



**DRAFT**

**“Affordable Health Care for America Act”**

House-Passed on Nov. 7, 2009  
(HR 3962)

**“Patient Protection and Affordable Care Act”**

Senate-Passed on Dec. 24, 2009  
(HR 3590), including  
Manager’s Amendment (S.AMDT 3276)

**“Health Care and Education Reconciliation Act of 2010”**

Senate-Passed on March 25, 2010  
House-Passed on March 25, 2010  
(HR 4872)

**HEALTH REFORM 2009 – 2010: A SIDE-BY-SIDE COMPARISON OF THE BILLS**

Summaries of Key Provisions in the House and Senate Health Care Reform and Reconciliation Bills as of March 31, 2010\*

**COVERAGE**

<p><u>Individual Mandate:</u> Effective in 2013, individuals will be required to have “acceptable health coverage.” Those without Insurance will pay a tax penalty of 2.5 percent of their adjusted income. Exceptions will be granted for those with qualifying low incomes.</p>	<p><u>Individual Mandate:</u> Most U.S. citizens and legal residents will be required to have health Insurance. Individuals without coverage will pay a tax penalty up to either \$750 or 2 percent of their income. These penalties are to be phased in gradually beginning in 2014 and reaching these caps in 2016. Beginning in 2017, the penalty will be adjusted annually with by the cost-of-living adjustment. Exemptions will be granted if coverage is unaffordable, which will be when the lowest cost plan option exceeds 8 percent of an individual’s income, and if the individual has income below 100 percent of the poverty level.</p>	<p><u>Individual Mandate:</u> Most U.S. citizens and legal residents will be required to have health insurance. Individuals without coverage will pay a tax penalty of up to either 2.5 percent of their income or \$695, whichever is higher in 2016. These penalties are to be phased in gradually beginning in 2014 and reaching these caps in 2016. Beginning in 2017, the penalty will be adjusted annually with by the cost-of-living adjustment. Exemptions will be granted if the coverage is unaffordable, which will be when the lowest cost plan option exceeds 8 percent of an individual’s income, and if the individual or family has an income below the tax filing threshold. (HR 3590, Sec. 1501 amended by Sec. 10106; as amended by HR 4872, Sec. 1002).</p>
<p><u>Employer Requirements:</u> Employers with 200 or more employees will be required to provide coverage or pay a penalty by contributing either a percentage of the premium cost for employee coverage or 8 percent of its</p>	<p><u>Employer Requirements:</u> Employers are not required to provide health insurance for their employees. For employers with more than 50 employees who do not offer coverage, if they have at least one full-time</p>	<p><u>Employer Requirements:</u> Employers are not required to provide health insurance for their employees. For employers with more than 50 employees who do not offer coverage, if they have at least one full-time</p>



**DRAFT**

**“Affordable Health Care for America Act”**

House-Passed on Nov. 7, 2009  
(HR 3962)

**“Patient Protection and Affordable Care Act”**

Senate-Passed on Dec. 24, 2009  
(HR 3590), including  
Manager’s Amendment (S.AMDT 3276)

**“Health Care and Education Reconciliation Act of 2010”**

Senate-Passed on March 25, 2010  
House-Passed on March 25, 2010  
(HR 4872)

<p>average wages into the Health Insurance Exchange Trust Fund. Companies with payrolls under \$500,000 annually are exempt from this requirement. For small employers with annual payrolls between \$500,000 and \$750,000, the pay to play assessment will be on a sliding scale. Employers that offer coverage must automatically enroll in a plan any individual who does not opt out.</p>	<p>employee whose coverage is subsidized by the government through the premium tax credit, the employer will face up to a \$750 fee for each full-time employee. Employers with 50 or more employees who do offer coverage and have at least one full-time employee receiving the premium tax credit will pay the lesser of \$3,000 per employee receiving the subsidy or \$750 per full-time employee.</p> <p>Employers with 50 or fewer employees are exempt from penalties.</p> <p>Employers that offer coverage must provide a free choice voucher to income-eligible employees who choose to enroll in a plan in the Exchange, exempting the employers from penalties they would otherwise pay for having employees that receive premium credits in the Exchange.</p> <p>Employers imposing a waiting period before employees can enroll in coverage will pay \$400 per full-time employee in a 30 to 60 day waiting period, and \$600 per full-time employee in a 60-90 day waiting period.</p> <p>Companies with more than 200 employees are required to automatically enroll their employees in coverage plans. Employees may opt out of coverage.</p>	<p><i>employee whose coverage is subsidized by the government through the premium tax credit, the employer will face up to a \$2,000 for each full-time employee, excluding the first 30 employees. Employers with 50 or more employees who do offer coverage and have at least one full-time employee receiving the premium tax credit will pay the lesser of \$3,000 per employee receiving the subsidy, or \$2,000 per full-time employee. (HR 3590, Sec. 1513 as amended by Sec. 10106; amended by HR 4872 Sec. 1003).</i></p> <p><i>The waiting period assessment is eliminated. (HR 3590, Sec. 1513 as amended by Sec. 10106; amended by HR 4872 Sec. 1003).</i></p> <p>Employers with 50 or fewer employees are exempt from penalties. (HR 3590, Sec. 1513 as amended by Sec. 10106).</p> <p>Employers that offer coverage must provide a free choice voucher to income-eligible employees who choose to enroll in a plan in the Exchange, exempting the employers from penalties they would otherwise pay for having employees that receive premium credits in the Exchange. (HR 3590, Sec. 1513 as amended by Sec. 10106).</p> <p>Companies with more than 200 employees are required to automatically enroll their employees in coverage plans. Employees may opt out of coverage. (HR 3590, Sec. 1513 as amended by Sec. 10106).</p>
--	--	---



**DRAFT**

**“Affordable Health Care for America Act”**

House-Passed on Nov. 7, 2009  
(HR 3962)

**“Patient Protection and Affordable Care Act”**

Senate-Passed on Dec. 24, 2009  
(HR 3590), including  
Manager’s Amendment (S.AMDT 3276)

**“Health Care and Education Reconciliation Act of 2010”**

Senate-Passed on March 25, 2010  
House-Passed on March 25, 2010  
(HR 4872)

<p><u>Medicaid Expansion:</u> Medicaid will be expanded to all individuals under age 65, including children, pregnant women, parents, and adults without dependent children, who have incomes up to 150 percent FPL. Medicaid payment rates for primary care providers will be increased to 100 percent of Medicare rates by 2012. States must submit a state plan amendment specifying the payment rates to be paid under the state’s Medicaid program. The mandated coverage expansions will be 100 percent federally financed through 2014, and will receive 91 percent federal financing in 2015 and beyond.</p>	<p><u>Medicaid Expansion:</u> Medicaid will be expanded to include all individuals under age 65, including children, pregnant women, parents, and adults without dependent children, as long as they have incomes up to 133 percent FPL.</p> <p>Newly Medicaid eligible adults will be guaranteed a benchmark benefit package consistent with the requirements of Section 1937 of the Social Security Act. The package must at least provide the essential health benefits, which will be financed with 100 percent federal funding for fiscal years 2014-2016, after which financing will be through an FMAP increase.</p> <p>For states already covering adults with incomes at or above 100 percent FPL, their FMAP increase will be 30.3 percent in 2017 and 31.3 percent in 2018. All other states will receive an FMAP increase of 34.3 percent in 2017 and 33.3 percent in 2018, except Nebraska, which will continue to receive 100 percent federal funding for new eligibles after 2017. Beginning in 2019, all states will receive an FMAP increase of 32.3 percentage points for the newly eligible. The increased FMAP for all states, except Nebraska, will be capped at 95percent. Certain states not eligible for the enhanced federal funding because they had already expanded Medicaid to adults with incomes above 133 percent FPL will receive a 2.2 percentage point increase in their FMAP for parents and childless adults who are not newly eligible for 2014</p>	<p><u>Medicaid Expansion:</u> Medicaid will be expanded to include all individuals under age 65, including children, pregnant women, parents, and adults without dependent children, as long as they have incomes up to 133 percent FPL. (HR 3590, Sec. 2001).</p> <p><i>Newly Medicaid eligible adults will be guaranteed a benchmark benefit package consistent with the requirements of Section 1937 of the Social Security Act. The package must at least provide the essential health benefits, which will be financed with 100 percent federal funding for 2014-2016, 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent for 2020 and beyond. (HR 4872, Sec. 1201).</i></p> <p><i>For states already covering adults with incomes up to 100 percent FPL, they will received a phased-in FMAP increase for non-pregnant childless adults to the extent necessary that in 2020, these states will receive the same 90 percent federal financing as other states. The federal government will not cover the entire cost of expanding Medicaid in Nebraska in perpetuity. (HR 4872, Sec. 1201).</i></p> <p><i>In 2013 and 2014, Medicaid payment rates for primary care doctors will be increased to equal Medicare reimbursement rates. States will receive 100 percent federal financing to pay for the increase. (HR 4872, Sec. 1202).</i></p>
--	---	---



**DRAFT**

**“Affordable Health Care for America Act”**

House-Passed on Nov. 7, 2009  
(HR 3962)

**“Patient Protection and Affordable Care Act”**

Senate-Passed on Dec. 24, 2009  
(HR 3590), including  
Manager’s Amendment (S.AMDT 3276)

**“Health Care and Education Reconciliation Act of 2010”**

Senate-Passed on March 25, 2010  
House-Passed on March 25, 2010  
(HR 4872)

	through 2019 or a .5 percentage point increase in the FMAP for 2014-2016.	
<p><u>Maintenance of Effort:</u> Maintain Medicaid eligibility standards, methodologies or procedures that were in place as of June 16, 2009, as a condition of receiving federal Medicaid matching payments. Extend the maintenance of eligibility requirement for children in Medicaid-expansion CHIP programs with incomes above 150 percent FPL. Maintain CHIP eligibility through 2013.</p>	<p><u>Maintenance of Effort:</u> Until the Exchanges are fully operational in 2014, states must maintain current Medicaid eligibility levels for adults. States must maintain current Medicaid and CHIP eligibility levels for children through October 1, 2019.</p> <p>A state will be exempt from the MOE requirement for non-disabled adults with incomes above 133 percent FPL for any year from January 2011 through December 31, 2013 if the state certifies that it is experiencing a budget deficit or will experience a deficit in the following year.</p>	<p><u>Maintenance of Effort:</u> Until the Exchanges are fully operational in 2014, states must maintain current Medicaid eligibility levels for adults. States must maintain current Medicaid and CHIP eligibility levels for children through October 1, 2019. (HR 3590, Sec. 2001.)</p> <p>A state will be exempt from the MOE requirement for non-disabled adults with incomes above 133 percent FPL for any year from January 2011 through December 31, 2013 if the state certifies that it is experiencing a budget deficit or will experience a deficit in the following year. (HR 3590, Sec. 2001.)</p>
<p><u>Individual Subsidies:</u> Premium and cost-sharing credits will be limited to U.S. citizens and legal immigrants who meet the income requirements and are otherwise not enrolled in coverage. Employees with access to employer-based coverage are eligible only if the cost of the employee’s premium is more than 12 percent of the individual’s income.</p> <p>Premium credits will be provided to eligible individuals and families with incomes up to 400 percent FPL. These credits will be used to purchase insurance through the Health Insurance Exchange, and their amounts will be</p>	<p><u>Individual Subsidies:</u> Premium credits and cost-sharing subsidies will be limited to U.S. citizens and legal immigrants meeting the income eligibility requirements. Employees offered coverage by their employer will not be eligible for premium credits unless the employer plan has an actuarial value of less than 60 percent or if the employee share of the premium exceeds 9.8 percent of the employee’s income.</p> <p>Premium credits will be provided to eligible individuals and families with incomes between 100percent-400 percent FPL. These credits will be used to purchase insurance through the Exchanges, and their amounts</p>	<p><i>Individual Subsidies: Premium credits and cost-sharing subsidies will be limited to U.S. citizens and legal immigrants meeting the income eligibility requirements. Employees offered coverage by their employer will not be eligible for premium credits unless the employer plan has an actuarial value of less than 60 percent or if the employee share of the premium exceeds 9.5 percent of the employee’s income. (HR 3590, Sec. 1401, as amended by Sec. 10105 and HR 4872, Sec. 1001).</i></p> <p><i>Premium credits will be provided to eligible individuals and families with incomes between 133percent-400 percent FPL. These credits will be used to purchase</i></p>

