per person coupled with income-related contribution: phases up from $95 in 2014 to $495 in 2015 to $750 in 2016; 50% for children; $2,250 family max; or, if higher than these flat dollar amounts, a contribution phasing up to 2 percent of income in 2016, capped at the the average premium level. Hardship exemption.
Immigration/ undocumented	No affordability credits for undocumented May purchase Exchange-regulated product with own funds (Additional information being developed for review)	No affordability credits for undocumented May ***not*** purchase Exchange-regulated product with own funds (Additional information being developed for review)

ISSUE	HOUSE	SENATE
Abortion	Stupak amendment (Additional information being developed for review)	Nelson amendment (Additional information being developed for review)
Start date for coverage, exchange	January 1, 2013	January 1, 2014
MISCELLANEOUS		
Anti-trust exemption for insurers	Repeals anti-trust exemption	Retains anti-trust exemption
Comparative Effectiveness Research	New Center at Agency for Health Care Research and Quality with independent public-private advisory commission	New private non-profit entity governed by private-public board
MEDICAID/CHIP		
Medicaid expansion and financing for new eligibles	Medicaid coverage extended to 150% of FPL 100% federal match first two years, then 91% federal match for all States	Medicaid coverage extended to 133% of FPL 100% federal match first two years, then 32.3 percentage point increase in each State's regular federal match (matching will vary from 82.3% to 95% among the States) States responsible for expansions at regular match
Medicaid access: primary care payments	Phase Medicaid primary care payments up to Medicare levels to improve and protect access ($57 billion cost)	No increase in Medicaid payment rates.
CHIP	Sunsets CHIP block grant at the end of 2013; children entitled to Medicaid or affordability credits in exchange	Extends CHIP block grant with additional funding through 2015; assumes Congress will reauthorize and provide additional funding at that time.
Territories	Provides $14.3 billion total: $9.3 b for Medicaid, $5 b for Exchange	Provides $5.3 billion for Medicaid; no option or funding for the Exchange
Disproportionate Share Hospital (DSH) Payments	Total cuts of $20 billion in Medicare and Medicaid DSH payments Medicare: $10 billion Medicaid: $10 billion	Total cuts of $43 billion in Medicare and Medicaid DSH payments Medicare: $24.4 billion Medicaid: $18.5 billion
MEDICARE		
Medicare physician payments (SGR)	Permanent fix in sustainable growth rate (SGR) formula for physicians in HR 3961, companion bill to health reform. ($209 billion cost)	No provision.

ISSUE	HOUSE	SENATE
Medicare commission	No provision.	New Independent Payment Advisory Board (IPAB) with fast track authority to implement Medicare payment changes with limited options for Congressional intervention or amendments. ($28 billion in savings due to savings target/trigger) Board also has authority to make recommendations related to total system costs, but no fast track authority to make changes beyond Medicare.
Medicare Advantage	Policy: Eliminates MA overpayments by phasing down payments over three years to ultimately achieve parity with traditional Medicare payment levels in the community. ($154 billion savings) Coding adjustment: $15.5 billion savings ***Total MA savings $170 billion*** Quality bonus: Establishes bonus program with strong standards for quality performance and low-cost areas	Policy: Does not eliminate overpayments; establishes new competitive bidding approach under which private MA plans will continue to be paid more than Medicare levels in some communities, less than Medicare in others. ($118 billion savings) Coding adjustment: $1.9 billion savings ***Total MA savings $120 billion*** Quality bonus: Establishes relatively weaker standards for bonus allocation, spreading money widely among most plans.
Geographic differences/ value-based purchasing	Two IOM studies with fast-track implementation; value-based purchasing can be tested through new Center for Medicare and Medicaid Innovation.	Implements "value modifier" to physician payments beginning in 2015 and to all payments to physicians in 2017. Increases payments for physician practice expenses in low-cost areas. Implements value-based purchasing for hospitals. Requires plans to be developed for other providers
Donut hole/rebates	Phases-out donut hole by 2019, financed with reinstated duals rebates and PhRMA discount	Adopts PhRMA discount; implements one-time, one-year $500 reduction in donut hole in 2010 only

ISSUE	HOUSE	SENATE
Income-related premiums	No change to Part B premium policy No income-related part D premium	Suspends indexing of threshold for income-related part B premium ($25 billion savings/premium revenue – increases premiums for beneficiaries) Institutes income-related part D premium and suspends indexing of the threshold ($11 billion savings/premium revenue - increases premiums for beneficiaries)
Low income subsidy (LIS) for Medicare part D and for Medicare Savings programs (MSP)	Improves administrative processes for low-income subsidy programs. Enhances eligibility through clarified asset test for LIS and MSP, and other part D improvements for those with modest incomes. ($11.8 billon Medicare cost)	Improves administrative processes for subsidy programs No change in eligibility standards
340B	Expands entities eligible for section 340B discounts; no expansion to inpatient drugs; no exceptions to group purchasing exclusion	Expands entities eligible for 340B; expands to inpatient drugs; new exceptions to group purchasing exclusion
Medicare hospital readmissions policy	Starting 2012, holds hospital and post-acute providers accountable for preventable hospital readmissions; applies to *all* hospitals, including critical access hospitals (CAH). Provides transitional care funding.	Starting 2013, holds only selected hospitals accountable for preventable hospital readmissions. Exceptions for certain rural hospitals, including Critical Access Hospitals. No transitional care funding for hospitals (only to community organizations)
Medicare graduate medical education (GME) policy	Redistributes 90% of unused residency slots for primary care training in urban and rural areas	Redistributes 65% of unused residency slots, with virtually all of the redistributed slots going to rural hospitals. Exempts most rural teaching hospitals from having unused residency slots redistributed.
PUBLIC HEALTH/WORKFORCE		
Mandatory appropriation	Total: $34 billion over 5 years Public health/wellness: $16.9 b over 5 CHCs: $12.0 b Workforce: $ 5.0 b Numerous other authorizations	Total: $25 billion over 5-10 years Public health/wellness: $15 b over 10 CHCs: $8.5 b over 5 Workforce/National Health Service Corps: $1.5 b over 5 Numerous other authorizations