**“Affordable Health Care for America Act”**

House-Passed on Nov. 7, 2009  
(HR 3962)

**“Patient Protection and Affordable Care Act”**

Senate-Passed on Dec. 24, 2009  
(HR 3590), including  
Manager’s Amendment (S.AMDT 3276)

**“Health Care and Education Reconciliation Act of 2010”**

Senate-Passed on March 25, 2010  
House-Passed on March 25, 2010  
(HR 4872)

<p>set on a sliding scale tied to specific income tiers.</p> <p>Cost-sharing subsidies will be provided to eligible Individuals and families with incomes up to 400 percent FPL.</p>	<p>will be set on a sliding scale tied to specific income tiers.</p> <p>Cost-sharing subsidies will be provided to eligible individuals and families with incomes between 100percent-200 percent FPL.</p>	<p><i>insurance through the Exchanges, and their amounts will be set on a sliding scale tied to specific income tiers. (HR 3590, Sec. 1401, as amended by Sec. 10105 and HR 4872, Sec. 1001).</i></p> <p><i>Cost-sharing subsidies will be provided to eligible individuals and families with incomes between 100 percent and 400 percent FPL. (HR 3590, Sec. 1401, as amended by Sec. 10105 and HR 4872, Sec. 1001).</i></p>
<p><u>Employer Subsidies:</u> Small employers with fewer than 25 employees and average wages of less than \$40,000 will receive a health coverage tax credit for up to two years. The credit phases out as firm size and average wage increases, and the credit is not applicable to employees earning more than \$80,000 per year.</p> <p>A temporary reinsurance program for employers providing coverage to Medicare-ineligible retirees over age 55 will reimburse employers for 80 percent of retiree claims between \$15,000 and \$90,000. \$10 billion over ten years is appropriated for the program, which will be effective 90 days after enactment.</p>	<p><u>Employer Subsidies:</u> Small employers with fewer than 25 employees and annual wages of less than \$50,000 that purchase health insurance for employees receiving a premium tax credit will receive a phased in tax credit subsidy. The credits employers receive will be based on a percentage of the employer’s contribution to the employee’s health plan, and will be phased out as the firm size and average wage increases.</p> <p>A temporary reinsurance program for employers providing coverage to Medicare-ineligible retirees over age 55 will reimburse employers for 80 percent of retiree claims between \$15,000 and \$90,000. \$5 billion is appropriated for the program, which will be effective 90 days after enactment, through January 1, 2014.</p>	<p><u>Employer Subsidies:</u> Small employers with fewer than 25 employees and annual wages of less than \$50,000 that purchase health insurance for employees receiving a premium tax credit will receive a phased in tax credit subsidy. The credits employers receive will be based on a percentage of the employer’s contribution to the employee’s health plan, and will be phased out as the firm size and average wage increases. (HR 3590, Sec. 1421 as amended by Sec. 10105).</p> <p>A temporary reinsurance program for employers providing coverage to Medicare-ineligible retirees over age 55 will reimburse employers for 80 percent of retiree claims between \$15,000 and \$90,000. \$5 billion is appropriated for the program, which will be effective 90 days after enactment, through January 1, 2014. (HR 3590, Sec. 1102, as amended by Sec. 10102).</p>
<p><u>CHIP:</u> the Children’s Health Insurance Program will be</p>	<p><u>CHIP:</u> States must maintain the current income eligibility</p>	<p><u>CHIP:</u> States must maintain the current income eligibility</p>



**DRAFT**

**“Affordable Health Care for America Act”**

House-Passed on Nov. 7, 2009  
(HR 3962)

**“Patient Protection and Affordable Care Act”**

Senate-Passed on Dec. 24, 2009  
(HR 3590), including  
Manager’s Amendment (S.AMDT 3276)

**“Health Care and Education Reconciliation Act of 2010”**

Senate-Passed on March 25, 2010  
House-Passed on March 25, 2010  
(HR 4872)

<p>repealed. Beginning in 2014, enrollees in state CHIP programs with incomes over 150 percent FPL will be required to obtain coverage through the Exchange. Children with incomes above 150 percent FPL enrolled in Medicaid-expansion CHIP programs will keep Medicaid coverage. In 2014, states will receive the enhanced CHIP match rate for these children. CHIP enrollees with incomes between 100 percent and 150 percent FPL will have their coverage transitioned to Medicaid, and states will receive the CHIP enhanced match rate for children above current levels and up to 150 percent FPL.</p>	<p>levels for children in Medicaid and CHIP until 2019.</p> <p>States must extend funding for CHIP through 2015, and the CHIP benefit package and cost-sharing rules will continue under current law.</p> <p>In 2015, states will receive a 23 percent increase in the CHIP match rate, with a cap of 100percent.</p> <p>Children otherwise eligible for CHIP but who are unable to participate due to enrollment caps will be eligible for tax credits in the state Exchanges.</p>	<p>levels for children in Medicaid and CHIP until 2019. (HR 3590, Sec. 2101).</p> <p>States must extend funding for CHIP through 2015, and the CHIP benefit package and cost-sharing rules will continue under current law. (HR 3590, Sec. 10203).</p> <p>In 2015, states will receive a 23 percent increase in the CHIP match rate, with a cap of 100percent. (HR 3590, Sec. 2101, as amended by Sec. 10203).</p> <p>Children otherwise eligible for CHIP but who are unable to participate due to enrollment caps will be eligible for tax credits in the state Exchanges. (HR 3590, Sec. 2101, as amended by Sec. 10203).</p>
---	---	--

**EXCHANGES**

<p><u>Creation and Structure:</u> Creates a National Health Insurance Exchange, through which individuals and employers can purchase qualified insurance, including both private health plans and the public health insurance option. Eligibility for employers will be phased in, starting with the smallest employers. States will be allowed to operate state-based exchanges if they demonstrate the capacity to meet the requirements for administering the exchange.</p> <p>Coverage will be restricted to those who are not enrolled in qualified or grandfathered employer or individual, Medicare, Medicaid, TRICARE or VA coverage.</p>	<p><u>Creation and Structure:</u> By January 1, 2014, state-based American Health Benefit Exchanges (The Exchange) and Small Business Health Options Program (SHOP) Exchanges, to be administered by a government agency or a non-profit organization, through which individuals and small businesses with up to 100 employees can purchase qualified coverage will be created.</p> <p>When first operational, the Exchanges will serve as gateways through which individuals and small businesses with up to 100 employees can purchase qualified coverage. States will be able to allow businesses with more than 100 employees to purchase</p>	<p><u>Creation and Structure:</u> By January 1, 2014, state-based American Health Benefit Exchanges (The Exchange) and Small Business Health Options Program (SHOP) Exchanges, to be administered by a government agency or a non-profit organization, through which individuals and small businesses with up to 100 employees can purchase qualified coverage will be created. (HR 3590, Sec. 1311).</p> <p>When first operational, the Exchanges will serve as gateways through which individuals and small businesses with up to 100 employees can purchase qualified coverage. States will be able to allow</p>
---	---	---



**DRAFT**

**“Affordable Health Care for America Act”**

House-Passed on Nov. 7, 2009  
(HR 3962)

**“Patient Protection and Affordable Care Act”**

Senate-Passed on Dec. 24, 2009  
(HR 3590), including  
Manager’s Amendment (S.AMDT 3276)

**“Health Care and Education Reconciliation Act of 2010”**

Senate-Passed on March 25, 2010  
House-Passed on March 25, 2010  
(HR 4872)

<p>Illegal immigrants could participate in the exchange, but would be ineligible for federal subsidies.</p>	<p>coverage beginning in 2017.</p> <p>Within one year of Enactment and until January 1, 2015, funding will be available through Planning and Establishment grants for states to establish the Exchange.</p> <p>States may form regional Exchanges or allow more than one Exchange to operate in a state as long as each Exchange serves a distinct geographic area.</p> <p>Coverage will be limited to US citizens and legal immigrants who are not incarcerated. Illegal immigrants could not participate in the exchange.</p> <p>By July 1, 2010, the Secretary, in consultation with the states, will establish a website allowing residents and small businesses in any state to access information about coverage options and ratings. The Secretary will assist states in developing their own such websites.</p>	<p>businesses with more than 100 employees to purchase coverage beginning in 2017. (HR 3590, Sec. 1312).</p> <p>Within one year of Enactment and until January 1, 2015, funding will be available through Planning and Establishment grants for states to establish the Exchange. (HR 3590, Sec. 1311).</p> <p>States may form regional Exchanges or allow more than one Exchange to operate in a state as long as each Exchange serves a distinct geographic area. (HR 3590, Sec. 1311).</p> <p>Coverage will be limited to US citizens and legal immigrants who are not incarcerated. Illegal immigrants could not participate in the exchange. (HR 3590, Sec. 1312).</p> <p>By July 1, 2010, the Secretary, in consultation with the states, will establish a website allowing residents and small businesses in any state to access information about coverage options and ratings. The Secretary will assist states in developing their own such websites. (HR 3590, Sec. 1103).</p>
<p><u>Public Plan</u>: The House plan creates a new public health insurance option to be offered through the Health Insurance Exchange that must meet the same requirements as private plans regarding benefit levels, provider networks, consumer protections, and cost-</p>	<p><u>Public Plan</u>: No public option. Instead, the Senate bill requires the Office of Personnel Management to contract with insurers to offer at least two multi-state plans in each Exchange, at least one of which must be offered by a non-profit, and at least one that does not</p>	<p><u>Public Plan</u>: No public option. Instead, the Reconciled Senate bill requires the Office of Personnel Management to contract with insurers to offer at least two multi-state plans in each Exchange, at least one of which must be offered by a non-profit, and at least one</p>



**DRAFT**

**“Affordable Health Care for America Act”**

House-Passed on Nov. 7, 2009  
(HR 3962)

**“Patient Protection and Affordable Care Act”**

Senate-Passed on Dec. 24, 2009  
(HR 3590), including  
Manager’s Amendment (S.AMDT 3276)

**“Health Care and Education Reconciliation Act of 2010”**

Senate-Passed on March 25, 2010  
House-Passed on March 25, 2010  
(HR 4872)

<p>sharing. The public plan will be required to offer basic, enhanced, and premium plans, and it may offer premium plus plans. The public plan may not provide coverage for abortions beyond what is permitted by current federal law. The public option will be financed through revenues from premiums, and will be required to negotiate rates with providers so that the public option rates are not lower than Medicare rates, nor are they to be higher than the average rates paid through other qualified health benefit plans.</p>	<p>extend abortion coverage beyond what is permitted by current federal law. Each multi-state plan must be licensed in each state in which it is operational, and it must meet the requirements of a qualified health plan. These plans will be offered separately from the Federal Employees Health Benefit Program, and will also have a separate risk pool.</p>	<p>that does not extend abortion coverage beyond what is permitted by current federal law. Each multi-state plan must be licensed in each state in which it is operational, and it must meet the requirements of a qualified health plan. These plans will be offered separately from the Federal Employees Health Benefit Program, and will also have a separate risk pool. (HR 3590, Sec. 1334, as amended by Sec. 10104).</p>
<p><u>Consumer Operated and Oriented Plan:</u> The Consumer Operated and Oriented Plan (CO-OP) program will provide funds to create non-profit, member run health insurance cooperatives in each state, which will provide insurance through the Exchange.</p>	<p><u>Consumer Operated and Oriented Plan:</u> The Consumer Operated and Oriented Plan (CO-OP) program will give out funds to create non-profit, member run health insurance cooperatives in each state, which will offer qualified health plans. The Secretary will award these funds no later than July 1, 2013.</p>	<p><u>Consumer Operated and Oriented Plan:</u> The Consumer Operated and Oriented Plan (CO-OP) program will give out funds to create non-profit, member run health insurance cooperatives in each state, which will offer qualified health plans. . The Secretary will award these funds no later than July 1, 2013. (HR 3590, Sec. 1322, as amended by Sec. 10104).</p>
<p><u>Benefit Tiers:</u> The Exchange will offer four benefit categories: -Basic plan =70 percent of the benefit costs of the plan; -Enhanced plan = 85 percent of benefit costs of the plan; -Premium plan = 95 percent of the benefit costs of the plan; -Premium plus plan is a premium plan that provides additional benefits, such as oral health and vision care.</p>	<p><u>Benefit Tiers:</u> There will be four benefit categories of plans to be offered through the Exchange and in the individual and small group markets, as well as a separate catastrophic plan. The catastrophic plan is available to those up to age 30, or to those who are exempt from the mandate to purchase coverage; it is only available in the individual market. – Bronze plan = 60 percent of the benefit costs of the plan – Silver plan = 70 percent of the benefit costs of the plan</p>	<p><u>Benefit Tiers:</u> There will be four benefit categories of plans to be offered through the Exchange and in the individual and small group markets, as well as a separate catastrophic plan. The catastrophic plan is available to those up to age 30, or to those who are exempt from the mandate to purchase coverage; it is only available in the individual market. – Bronze plan = 60 percent of the benefit costs of the plan – Silver plan = 70 percent of the benefit costs of the plan</p>

**“Affordable Health Care for America Act”**

House-Passed on Nov. 7, 2009  
(HR 3962)

**“Patient Protection and Affordable Care Act”**

Senate-Passed on Dec. 24, 2009  
(HR 3590), including  
Manager’s Amendment (S.AMDT 3276)

**“Health Care and Education Reconciliation Act of 2010”**

Senate-Passed on March 25, 2010  
House-Passed on March 25, 2010  
(HR 4872)

	<ul style="list-style-type: none"> <li>– Gold plan = 80 percent of the benefit costs of the plan</li> <li>– Platinum plan = 90 percent of the benefit costs of the plan.</li> </ul>	<ul style="list-style-type: none"> <li>– Gold plan = 80 percent of the benefit costs of the plan</li> <li>– Platinum plan = 90 percent of the benefit costs of the plan. (HR 3590, Sec. 1302, as amended by Sec. 10104).</li> </ul>
	<p><u>Basic Health Plan:</u> States will have the option to create a Basic Health Plan for uninsured individuals with incomes between 133-200 percent FPL who would otherwise be eligible to receive premium subsidies in the Exchange. States will receive 95 percent of the funds that would have been paid as federal premium and cost-sharing subsidies for eligible individuals to establish the Basic Health Plan. Individuals with incomes between 133-200 percent FPL in states creating Basic Health Plans will not be eligible for subsidies in the Exchanges.</p>	<p><u>Basic Health Plan:</u> States will have the option to create a Basic Health Plan for uninsured individuals with incomes between 133-200 percent FPL who would otherwise be eligible to receive premium subsidies in the Exchange. States will receive 95 percent of the funds that would have been paid as federal premium and cost-sharing subsidies for eligible individuals to establish the Basic Health Plan. Individuals with incomes between 133-200 percent FPL in states creating Basic Health Plans will not be eligible for subsidies in the Exchanges. (HR 3590, Sec. 1331).</p>
<p><u>Temporary High-Risk Pool:</u> Effective January 1, 2010 and until the Health Insurance Exchange is established, a national high-risk pool will provide coverage to individuals, as well as to their spouses and dependants, with pre-existing medical conditions. Those who have been denied coverage, offered unaffordable coverage, have an eligible medical condition or have been uninsured for at least six months may enroll.</p>	<p><u>Temporary High-Risk Pool:</u> Effective within 90 days of enactment and lasting until January 1, 2014, a national high-risk pool will provide coverage to individuals with pre-existing medical conditions. Those U.S. citizens and legal immigrants who have been uninsured for at least six months may enroll. \$5 billion is appropriated to finance the program.</p>	<p><u>Temporary High-Risk Pool:</u> Effective within 90 days of enactment and lasting until January 1, 2014, a national high-risk pool will provide coverage to individuals with pre-existing medical conditions. Those U.S. citizens and legal immigrants who have been uninsured for at least six months may enroll. \$5 billion is appropriated to finance the program. (HR 3590, Sec. 1101).</p>
<p><u>Dependent Coverage:</u> Children up to age 27 will receive coverage in all individual and group policies, effective January 1, 2010.</p>	<p><u>Dependent Coverage:</u> Children up to age 26 will receive coverage in all individual and group policies, effective six months following enactment.</p>	<p><u>Dependent Coverage:</u> Children up to age 26 will receive coverage in all individual and group policies (HR 3590, Sec. 2714).</p>



**DRAFT**

**“Affordable Health Care for America Act”**

House-Passed on Nov. 7, 2009  
(HR 3962)

**“Patient Protection and Affordable Care Act”**

Senate-Passed on Dec. 24, 2009  
(HR 3590), including  
Manager’s Amendment (S.AMDT 3276)

**“Health Care and Education Reconciliation Act of 2010”**

Senate-Passed on March 25, 2010  
House-Passed on March 25, 2010  
(HR 4872)

		<p><i>For plan years before 2014, only adult children with grandfathered group plans who are not eligible for employer-sponsored coverage may stay on their parent’s plan. (HR 4872, Sec. 2301).</i></p> <p><i>Grandfathered group and individual plans will be required to extend dependent coverage to adult children up to age 26. (HR 4872, Sec. 2301).</i></p>
<p><u>Essential Benefits Package:</u> An essential health benefits package will provide a comprehensive set of services and will cover at least 70 percent of the actuarial value of the covered benefits, will limit annual cost-sharing to the current law limits, and must not be more extensive than the typical employer plan.</p> <p>All qualified health benefits plans, including those offered through the Exchanges and the individual and small group markets outside the Exchanges, will offer at least the essential health benefits package. Grandfathered individual and employer-sponsored plans are exempt from this requirement.</p> <p>Essential health benefit plans will include at least the following benefits: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse services, labs, prescription drugs, rehabilitative services and devices, preventive and wellness, and pediatrics.</p>	<p><u>Essential Benefits Package:</u> Effective January 1, 2014, an essential health benefits package will provide a comprehensive set of services and will cover at least 60 percent of the actuarial value of the covered benefits, will limit annual cost sharing to the current law limits, and must not be more extensive than the typical employer plan.</p> <p>All qualified health benefits plans, including those offered through the Exchanges and the individual and small group markets outside the Exchanges, will offer at least the essential health benefits package. Grandfathered individual and employer-sponsored plans are exempt from this requirement.</p> <p>All plans sold in the non group and small group markets will be required to cover the following benefits: preventive and primary care, including wellness services and chronic disease management, physician services, outpatient services, emergency services, ambulatory</p>	<p><u>Essential Benefits Package:</u> Effective January 1, 2014, essential health benefits package will provide a comprehensive set of services and will cover at least 60 percent of the actuarial value of the covered benefits, will limit annual cost sharing to the current law limits, and must not be more extensive than the typical employer plan. (HR 3590, Sec. 1302, as amended by Sec. 10104).</p> <p>All qualified health benefits plans, including those offered through the Exchanges and the individual and small group markets outside the Exchanges, will offer at least the essential health benefits package. Grandfathered individual and employer-sponsored plans are exempt from this requirement. (HR 3590, Sec. 2707).</p> <p>All plans sold in the non group and small group markets will be required to cover the following benefits: preventive and primary care, including wellness services and chronic disease management, physician services,</p>

**“Affordable Health Care for America Act”**

House-Passed on Nov. 7, 2009  
(HR 3962)

**“Patient Protection and Affordable Care Act”**

Senate-Passed on Dec. 24, 2009  
(HR 3590), including  
Manager’s Amendment (S.AMDT 3276)

**“Health Care and Education Reconciliation Act of 2010”**

Senate-Passed on March 25, 2010  
House-Passed on March 25, 2010  
(HR 4872)

	<p>patient services, hospitalization, day surgery and related anesthesia, diagnostic imaging, screenings including x-rays, rehabilitative and habilitative services and devices, laboratory services, maternity and newborn care, pediatric services including dental and vision, medical/surgical care, prescription drugs, radiation, chemotherapy, and mental health and substance abuse services, including behavioral health treatment, that meet minimum standards set by federal and state laws.</p>	<p>outpatient services, emergency services, ambulatory patient services, hospitalization, day surgery and related anesthesia, diagnostic imaging, screenings including x-rays, rehabilitative and habilitative services and devices, laboratory services, maternity and newborn care, pediatric services including dental and vision, medical/surgical care, prescription drugs, radiation, chemotherapy, and mental health and substance abuse services, including behavioral health treatment, that meet minimum standards set by federal and state laws. (HR 3590, Sec. 1302, as amended by Sec. 10104).</p>
<p><u>Insurance Regulations:</u> Insurers will no longer be able to deny coverage or charge higher premiums based on pre-existing conditions or gender.</p>	<p><u>Insurance Regulations:</u> Insurers will no longer be able to deny coverage or charge higher premiums based on pre-existing conditions or gender, nor will they be permitted to place lifetime dollar limits on coverage or rescind coverage when an individual becomes sick or disabled. For children, these regulations will be effective within six months of enactment.</p> <p>For adults, the ban on exclusion based on pre-existing conditions will be effective in 2014, when the exchanges become operational.</p> <p>Effective January 1, 2014, coverage waiting periods will be limited to 90 days.</p>	<p><u>Insurance Regulations:</u> Insurers will no longer be able to deny coverage or charge higher premiums based on pre-existing conditions or gender, nor will they be permitted to place lifetime dollar limits on coverage or rescind coverage when an individual becomes sick or disabled. For children, these regulations will be effective within six months of enactment. (HR 3590, Sec. 1201, as amended by Sec. 10103).</p> <p><i>For adults, the ban on exclusion based on pre-existing conditions will be effective in 2014, when the exchanges become operational. This applies to grandfathered group plans as well. (HR 3590, Sec. 1201, as amended by Sec. 10103 and HR 4872, Sec. 2301).</i></p> <p><i>The ban on exclusion based on medical condition and annual limits will be extended to all employer-sponsored health plans, including those grandfathered in, by 2014.</i></p>



**DRAFT**

**“Affordable Health Care for America Act”**

House-Passed on Nov. 7, 2009  
(HR 3962)

**“Patient Protection and Affordable Care Act”**

Senate-Passed on Dec. 24, 2009  
(HR 3590), including  
Manager’s Amendment (S.AMDT 3276)

**“Health Care and Education Reconciliation Act of 2010”**

Senate-Passed on March 25, 2010  
House-Passed on March 25, 2010  
(HR 4872)