ISSUE	HOUSE	SENATE
REVENUE		
Total revenue	**$564.5 B**	**$460.3 B**
Primary revenue sources		
5.4% surcharge on income in excess of $500,000 ($1 million for joint returns)	$460.5B (effective 2011)	No provision.
40% excise tax on group health coverage in excess of $8,500/23,000	No provision.	$148.9B (effective 2013)
Additional 0.9% Medicare HI payroll tax on wages in excess of $200,000 (single)/$250,000 (joint return)	No provision.	$86.8B (effective 2013)
Health industry fees		
Impose annual $2.3B fee on manufacturers and importers of branded drugs (allocated based on proportional market share)	No provision.	$22.2B (effective 2010)
Medical devices	$20.0B (effective 2013; structured as 2.5% excise tax)	$19.2B (effective 2011; structured as $2B industry fee based on market share through 2017; $3B industry fee for 2018 and later)
Impose annual fee on health insurance providers (allocated based on proportional share of total health insurance premiums); excludes self-insured plans	No provision.	$59.6B (effective 2011; $2B industry fee in 2011; $4B in 2012; $7B in 2013; $9B in 2014 – 2016; $10B for 2017 and later)
Fee on insured and self insured plans for comparative effectiveness research (effective 2013)	$2.0B	$2.6B
Miscellaneous health-related revenue provisions		

ISSUE	HOUSE	SENATE
Raise 7.5% AGI floor on medical expenses deduction to 10%	No provision.	$15.2B (effective 2013)
10% excise tax on indoor tanning services	No provision.	$2.7B (effective July 1, 2010)
Limit reimbursement of over-the counter medications from HSAs, FSAs, and MSAs (effective 2011)	$5.0B	$5.0B
Limit Health FSAs to 2,500 (indexed to CPI-U)	$13.3B (effective 2013)	$13.3B (effective 2011; includes interaction with tax on high cost plans)
Increase penalties on nonqualified distributions from HSAs (effective 2011)	$1.3B	$1.3B
Eliminate deduction for expenses allocable to Medicare Part D subsidy	$2.2B (effective 2013)	$5.4B (effective 2011)
500K deduction limitation on remuneration to employees, officers, and directors of health insurance providers (effective 2013)	No provision.	$0.6B
Modification of section 833 treatment of certain health organizations (effective 2010)	No provision.	$0.4B
Tax compliance provisions unrelated to health care sector		
Corporate information reporting (effective 2012)	$17.1B	$17.1B

ISSUE	HOUSE	SENATE
Repeal implementation of world wide interest allocation (effective date of enactment)	$6.0B	No provision.
Limit treaty benefits for certain deductible payments (effective date of enactment)	$7.5B	No provision.
Codify economic substance doctrine and impose penalties for underpayments (effective date of enactment)	$5.7B	No provision.
Exclusion of unprocessed fuels from cellulosic producer credit (effective date of enactment)	$23.9B	No provision.

Illustrative Comparison of Premiums, AVs and Maximum Out-of-Pocket (OOP) levels

INCOME		HOUSE			Senate		
		Maximum Premium as % of Income	**AVs**	**OOP Cap in 2013 dollars (indiv/family)**	**Maximum Premium as % of Income**	**AVs**	**OOP Cap Projected HSA levels in 2013 (indiv/family)****
<100 -	133% FPL*	1.5%	97	$500/$1,000	2%	90	$2,050/$4,100
133% -	150% FPL*	1.5 - 3%	97	$500/$1,000	4.0 - 4.6%	90	$2,050/$4,100
150% -	200% FPL	3% - 5.5%	93	$1,000/$2,000	4.6 - 6.3%	80	$2,050/$4,100
200% -	250% FPL	5.5% - 8%	85	$2,000/$4,000	6.3 – 8.1%	70	$3,075/$6,150
250% -	300% FPL	8% - 10%	78	$4,000/$8,000	8.1 – 9.8%	70	$3,075/$6,150
300% -	350% FPL	10% -11%	72	$4,500/$9,000	9.8%	70	$4,100/$8,200
350% -	400% FPL	11% -12%	70	$5,000/$10,000	9.8%	70	$4,100/$8,200
Above 400% FPL			70	$5,000/$10,000		60	6,150/$12,300

*Under House bill, those under 150% FPL enroll in Medicaid unless they are not eligible for Medicaid; under Senate bill same rules for those under 133%

**The Senate Bill out-of-pocket caps are specified as a percent of the applicable Health Savings Account limits. The Senate numbers are JCT projections for 2013; HSA levels for 2014 (Senate implementation date) are projected to be $6,200/$12,300.

Note: Additional detail on impact of differences is being developed.