		<p>(HR 4872, Sec. 2301).</p> <p><i>The ban on lifetime dollar limits and coverage rescission will be extended to all existing health plans, including those grandfathered in, within six months of enactment. (HR 4872, Sec. 2301).</i></p> <p><i>Effective January 1, 2014, coverage waiting periods for all plans, including qualifying grandfathered plans, will be limited to 90 days. (HR 3590, Sec. 1201, as amended by Sec. 10103 and HR 4872, Sec. 2301).</i></p>
	<p><u>State Innovation Waivers:</u> State plan years beginning January 1, 2017 are eligible for State Innovation Waivers. Under these waivers, a state may enact a law to waive, for five years, any of the health insurance requirements within the state. Waivers will only be granted if the state’s coverage plan is at least as comprehensive, affordable and widespread as the qualified plans offered through the Exchange that the state plan will replace. The state plan must also not increase the federal deficit.</p>	<p><u>State Innovation Waivers:</u> State plan years beginning January 1, 2017 are eligible for State Innovation Waivers. Under these waivers, a state may enact a law to waive, for five years, any of the health insurance requirements within the state. Waivers will only be granted if the state’s coverage plan is at least as comprehensive, affordable and widespread as the qualified plans offered through the Exchange that the state plan will replace. The state plan must also not increase the federal deficit. (HR 3590, Sec. 1332).</p>
<b>FINANCING</b>		
<p><u>Federal Budget Impact:</u> The Congressional Budget Office estimates outlays to be \$894 billion over ten years, resulting in a net reduction of the deficit of \$104 billion in the same time frame.</p>	<p><u>Federal Budget Impact:</u> The Congressional Budget Office estimates outlays to be \$871 billion over ten years, resulting in a net reduction of the deficit by \$132 billion in the same time frame.</p>	<p><u>Federal Budget Impact:</u> The Congressional Budget Office estimates the Reconciliation bill’s coverage will cost \$938 billion over ten years, while the health provisions will reduce the deficit by \$124 billion in the same time frame. The education provisions in the bill are estimated</p>



**DRAFT**

**“Affordable Health Care for America Act”**

House-Passed on Nov. 7, 2009  
(HR 3962)

**“Patient Protection and Affordable Care Act”**

Senate-Passed on Dec. 24, 2009  
(HR 3590), including  
Manager’s Amendment (S.AMDT 3276)

**“Health Care and Education Reconciliation Act of 2010”**

Senate-Passed on March 25, 2010  
House-Passed on March 25, 2010  
(HR 4872)

		<p><i>to reduce the deficit by an additional \$19 billion, resulting in a total ten-year reduction of \$143 billion.</i></p>
<p><u>Revenue Sources:</u> These costs will be financed through a combination of savings from Medicare and Medicaid and new taxes and fees. The net savings from Medicare and Medicaid are estimated to be \$426 billion over ten years. The largest source of new revenue, approximately \$461 billion, will come from a 5.4 percent surcharge imposed on families with incomes above \$1,000,000 and individuals with incomes above \$500,000. Additional revenue provisions in the form of additional tax changes will generate \$97 billion over the same time period.</p>	<p><u>Revenue Sources:</u> These costs will be financed through a combination of savings from Medicare and Medicaid and new taxes and fees. The net savings from Medicare and Medicaid are estimated to be \$438 billion over ten years. The largest source of new revenue, approximately \$149 billion over ten years, will result from an excise tax on high-cost insurance. Additional revenue provisions include fees on certain manufacturers and insurers, an increase in hospital insurance contributions for high high-income taxpayers, and other provisions that will generate \$264 billion over the same time period.</p> <p>\$116 billion will be cut from federal subsidies for privately offered Medicare Advantage plans.</p>	<p><i>Revenue Sources: These costs will be financed through a combination of savings from Medicare and Medicaid and new taxes and fees. The bill’s excise tax on high-cost insurance will generate \$32 billion of new revenue in ten years, and will be implemented in 2018. The tax will affect plans that cost more than \$10,200 for individuals and \$27,500 for families, to be adjusted for inflation. (HR 4872, Sec. 1401).</i></p> <p><i>For taxable years after December 31, 2012, the Medicare payroll tax will be extended to investment income, so that individuals earning more than \$200,000 or families earning more than \$250,000 will pay a 3.8 percent Medicare tax on investment income. (HR 4872, Sec. 1411).</i></p> <p><i>An additional \$16 billion will be cut from Medicare Advantage plans. (HR 4872, Sec. 1102).</i></p> <p><i>For sales of medical devices after December 31, 2012, a 2.3 percent excise tax will be levied on the sale price of most medical devices. (HR 4872, Sec. 4191).</i></p>

**QUALITY AND SYSTEM IMPROVEMENTS**

<p><u>Medical Malpractice:</u> States enacting qualifying alternative medical liability laws will receive incentive</p>	<p><u>Medical Malpractice:</u> States will receive five year demonstration grants to develop, implement, and</p>	<p><u>Medical Malpractice:</u> States will receive five year demonstration grants to develop, implement, and</p>
---	--	--



**DRAFT**

**“Affordable Health Care for America Act”**

House-Passed on Nov. 7, 2009  
(HR 3962)

**“Patient Protection and Affordable Care Act”**

Senate-Passed on Dec. 24, 2009  
(HR 3590), including  
Manager’s Amendment (S.AMDT 3276)

**“Health Care and Education Reconciliation Act of 2010”**

Senate-Passed on March 25, 2010  
House-Passed on March 25, 2010  
(HR 4872)

payments to do so.	evaluate alternatives to current tort litigations.	evaluate alternatives to current tort litigations. (HR 3590, Sec. 10607).
<u>Independence at Home:</u> The Independence at Home demonstration program will provide high-risk Medicare beneficiaries with primary care services in their homes, and participating teams of health professionals will share in any savings if they are able to reduce preventable hospitalizations, prevent hospital readmissions, improve health outcomes, improve the efficiency of care, reduce the cost of health care services, and achieve patient satisfaction.	<u>Independence at Home:</u> The Independence at Home demonstration program will provide high-risk Medicare beneficiaries with primary care services in their homes, and participating teams of health professionals will share in any savings if they are able to reduce preventable hospitalizations, prevent hospital readmissions, improve health outcomes, improve the efficiency of care, reduce the cost of health care services, and achieve patient satisfaction. The demonstration program will begin no later than January 1, 2012.	<u>Independence at Home:</u> The Independence at Home demonstration program will provide high-risk Medicare beneficiaries with primary care services in their homes, and participating teams of health professionals will share in any savings if they are able to reduce preventable hospitalizations, prevent hospital readmissions, improve health outcomes, improve the efficiency of care, reduce the cost of health care services, and achieve patient satisfaction. The demonstration program will begin no later than January 1, 2012. (HR 3590, Sec. 3024).
	<u>Special adjustment to the FMAP for certain states recovering from a major disaster:</u> Beginning January 1, 2011, qualifying states will receive increased FMAPs. Eligible states are those in which during the seven preceding fiscal years, the President has declared the state to be a major national disaster, and as a result of this disaster, every county or parish in the state warranted federal government assistance.	<u>Special adjustment to the FMAP for certain states recovering from a major disaster:</u> Beginning January 1, 2011, qualifying states will receive increased FMAPs. Eligible states are those in which during the seven preceding fiscal years, the President has declared the state to be a major national disaster, and as a result of this disaster, every county or parish in the state warranted federal government assistance. (HR 3590, Sec. 2006).
<u>Dual Eligibles:</u> Creates a new office within the Centers for Medicare and Medicaid services (CMS) to improve coordination of care for dual eligibles.	<u>Dual Eligibles:</u> No later than March 1, 2010, there will be a new office, the Federal Coordinated Health Care Office for Dual Eligible Beneficiaries, within the Centers for	<u>Dual Eligibles:</u> No later than March 1, 2010, there will be a new office, the Federal Coordinated Health Care Office for Dual Eligible Beneficiaries, within the Centers for



**DRAFT**

**“Affordable Health Care for America Act”**

House-Passed on Nov. 7, 2009  
(HR 3962)

**“Patient Protection and Affordable Care Act”**

Senate-Passed on Dec. 24, 2009  
(HR 3590), including  
Manager’s Amendment (S.AMDT 3276)

**“Health Care and Education Reconciliation Act of 2010”**

Senate-Passed on March 25, 2010  
House-Passed on March 25, 2010  
(HR 4872)

<p>By January 1, 2011, the Center for Medicare and Medicaid Innovation within CMS will be established to, in part, test innovative payment and service delivery models to reduce program expenditures while simultaneously preserving or enhancing the quality of care furnished.</p>	<p>Medicare and Medicaid services (CMS) to more effectively integrate Medicare and Medicaid benefits and to improve coordination between the federal government and states in order to improve access to and quality of care and services for dual eligibles.</p> <p>By January 1, 2011, the Center for Medicare and Medicaid Innovation within CMS will be established to, in part, test innovative payment and service delivery models to reduce program expenditures while simultaneously preserving or enhancing the quality of care furnished. The Center allows states to test and evaluate models for fully integrating care for dual eligibles within the state, as well as payment reform models for the medical care residents of the state, including dual eligibles. Payment models will be implemented on a nationwide basis, with exceptions for states demonstrating that such implementation would not be feasible or appropriate to the health care delivery system of that state.</p> <p>No earlier than January 1, 2012, cost-sharing will be eliminated for dual eligibles receiving home and community based services who would otherwise be institutionalized.</p>	<p>Medicare and Medicaid services (CMS) to more effectively integrate Medicare and Medicaid benefits and to improve coordination between the federal government and states in order to improve access to and quality of care and services for dual eligibles. (HR 3590, Sec. 2602).</p> <p>By January 1, 2011, the Center for Medicare and Medicaid Innovation within CMS will be established to, in part, test innovative payment and service delivery models to reduce program expenditures while simultaneously preserving or enhancing the quality of care furnished. The Center allows states to test and evaluate models for fully integrating care for dual eligibles within the state, as well as payment reform models for the medical care residents of the state, including dual eligibles. Payment models will be implemented on a nationwide basis, with exceptions for states demonstrating that such implementation would not be feasible or appropriate to the health care delivery system of that state. (HR 3590, Sec. 3021).</p> <p>No earlier than January 1, 2012, cost-sharing will be eliminated for dual eligibles receiving home and community based services who would otherwise be institutionalized. (HR 3590, Sec. 3309).</p>
	<p><u>Hospice:</u> Medicaid hospice care for a child does not constitute a waiver of any other services the child may be eligible to receive related to the treatment of the</p>	<p><u>Hospice:</u> Medicaid hospice care for a child does not constitute a waiver of any other services the child may be eligible to receive related to the treatment of the</p>



**DRAFT**

**“Affordable Health Care for America Act”**

House-Passed on Nov. 7, 2009  
(HR 3962)

**“Patient Protection and Affordable Care Act”**

Senate-Passed on Dec. 24, 2009  
(HR 3590), including  
Manager’s Amendment (S.AMDT 3276)

**“Health Care and Education Reconciliation Act of 2010”**

Senate-Passed on March 25, 2010  
House-Passed on March 25, 2010  
(HR 4872)

	child’s condition.	child’s condition. (HR 3590, Sec. 3132).
<u>National Strategy to Improve Health Care Quality:</u> Establishes the Center for Quality Improvement, which will identify, develop, evaluate, disseminate, and implement best practices in the delivery of health care services. The Center will also develop national priorities for performance improvement as well as quality measures for the delivery of health care services.	<u>National Strategy to Improve Health Care Quality:</u> Instructs the Secretary to develop a national quality improvement strategy by January 1, 2011. The strategy will focus on how to improve the delivery of health care services, patient health outcomes and population health.	<u>National Strategy to Improve Health Care Quality:</u> Instructs the Secretary to develop a national quality improvement strategy by January 1, 2011. The strategy will focus on how to improve the delivery of health care services, patient health outcomes and population health. (HR 3590, Sec. 3011, as amended by Sec. 10302).
		<i>Implementation Funding: Establishes the Health Insurance Reform Implementation Fund within the Department of Health and Human Services. \$1 billion is appropriated to the fund to implement the Patient Protection and Affordable Care Act and its amendments. (HR 4872, Sec. 1005).</i>
<u>Community-based Collaborative Care Network Program</u> The Secretary will award grants to support health care providers as they work to coordinate and integrate health care services for low-income uninsured and underinsured populations	<u>Community-based Collaborative Care Network Program</u> The Secretary will award grants to support health care providers as they work to coordinate and integrate health care services for low-income uninsured and underinsured populations. Funds are authorized to be appropriated as necessary to carry out this program for five years, beginning in FY 2011.	<u>Community-based Collaborative Care Network Program</u> The Secretary will award grants to support health care providers as they work to coordinate and integrate health care services for low-income uninsured and underinsured populations. . Funds are authorized to be appropriated as necessary to carry out this program for five years, beginning in FY 2011. (HR 3590, Sec. 10332, 340H).
<u>Financial Disclosure:</u> Requires health plans seeking	<u>Financial Disclosure:</u> Requires health plans seeking	<u>Financial Disclosure:</u> Requires health plans seeking



**DRAFT**

**“Affordable Health Care for America Act”**

House-Passed on Nov. 7, 2009  
(HR 3962)

**“Patient Protection and Affordable Care Act”**

Senate-Passed on Dec. 24, 2009  
(HR 3590), including  
Manager’s Amendment (S.AMDT 3276)

**“Health Care and Education Reconciliation Act of 2010”**

Senate-Passed on March 25, 2010  
House-Passed on March 25, 2010  
(HR 4872)

<p>certification as a qualified health plan to make periodic financial disclosures of financial relationships between health entities, including physicians, hospitals, pharmacists, other providers, and manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies.</p>	<p>certification as a qualified health plan to make periodic financial disclosures of financial relationships between health entities, including physicians, hospitals, pharmacists, other providers, and manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies.</p>	<p>certification as a qualified health plan to make periodic financial disclosures of financial relationships between health entities, including physicians, hospitals, pharmacists, other providers, and manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies. (HR 3590, Sec. 1303, as amended by Sec. 10104).</p>
<p><u>Anti-Trust Exemption:</u> Provides for a partial repeal of the McCarran-Ferguson Act, effectively repealing the health insurance industry’s exemption from federal antitrust laws.</p>		
<p><u>Payment Reform/Bundling:</u> The Secretary will be given three years to develop a plan to reform the payment system for post acute care (PAC) under Medicare. The plan will include specifications for bundled payments, and will aim to improve the coordination, quality and efficacy of PAC services and the outcomes for individuals, including reducing hospital readmissions.</p> <p>By January 1, 2011, the acute care episode demonstration program will be converted to a pilot program, and expanded to include post acute services. In respect to this newly created pilot program, bundled payments may be applied to hospitals, post acute care providers and physicians, including collaborative care</p>	<p><u>Payment Reform/Bundling:</u> By January 1, 2013, the Secretary must develop and implement a Medicare pilot program for integrated care focusing on coordination, quality and efficiency improvement. The pilot program will be conducted for five years and will include the use of bundled payment models.</p> <p>The Secretary may extend the pilot program after January 1, 2016, if such expansion is expected to improve quality and reduce costs.</p> <p>This section establishes a demonstration project, to last from January 1, 2012 through December 31, 2016. The purpose will be to study and evaluate the use of bundled payments for hospital and physician services</p>	<p><u>Payment Reform/Bundling:</u> By January 1, 2013, the Secretary must develop and implement a Medicare pilot program for integrated care focusing on coordination, quality and efficiency improvement. The pilot program will be conducted for five years and will include the use of bundled payment models. (HR 3590, Sec. 3023).</p> <p>The Secretary may extend the pilot program after January 1, 2016, if such expansion is expected to improve quality and reduce costs. (HR 3590, Sec. 10308).</p> <p>This section establishes a demonstration project, to last from January 1, 2012 through December 31, 2016. The</p>



**DRAFT**

**“Affordable Health Care for America Act”**

House-Passed on Nov. 7, 2009  
(HR 3962)

**“Patient Protection and Affordable Care Act”**

Senate-Passed on Dec. 24, 2009  
(HR 3590), including  
Manager’s Amendment (S.AMDT 3276)

**“Health Care and Education Reconciliation Act of 2010”**

Senate-Passed on March 25, 2010  
House-Passed on March 25, 2010  
(HR 4872)

networks and continuing care hospitals.	under Medicaid. Up to eight states will be selected by the Secretary to participate in the project.	purpose will be to study and evaluate the use of bundled payments for hospital and physician services under Medicaid. Up to eight states will be selected by the Secretary to participate in the project. (HR 3590, Sec. 2704).
<u>Medicare Senior Housing Plans:</u> This section amends Sec. 1859 of the SSA to create Medicare Advantage Senior Housing Facility Plans. These plans serve individuals living in a continuing care retirement community by providing onsite primary care services and transportation to offsite providers.	<u>Medicare Senior Housing Plans</u> This section amends Sec. 1859 of the SSA to make permanent Medicare Advantage Senior Housing Facility Demonstration Plans. These plans serve individuals living in a continuing care retirement community by providing onsite primary care services and transportation to offsite providers. This section will take effect on January 1, 2010, and will apply to plan years beginning on or after this date.	<u>Medicare Senior Housing Plans</u> This section amends Sec. 1859 of the SSA to make permanent Medicare Advantage Senior Housing Facility Demonstration Plans. These plans serve individuals living in a continuing care retirement community by providing onsite primary care services and transportation to offsite providers. This section will take effect on January 1, 2010, and will apply to plan years beginning on or after this date. (HR 3590, Sec. 3208).
	<u>Expansion of the Recovery Audit Contractor Program:</u> By December 31, 2010, states must have programs contracting with Medicare Recovery audit contractors to identify, and recoup where necessary, underpayments and overpayments with respect to services.	<u>Expansion of the Recovery Audit Contractor Program:</u> By December 31, 2010, states must have programs contracting with Medicare Recover audit contractors to identify, and recoup where necessary, underpayments and overpayments with respect to services. (HR 3590, Sec. 3309).
<u>Reduction or Elimination of Medicare Part D Coverage</u>	<u>Reduction or Elimination of Medicare Part D Coverage</u> <u>Gap:</u> The initial coverage limit will be increased by \$500	<u>Reduction or Elimination of Medicare Part D Coverage</u> <u>Gap:</u> Medicare beneficiaries who reach the Part D

**“Affordable Health Care for America Act”**

House-Passed on Nov. 7, 2009  
(HR 3962)

**“Patient Protection and Affordable Care Act”**

Senate-Passed on Dec. 24, 2009  
(HR 3590), including  
Manager’s Amendment (S.AMDT 3276)

**“Health Care and Education Reconciliation Act of 2010”**

Senate-Passed on March 25, 2010  
House-Passed on March 25, 2010  
(HR 4872)

<p><u>Gap:</u> This section provides for an immediate reduction in the coverage gap, or donut hole, by increasing the initial coverage limit (ICL) by \$500 in 2010. For 2011 until 2019, the ICL will increase annually, while the annual out of pocket threshold will simultaneously decrease until 2019, when there will be continual coverage. This phase out of the donut hole will be paid for by requiring drug manufacturers to provide Medicaid rebates for any covered part D drugs that were dispensed after December 31, 2009 and used by full dual eligibles and low-income subsidy recipients.</p>	<p>for 2010 only, aiming to decrease the time that a Part D enrollee will need to be in the coverage gap. The ICL for subsequent years will be determined apart from this temporary increase.</p>	<p><i>coverage gap in 2010 will receive a one-time \$250 rebate. (HR 4872, Sec. 1101).</i></p> <p><i>A phased-in Part D beneficiary coinsurance rate will result in a 25 percent rate by 2020. Between 2014 and 2019, the out-of-pocket amount that qualified an enrollee for catastrophic coverage will be reduced. (HR 3590, Sec. 3301, as amended by HR 4872, Sec. 1101).</i></p>
<p><u>Medicare Coverage Gap Discount Program:</u> Drug manufacturers will be required to provide a 50 percent discount to Part D beneficiaries for brand name drugs and biologics purchased during the coverage gap. The applicable discount will be treated as a true out of pocket cost. The discounts will apply to prescription drug and MA-PD plans, not to Title XIX state plans. As such, the PDP sponsors and MA organizations, not the states, will be responsible for providing necessary information to the manufacturers.</p>	<p><u>Medicare Coverage Gap Discount Program:</u> Effective July 1, 2010, drug manufacturers will be required to provide a 50 percent discount on brand name drugs and biologics for Part D beneficiaries in the coverage gap. The full negotiated price of the purchased drug will be treated as an incurred cost for the enrollee. The discounts will apply to prescription drug and MA-PD plans. A third contracted party will be responsible for receiving and transmitting information between involved parties.</p>	<p><u>Medicare Coverage Gap Discount Program:</u> Effective January 1, 2011, drug manufacturers will be required to provide a 50 percent discount on brand name drugs and biologics for prescriptions filled in the Medicare Part D coverage gap. A phased-in federal subsidy program, beginning in 2011, will result in a 75 percent federal subsidy of generic drugs by 2020. (HR 3590, Sec. 3301, as amended by HR 4872, Sec. 1101).</p>
<p><u>Improved Access to Part D for LIS Beneficiaries:</u> Effective January 1, 2012, this section modifies the resource test</p>	<p><u>Improved Access to Part D for LIS Beneficiaries:</u> This section appropriates funds to enhance outreach and assistance for low income programs for FY 2010- 2012.</p>	<p><u>Improved Access to Part D for LIS Beneficiaries:</u> This section appropriates funds to enhance outreach and assistance for low income programs for FY 2010- 2012.</p>



**DRAFT**

**“Affordable Health Care for America Act”**

House-Passed on Nov. 7, 2009  
(HR 3962)

**“Patient Protection and Affordable Care Act”**

Senate-Passed on Dec. 24, 2009  
(HR 3590), including  
Manager’s Amendment (S.AMDT 3276)

**“Health Care and Education Reconciliation Act of 2010”**

Senate-Passed on March 25, 2010  
House-Passed on March 25, 2010  
(HR 4872)

<p>used to determine eligibility for income related subsidies and Medicare cost sharing by increasing the asset test to \$17,000 for individuals and \$34,000 for couples, along with an annual percentage increase in accordance with the CPI.</p>	<p>SHIPs, through the CMS Program Management Account, will have access to \$15 million. AoA will receive \$15 million for AAAs, another \$10 million for ADRCs and \$5 million for AoA to contract with the National Center for Benefits and Outreach Enrollment.</p>	<p>SHIPs, through the CMS Program Management Account, will have access to \$15 million. AoA will receive \$15 million for AAAs, another \$10 million for ADRCs and \$5 million for AoA to contract with the National Center for Benefits and Outreach Enrollment. (HR 3590, Sec. 3306).</p>
<p><u>Elimination of Part D Cost Sharing for selected non-institutionalized Dual Eligibles:</u> Eliminates cost sharing for full benefit dual eligible individuals receiving home and community based care who would otherwise require institutionalization. Effective January 1, 2011.</p>	<p><u>Elimination of Part D Cost Sharing for selected non-institutionalized Dual Eligibles:</u> Makes cost sharing for full benefit dual eligible individuals receiving home and community based care equal to the cost-sharing for those receiving institutionalized care. Effective no earlier than January 1, 2012.</p>	<p><u>Elimination of Part D Cost Sharing for selected non-institutionalized Dual Eligibles:</u> Makes cost sharing for full benefit dual eligible individuals receiving home and community based care equal to the cost-sharing for those receiving institutionalized care. Effective no earlier than January 1, 2012. (HR 3590, Sec. 3309).</p>
<p><u>Negotiation of Lower Covered Part D Drug Prices:</u> This section authorizes the Secretary of HHS to negotiate with drug manufacturers to reduce the price of Part D drugs for Medicare beneficiaries. The resulting prices would exist as a ceiling, allowing plan administrators to obtain further drug price reductions.</p>		
<p><u>Medicare Advantage Payment Plans:</u> Medicare Advantage payments will be phased down to equal fee-for-service payments by 2013.</p>	<p><u>Medicare Advantage Payment Plans:</u> Medicare Advantage payments will be based on the average of plan bids in each market, phased in over four years.</p>	<p><u>Medicare Advantage Payment Plans:</u> Medicare Advantage payments will freeze in 2011. In 2012, the benchmarks will be reduced, and the payments will be set to different percentages of fee-for-service rates. These payments will vary from 95 percent of Medicare</p>



**DRAFT**

**“Affordable Health Care for America Act”**

House-Passed on Nov. 7, 2009  
(HR 3962)

**“Patient Protection and Affordable Care Act”**

Senate-Passed on Dec. 24, 2009  
(HR 3590), including  
Manager’s Amendment (S.AMDT 3276)

**“Health Care and Education Reconciliation Act of 2010”**

Senate-Passed on March 25, 2010  
House-Passed on March 25, 2010  
(HR 4872)

		<p><i>spending in high-cost areas to 115 percent of Medicare spending in low-cost areas. Beginning in 2011, this restructured payment system will be phased in over three years in most areas, with longer phase-in periods in other areas, depending on the level of payment reductions. (HR 4872, Sec. 1102).</i></p> <p><i>Beginning in 2014, the plans will be required to spend at least 85 percent of revenue on medical costs or activities improving quality of care. (HR 4872, Sec. 1103).</i></p>
<p><u>Medicaid DSH:</u> Effective January 1, 2010, reduce Medicaid DSH allotments by \$1.5 billion in 2017, \$2.5 billion in 2018, and \$6 billion in 2019. The most reductions will occur in states with the lowest uninsured rates, as well as those that do not target DSH payments.</p>	<p><u>Medicaid DSH:</u> Effective as of October 1, 2011, reduce a state’s Medicaid DSH allotment by 50 percent or 25 percent in low DSH states, once the state’s uninsured rate decreases by at least 45percent.</p>	<p><u>Medicaid DSH:</u> Effective as of October 1, 2011, and beginning in 2014, Medicaid DSH allotments to states will be reduced by \$.5 billion in 2014, \$.6 billion in 2015, \$.6 billion in 2016, \$1.8 billion in 2017, \$5 billion in 2018, \$5.6 billion in 2019, and \$4 billion in 2020. The most reductions will occur in states with the lowest uninsured rates, as well as those that do not target DSH payments. (HR 3590, Sec. 2551, as amended by HR 3590 Sec. 10201 and HR 4872, Sec. 1203).</p>
	<p><u>Medicaid Health Home:</u> Effective January 1, 2011, states will have the option to amend their plans to permit Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a health home. States who</p>	<p><u>Medicaid Health Home:</u> Effective January 1, 2011, states will have the option to amend their plans to permit Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a health home. States who</p>



**DRAFT**

**“Affordable Health Care for America Act”**

House-Passed on Nov. 7, 2009  
(HR 3962)

**“Patient Protection and Affordable Care Act”**

Senate-Passed on Dec. 24, 2009  
(HR 3590), including  
Manager’s Amendment (S.AMDT 3276)

**“Health Care and Education Reconciliation Act of 2010”**

Senate-Passed on March 25, 2010  
House-Passed on March 25, 2010  
(HR 4872)

	choose to amend their plans allowing for this option will receive a 90 percent FMAP for two years.	choose to amend their plans allowing for this option will receive a 90 percent FMAP for two years. (HR 3590, Sec. 2703).
	<u>State Balancing Incentive Payments Program:</u> Effective October 1, 2011 – September 30, 2015, selected states will receive an increased FMAP of 5 percent or 2 percent with respect to medical assistance expenditures for non-institutionally-based long-term services and supports provided under the state Medicaid program. States whose LTSS Medicaid expenditures on home and community based services equal less than 25 percent of their total Medicaid LTSS are eligible for the 5 percent increase; states whose LTSS Medicaid expenditures on home and community based services equal less than 50 percent of their total Medicaid LTSS are eligible for the 2 percent increase. States must agree to make structural changes within 6 months including: no wrong door single-entry-point system; conflict-free case management services; core standardized assessment services. The Secretary shall select participating states from among the applicants.	<u>State Balancing Incentive Payments Program:</u> Effective October 1, 2011 – September 30, 2015, selected states will receive an increased FMAP of 5 percent or 2 percent with respect to medical assistance expenditures for non-institutionally-based long-term services and supports provided under the state Medicaid program. States whose LTSS Medicaid expenditures on home and community based services equal less than 25 percent of their total Medicaid LTSS are eligible for the 5 percent increase; states whose LTSS Medicaid expenditures on home and community based services equal less than 50 percent of their total Medicaid LTSS are eligible for the 2 percent increase. States must agree to make structural changes within 6 months including: no wrong door single-entry-point system; conflict-free case management services; core standardized assessment services. The Secretary shall select participating states from among the applicants. (HR 3590, Sec. 10202).
	<u>Money Follows the Person Rebalancing Demonstration:</u> Effective 30 days following enactment, Money Follows the Person will be authorized for each of fiscal years 2011-2016. This section modifies eligibility requirements by reducing the institutional residency	<u>Money Follows the Person Rebalancing Demonstration:</u> Effective 30 days following enactment, Money Follows the Person will be authorized for each of fiscal years 2011-2016. This section modifies eligibility requirements by reducing the institutional residency

**“Affordable Health Care for America Act”**

House-Passed on Nov. 7, 2009  
(HR 3962)

**“Patient Protection and Affordable Care Act”**

Senate-Passed on Dec. 24, 2009  
(HR 3590), including  
Manager’s Amendment (S.AMDT 3276)

**“Health Care and Education Reconciliation Act of 2010”**

Senate-Passed on March 25, 2010  
House-Passed on March 25, 2010  
(HR 4872)

	<p>period to not more than 90 consecutive days and by eliminating the state’s flexibility in setting this residency period themselves. Currently, states set this requirement within DRA’s guidelines, which require that individuals reside in a facility for not less than 6 months, and not more than 2 years.</p>	<p>period to not more than 90 consecutive days and by eliminating the state’s flexibility in setting this residency period themselves. Currently, states set this requirement within DRA’s guidelines, which require that individuals reside in a facility for not less than 6 months, and not more than 2 years. (HR 3590, Sec. 2403).</p>
	<p><u>Community-Based Care Transitions Program:</u> This section creates a new, five year, \$500 million HHS program that will begin January 1, 2011. Selected hospitals with high readmission rates and qualifying community based organizations will receive funding to provide improved care transition services to high risk Medicare beneficiaries. The Secretary will have discretion in transferring the funds from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund to the CMS Program Management Account.</p>	<p><u>Community-Based Care Transitions Program:</u> This section creates a new, five year, \$500 million HHS program that will begin January 1, 2011. Selected hospitals with high readmission rates and qualifying community based organizations will receive funding to provide improved care transition services to high risk Medicare beneficiaries. The Secretary will have discretion in transferring the funds from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund to the CMS Program Management Account. (HR 3590, Sec. 3026).</p>
	<p><u>Patient Navigator Program:</u> This section reauthorizes the Patient Navigator Program, extending it through 2015 at its current funding level of \$3.5 million per year. As a condition of receiving a grant, the applicant must satisfy to the Secretary that potentially grant funded patient</p>	<p><u>Patient Navigator Program:</u> This section reauthorizes the Patient Navigator Program, extending it through 2015 at its current funding level of \$3.5 million per year. As a condition of receiving a grant, the applicant must satisfy to the Secretary that potentially grant funded patient</p>



**DRAFT**

**“Affordable Health Care for America Act”**

House-Passed on Nov. 7, 2009  
(HR 3962)

**“Patient Protection and Affordable Care Act”**

Senate-Passed on Dec. 24, 2009  
(HR 3590), including  
Manager’s Amendment (S.AMDT 3276)

**“Health Care and Education Reconciliation Act of 2010”**

Senate-Passed on March 25, 2010  
House-Passed on March 25, 2010  
(HR 4872)

	navigators meet minimum core proficiencies, to be set by the applicant.	navigators meet minimum core proficiencies, to be set by the applicant. (HR 3590, Sec. 3510).
<b>LONG-TERM CARE</b>		
<p><u>CLASS Plan:</u> The Community Living Assistance Services and Support (CLASS) program is to be a national, voluntary insurance program for purchasing community living assistance services and supports. The CLASS Independence Benefit Plan will include a five year vesting period and a three year work requirement for eligibility of benefits. Benefits will trigger for an individual when he or she is determined to have a qualifying functional limitation that is expected to last for a continuous period of more than 90 days. Eligible beneficiaries will receive a cash benefit of no less than an average of \$50 per day, and the amount received will be scaled to correspond with the enrollee’s functional ability.</p> <p>The benefit will not be subject to a lifetime or aggregate limit, and the funds can be used to purchase nonmedical services and supports that the beneficiary needs to maintain his or her independence at home or in another residential setting of their choice in the community, including such expenditures as home modifications, assistive technology, accessible transportation,</p>	<p><u>CLASS Plan:</u> The Community Living Assistance Services and Support (CLASS) program is to be a national, voluntary insurance program for purchasing community living assistance services and supports. The CLASS Independence Benefit Plan will include a five year vesting period and a three year work requirement for eligibility of benefits. Benefits will trigger for an individual when he or she is determined to have a qualifying functional limitation that is expected to last for a continuous period of more than 90 days. Eligible beneficiaries will receive a cash benefit of no less than an average of \$50 per day, and the amount received will be scaled to correspond with the enrollee’s functional ability.</p> <p>The benefit will not be subject to a lifetime or aggregate limit, and the funds can be used to purchase nonmedical services and supports that the beneficiary needs to maintain his or her independence at home or in another residential setting of their choice in the community, including such expenditures as home modifications, assistive technology, accessible transportation,</p>	<p><u>CLASS Plan:</u> The Community Living Assistance Services and Support (CLASS) program is to be a national, voluntary insurance program for purchasing community living assistance services and supports. The CLASS Independence Benefit Plan will include a five year vesting period and a three year work requirement for eligibility of benefits. Benefits will trigger for an individual when he or she is determined to have a qualifying functional limitation that is expected to last for a continuous period of more than 90 days. Eligible beneficiaries will receive a cash benefit of no less than an average of \$50 per day, and the amount received will be scaled to correspond with the enrollee’s functional ability.</p> <p>The benefit will not be subject to a lifetime or aggregate limit, and the funds can be used to purchase nonmedical services and supports that the beneficiary needs to maintain his or her independence at home or in another residential setting of their choice in the community, including such expenditures as home modifications, assistive technology, accessible transportation,</p>



**DRAFT**

**“Affordable Health Care for America Act”**

House-Passed on Nov. 7, 2009  
(HR 3962)

**“Patient Protection and Affordable Care Act”**

Senate-Passed on Dec. 24, 2009  
(HR 3590), including  
Manager’s Amendment (S.AMDT 3276)

**“Health Care and Education Reconciliation Act of 2010”**

Senate-Passed on March 25, 2010  
House-Passed on March 25, 2010  
(HR 4872)

<p>homemaker services, respite care, personal assistance services, home care aides and nursing support, assistance with decision making concerning medical care, or living will or power of attorney development assistance.</p> <p>Institutionalized Medicaid beneficiaries, including those receiving PACE program services, will retain 5 percent of the cash benefit, with the remainder to be applied to the facility’s cost in providing the beneficiary’s care, and Medicaid will provide any necessary secondary coverage. Beneficiaries receiving home and community based services under Medicaid will retain 50 percent of their cash benefit, the remainder of which will be applied to the cost of the State in providing such assistance, but will not be used by the state to claim federal matching funds. Medicaid will provide secondary coverage for the remainder of any HCBS costs. Non-institutionalized beneficiaries receiving PACE program services will retain 50 percent of their cash benefit; with the remainder being applied to the state’s cost in providing such assistance. The state may not use these funds to claim federal matching funds under Medicaid. Benefits paid to an eligible beneficiary will not be used to determine eligibility for benefits under any other Federal, State or locally funded assistance program.</p>	<p>homemaker services, respite care, personal assistance services, home care aides and nursing support, assistance with decision making concerning medical care, or living will or power of attorney development assistance.</p> <p>Institutionalized Medicaid beneficiaries, including those receiving PACE program services, will retain 5 percent of the cash benefit, with the remainder to be applied to the facility’s cost in providing the beneficiary’s care, and Medicaid will provide any necessary secondary coverage. Beneficiaries receiving home and community based services under Medicaid will retain 50 percent of their cash benefit, the remainder of which will be applied to the cost of the State in providing such assistance, but will not be used by the state to claim federal matching funds. Medicaid will provide secondary coverage for the remainder of any HCBS costs. Non-institutionalized beneficiaries receiving PACE program services will retain 50 percent of their cash benefit; with the remainder being applied to the state’s cost in providing such assistance. The state may not use these funds to claim federal matching funds under Medicaid. Benefits paid to an eligible beneficiary will not be used to determine eligibility for benefits under any other Federal, State or locally funded assistance program.</p>	<p>homemaker services, respite care, personal assistance services, home care aides and nursing support, assistance with decision making concerning medical care, or living will or power of attorney development assistance.</p> <p>Institutionalized Medicaid beneficiaries, including those receiving PACE program services, will retain 5 percent of the cash benefit, with the remainder to be applied to the facility’s cost in providing the beneficiary’s care, and Medicaid will provide any necessary secondary coverage. Beneficiaries receiving home and community based services under Medicaid will retain 50 percent of their cash benefit, the remainder of which will be applied to the cost of the State in providing such assistance, but will not be used by the state to claim federal matching funds. Medicaid will provide secondary coverage for the remainder of any HCBS costs. Non-institutionalized beneficiaries receiving PACE program services will retain 50 percent of their cash benefit; with the remainder being applied to the state’s cost in providing such assistance. The state may not use these funds to claim federal matching funds under Medicaid. Benefits paid to an eligible beneficiary will not be used to determine eligibility for benefits under any other Federal, State or locally funded assistance program.</p>
--	--	--



**DRAFT**

**“Affordable Health Care for America Act”**

House-Passed on Nov. 7, 2009  
(HR 3962)

**“Patient Protection and Affordable Care Act”**

Senate-Passed on Dec. 24, 2009  
(HR 3590), including  
Manager’s Amendment (S.AMDT 3276)

**“Health Care and Education Reconciliation Act of 2010”**

Senate-Passed on March 25, 2010  
House-Passed on March 25, 2010  
(HR 4872)

<p>By amending the IRS code, this section ensures that CLASS plan premiums and benefits will be treated similarly as those for qualified long-term care insurance policies.</p> <p>States will comply with Medicaid primary and secondary payer rules with respect to the CLASS program. To ensure the infrastructure of the program is effective, within two years of the date of enactment, states are required to assess the efficacy of the CLASS program and to designate fiscal agents for personal care workers serving CLASS program beneficiaries.</p>	<p>By amending the IRS code, this section ensures that CLASS plan premiums and benefits will be treated similarly as those for qualified long-term care insurance policies.</p> <p>States will comply with Medicaid primary and secondary payer rules with respect to the CLASS program. To ensure the infrastructure of the program is effective, within two years of the date of enactment, states are required to assess the efficacy of the CLASS program and to designate fiscal agents for personal care workers serving CLASS program beneficiaries.</p>	<p>By amending the IRS code, this section ensures that CLASS plan premiums and benefits will be treated similarly as those for qualified long-term care insurance policies.</p> <p>States will comply with Medicaid primary and secondary payer rules with respect to the CLASS program. To ensure the infrastructure of the program is effective, within two years of the date of enactment, states are required to assess the efficacy of the CLASS program and to designate fiscal agents for personal care workers serving CLASS program beneficiaries. (HR 3590, Sec. 8002).</p>
<p><u>Additional CLASS Plan provisions:</u> Non-working, non-institutionalized spouses of employed workers are eligible for enrollment</p>	<p><u>Additional CLASS Plan Provisions:</u> The Senate passed CLASS plan will also be financed by voluntary payroll deductions for all working adults ages 18 and older, but Sec. 3208 specifies that no taxpayer funds will be used to pay benefits under the CLASS plan; it will only be financed by the premiums deposited by CLASS program participants in the CLASS Independence Fund, and any associated interest earnings. The Senate plan also caps the monthly enrollment premium at \$5.00 for full time students under the age of 22 and individuals whose income is below the poverty line. Beginning January 1,</p>	<p><u>Additional CLASS Plan Provisions:</u> The Senate passed CLASS plan will also be financed by voluntary payroll deductions for all working adults ages 18 and older, but Sec. 3208 specifies that no taxpayer funds will be used to pay benefits under the CLASS plan; it will only be financed by the premiums deposited by CLASS program participants in the CLASS Independence Fund, and any associated interest earnings. The Senate plan also caps the monthly enrollment premium at \$5.00 for full time students under the age of 22 and individuals whose income is below the poverty line. Beginning October 1,</p>



**DRAFT**

**“Affordable Health Care for America Act”**

House-Passed on Nov. 7, 2009  
(HR 3962)

**“Patient Protection and Affordable Care Act”**

Senate-Passed on Dec. 24, 2009  
(HR 3590), including  
Manager’s Amendment (S.AMDT 3276)

**“Health Care and Education Reconciliation Act of 2010”**

Senate-Passed on March 25, 2010  
House-Passed on March 25, 2010  
(HR 4872)

	<p>2011, all working adults will be automatically enrolled in the program, unless they choose to opt-out.</p>	<p>2012, is the designation by the Secretary of CLASS Independence Benefit Plan, which shall be published in a final rule that allows for a period of public comment. (HR 3590, Sec. 8002).</p>
<p><u>Nursing Home Transparency:</u> Skilled nursing facilities (SNFs) and nursing facilities (NFs) will be required to disclose information relating to ownership, organizational structure and management of the facility.</p> <p>This section provides for enhanced accountability requirements. Within 36 months after enactment, SNFs and NFs must implement an ethics program designed to promote quality of care by developing compliance standards and procedures aimed to reduce criminal, civil and administrative violations. SNFs and NFs will also be required to comply with a new quality assurance and performance program (QAPI), to be implemented by the end of 2011.</p> <p>The Nursing Home Compare Medicare website will be required to include clearly understandable staffing data for each SNF and NF, the standardized complaint form, complaint summary information, as well as links to individual state websites containing information regarding state survey and certification programs. States</p>	<p><u>Nursing Home Transparency:</u> Skilled nursing facilities (SNFs) and nursing facilities (NFs) will be required to disclose information relating to ownership, organizational structure and management of the facility.</p> <p>This section provides for enhanced accountability requirements. Within 36 months after enactment, SNFs and NFs must implement an ethics program designed to promote quality of care by developing compliance standards and procedures aimed to reduce criminal, civil and administrative violations. SNFs and NFs will also be required to comply with a new quality assurance and performance program (QAPI), to be implemented by the end of 2011.</p> <p>The Nursing Home Compare Medicare website will be required to include clearly understandable staffing data for each SNF and NF, the standardized complaint form, complaint summary information, as well as links to individual state websites containing information regarding state survey and certification programs. States</p>	<p><u>Nursing Home Transparency:</u> Skilled nursing facilities (SNFs) and nursing facilities (NFs) will be required to disclose information relating to ownership, organizational structure and management of the facility. (HR 3590, Sec. 6101).</p> <p>This section provides for enhanced accountability requirements. Within 36 months after enactment, SNFs and NFs must implement an ethics program designed to promote quality of care by developing compliance standards and procedures aimed to reduce criminal, civil and administrative violations. SNFs and NFs will also be required to comply with a new quality assurance and performance program (QAPI), to be implemented by the end of 2011. (HR 3590, Sec. 11281).</p> <p>The Nursing Home Compare Medicare website will be required to include clearly understandable staffing data for each SNF and NF, the standardized complaint form, complaint summary information, as well as links to individual state websites containing information</p>



**DRAFT**

**“Affordable Health Care for America Act”**

House-Passed on Nov. 7, 2009  
(HR 3962)

**“Patient Protection and Affordable Care Act”**

Senate-Passed on Dec. 24, 2009  
(HR 3590), including  
Manager’s Amendment (S.AMDT 3276)

**“Health Care and Education Reconciliation Act of 2010”**

Senate-Passed on March 25, 2010  
House-Passed on March 25, 2010  
(HR 4872)

<p>will be required to submit to the Secretary any information relating to recommendations made to SNFs or NFs by the time the state sends the same information to the facility.</p> <p>SNFs will be required to separately report expenditures for direct care staff, indirect care services, capital assets and administrative services.</p> <p>The Secretary will develop a standardized complaint form for residents, anyone acting on their behalf, and any person working at the SNF, or a representative of such a worker, to use in filing a complaint against a facility with a State survey and certification agency and a State long-term ombudsman program. The states will be responsible for making the standardized complaint form available to qualifying parties. States must implement a complaint resolution process.</p>	<p>will be required to submit to the Secretary any information relating to recommendations made to SNFs or NFs by the time the state sends the same information to the facility.</p> <p>SNFs will be required to separately report expenditures for direct care staff, indirect care services, capital assets and administrative services.</p> <p>The Secretary will develop a standardized complaint form for residents, anyone acting on their behalf, and any person working at the SNF, or a representative of such a worker, to use in filing a complaint against a facility with a State survey and certification agency and a State long-term ombudsman program. The states will be responsible for making the standardized complaint form available to qualifying parties. States must implement a complaint resolution process.</p>	<p>regarding state survey and certification programs. States will be required to submit to the Secretary any information relating to recommendations made to SNFs or NFs by the time the state sends the same information to the facility. (HR 3590, Sec. 6103).</p> <p>SNFs will be required to separately report expenditures for direct care staff, indirect care services, capital assets and administrative services. (HR 3590, Sec. 6104).</p> <p>The Secretary will develop a standardized complaint form for residents, anyone acting on their behalf, and any person working at the SNF, or a representative of such a worker, to use in filing a complaint against a facility with a State survey and certification agency and a State long-term ombudsman program. The states will be responsible for making the standardized complaint form available to qualifying parties. States must implement a complaint resolution process. (HR 3590, Sec. 6105).</p>
<p><u>Criminal Background Checks:</u> For the fiscal years 2010 through 2012, up to \$160 million is appropriated for the implementation of a nationwide background check program to conduct checks on prospective direct patient access employees. Participating states will receive a</p>	<p><u>Criminal Background Checks:</u> For the fiscal years 2010 through 2012, up to \$160 million is appropriated for the implementation of a nationwide background check program to conduct checks on prospective direct patient access employees. Participating states will receive a</p>	<p><u>Criminal Background Checks:</u> For the fiscal years 2010 through 2012, up to \$160 million is appropriated for the implementation of a nationwide background check program to conduct checks on prospective direct patient access employees. Participating states will receive a</p>



**DRAFT**

**“Affordable Health Care for America Act”**

House-Passed on Nov. 7, 2009  
(HR 3962)

**“Patient Protection and Affordable Care Act”**

Senate-Passed on Dec. 24, 2009  
(HR 3590), including  
Manager’s Amendment (S.AMDT 3276)

**“Health Care and Education Reconciliation Act of 2010”**

Senate-Passed on March 25, 2010  
House-Passed on March 25, 2010  
(HR 4872)

<p>Federal match of three times the amount of the state guarantee. The state match may be comprised solely of donations from public or private entities. In turn, these states will be required, among other things, to monitor compliance with the nationwide program, develop an appeals process and designate a single state agency to focus on oversight.</p>	<p>Federal match of three times the amount of the state guarantee, with some states federal funding capped at \$3 million and others at \$1.5. The state match may be comprised solely of donations from public or private entities. In turn, these states will be required, among other things, to monitor compliance with the nationwide program, develop an appeals process and designate a single state agency to focus on oversight</p>	<p>Federal match of three times the amount of the state guarantee, with some states federal funding capped at \$3 million and others at \$1.5. The state match may be comprised solely of donations from public or private entities. In turn, these states will be required, among other things, to monitor compliance with the nationwide program, develop an appeals process and designate a single state agency to focus on oversight (HR 3590, Sec. 6201).</p>
<p><u>Workforce Promotion:</u> Amends the OAA to establish a Personal Care Attendant Workforce Advisory Panel to examine workforce issues and promote the direct care workforce. The Panel will formulate a report on core competencies for home care aides which will result in an AoA directed three year, four state demonstration projects to evaluate the Panel’s findings. This section promotes family caregiver support as it modifies the appropriations for the Family Caregiver Support Program by increasing its funding to \$250 million for each fiscal year from 2011 – 2013.</p>	<p><u>Workforce Promotion:</u> Establishes demonstration projects to address health professions workforce needs. These are projects in which grants will be awarded to eligible entities, which may include states, Indian tribes or tribal organizations, to give low income individuals the opportunity to obtain education and training for occupations in the health care field. A maximum of six states will receive funding for at least three years through a competitive grant program to develop core training competencies and certification programs for home care aides. \$85 million for each of fiscal years 2010 – 2014 is appropriated to fund both of these programs, with not more than \$5 million for each of fiscal years 2010 – 2012 to go to personal and home care aide demonstration.</p>	<p><u>Workforce Promotion:</u> Establishes demonstration projects to address health professions workforce needs. These are projects in which grants will be awarded to eligible entities, which may include states, Indian tribes or tribal organizations, to give low income individuals the opportunity to obtain education and training for occupations in the health care field. A maximum of six states will receive funding for at least three years through a competitive grant program to develop core training competencies and certification programs for home care aides. \$85 million for each of fiscal years 2010 – 2014 is appropriated to fund both of these programs, with not more than \$5 million for each of fiscal years 2010 – 2012 to go to personal and home care aide demonstration. (HR 3590, Sec. 5507).</p>



**DRAFT**

**“Affordable Health Care for America Act”**

House-Passed on Nov. 7, 2009  
(HR 3962)

**“Patient Protection and Affordable Care Act”**

Senate-Passed on Dec. 24, 2009  
(HR 3590), including  
Manager’s Amendment (S.AMDT 3276)

**“Health Care and Education Reconciliation Act of 2010”**

Senate-Passed on March 25, 2010  
House-Passed on March 25, 2010  
(HR 4872)

<p><u>Workforce Training and Education:</u> This section establishes a primary care training and capacity building program that will award grants and contracts to qualifying entities to provide training in geriatrics.</p>	<p><u>Workforce Training and Education:</u> Institutions of higher education willing to provide new training opportunities for direct care workers employed in long-term settings will receive grant funding to offset the cost of tuition and enrollment fees for these individuals. To receive this assistance, participating individuals must agree to work in geriatrics, disability services, long-term services and supports or chronic care management for at least two years following the completion of the assistance period. A total of \$10 million for FY 2011-2013 is authorized to be appropriated to fund these grants.</p> <p>Geriatric education centers receiving grants and contracts supplementing their federal, state and local funds will be required to develop a geriatric focused fellowship program, and either provide nominal cost family caregiver and direct care provider trainings, or incorporate best practices into all appropriate training courses. A maximum of 24 geriatric education centers will receive these awards, each of which will be in the amount of \$150,000. \$10.8 million is authorized to be appropriated for FY 2011- 2014 for these grants. An additional \$10 million is authorized for fiscal years 2011-2013 for qualifying individuals who agree to teach or practice in the field of geriatrics, long-term care or</p>	<p><u>Workforce Training and Education:</u> Institutions of higher education willing to provide new training opportunities for direct care workers employed in long-term settings will receive grant funding to offset the cost of tuition and enrollment fees for these individuals. To receive this assistance, participating individuals must agree to work in geriatrics, disability services, long-term services and supports or chronic care management for at least two years following the completion of the assistance period. A total of \$10 million for FY 2011-2013 is authorized to be appropriated to fund these grants. (HR 3590, Sec. 5302).</p> <p>Geriatric education centers receiving grants and contracts supplementing their federal, state and local funds will be required to develop a geriatric focused fellowship program, and either provide nominal cost family caregiver and direct care provider trainings, or incorporate best practices into all appropriate training courses. A maximum of 24 geriatric education centers will receive these awards, each of which will be in the amount of \$150,000. \$10.8 million is authorized to be appropriated for FY 2011- 2014 for these grants. An additional \$10 million is authorized for fiscal years 2011-2013 for qualifying individuals who agree to teach or practice in the field of geriatrics, long-term care or</p>
---	---	---

**“Affordable Health Care for America Act”**

House-Passed on Nov. 7, 2009  
(HR 3962)

**“Patient Protection and Affordable Care Act”**

Senate-Passed on Dec. 24, 2009  
(HR 3590), including  
Manager’s Amendment (S.AMDT 3276)

**“Health Care and Education Reconciliation Act of 2010”**

Senate-Passed on March 25, 2010  
House-Passed on March 25, 2010  
(HR 4872)

	<p>chronic care management for at least five years.</p>	<p>chronic care management for at least five years. (HR 3590, Sec. 5305).</p>
	<p><u>Elder Justice</u>: The Elder Justice Act authorizes several grant programs, including: grants creating and incentivizing training and certification programs for long-term care workers; awards to provide workplace management technical assistance in efforts to increase direct care worker retention rates; and grants to long-term care facilities to encourage their use of EHR technology.</p> <p>Additionally, this Act authorizes \$100 million for each of fiscal years 2011-2014 for grants to the states for the purpose of enhancing adult protective service (APS) programs. Another \$25 million is authorized for each of fiscal years 2011-2014 for grants to states to conduct demonstration programs testing methods of elder abuse detection or prevention.</p> <p>Additional funding is authorized to support the long-term care ombudsman programs at the state and local levels, and for each of fiscal years 2011-2014, \$5 million is available for grants to state agencies that perform surveys of SNFs or NFs to streamline the operations of such facilities.</p>	<p><u>Elder Justice</u>: The Elder Justice Act authorizes several grant programs, including: grants creating and incentivizing training and certification programs for long-term care workers; awards to provide workplace management technical assistance in efforts to increase direct care worker retention rates; and grants to long-term care facilities to encourage their use of EHR technology. (HR 3590, Sec. 6703, Sec. 2041).</p> <p>Additionally, this Act authorizes \$100 million for each of fiscal years 2011-2014 for grants to the states for the purpose of enhancing adult protective service (APS) programs. Another \$25 million is authorized for each of fiscal years 2011-2014 for grants to states to conduct demonstration programs testing methods of elder abuse detection or prevention. (HR 3590, Sec. 6703, Sec. 2042).</p> <p>Additional funding is authorized to support the long-term care ombudsman programs at the state and local levels, and for each of fiscal years 2011-2014, \$5 million is available for grants to state agencies that perform surveys of SNFs or NFs to streamline the operations of</p>



**DRAFT**

**“Affordable Health Care for America Act”**

House-Passed on Nov. 7, 2009  
(HR 3962)

**“Patient Protection and Affordable Care Act”**

Senate-Passed on Dec. 24, 2009  
(HR 3590), including  
Manager’s Amendment (S.AMDT 3276)

**“Health Care and Education Reconciliation Act of 2010”**

Senate-Passed on March 25, 2010  
House-Passed on March 25, 2010  
(HR 4872)

		such facilities. (HR 3590, Sec. 6703, Sec. 2043).
<p><u>ARRA FMAP Extension:</u> Extends the temporary increase to state’s Federal Medical Assistance Percentage (FMAP) contained in ARRA through June 30, 2011. The state’s maintenance of effort will remain the same as outlined in ARRA.</p>		
<p><u>Adult Day Health Care Services:</u> Secretary of HHS cannot deny Federal funding for adult day services, so long as these services are consistent with the relevant provisions contained in that state’s Medicaid plan, which must have been approved during or before 1994. The Secretary cannot withdraw approval of any part of a qualifying state Medicaid plan that provides for adult day services. This section applies retroactively to services provided on or after October 1, 2008.</p>		
	<p><u>Community First Choice Option:</u> Gives states the option, beginning October 1, 2010, of amending their state Medicaid plans to provide home and community based attendant services and supports to (1) consumers eligible for medical assistance under the state plan whose incomes do not exceed 150 percent FPL, or, if</p>	<p><i>Community First Choice Option: Gives states the option, beginning October 1, 2011, of amending their state Medicaid plans to provide home and community based attendant services and supports to (1) consumers eligible for medical assistance under the state plan whose incomes do not exceed 150 percent FPL, or, if</i></p>



**DRAFT**

**“Affordable Health Care for America Act”**

House-Passed on Nov. 7, 2009  
(HR 3962)

**“Patient Protection and Affordable Care Act”**

Senate-Passed on Dec. 24, 2009  
(HR 3590), including  
Manager’s Amendment (S.AMDT 3276)

**“Health Care and Education Reconciliation Act of 2010”**

Senate-Passed on March 25, 2010  
House-Passed on March 25, 2010  
(HR 4872)

	<p>greater, to (2) consumers who meet their state’s nursing facility clinical eligibility standards. Available services include ADL task assistance, electronic service backup systems, and training on the management of attendants. Permissible services include transition costs from the facility to the community based home setting, and additional, qualifying, individual needs. Participating states will receive a 6 percentage point FMAP increase. The state must meet certain requirements for their amendment to be approved, such as maintaining or exceeding their previous fiscal year’s medical assistance expenditure levels in the first full FY of the program’s implementation. The services authorized under this section will be evaluated based on data provided to the Secretary by the states.</p>	<p><i>greater, to (2) consumers who meet their state’s nursing facility clinical eligibility standards. Available services include ADL task assistance, electronic service backup systems, and training on the management of attendants. Permissible services include transition costs from the facility to the community based home setting, and additional, qualifying, individual needs. Participating states will receive a 6 percentage point FMAP increase. The state must meet certain requirements for their amendment to be approved, such as maintaining or exceeding their previous fiscal year’s medical assistance expenditure levels in the first full FY of the program’s implementation. The services authorized under this section will be evaluated based on data provided to the Secretary by the states. (HR 3590, Sec. 2401, as amended by HR 4872, Sec. 1205).</i></p>
	<p><u>Protection for Recipients of HCBS against Spousal Impoverishment:</u> For five years, beginning on January 1, 2014, states will be required to apply spousal impoverishment rules to HCBS beneficiaries.</p>	<p><u>Protection for Recipients of HCBS against Spousal Impoverishment:</u> For five years, beginning on January 1, 2014, states will be required to apply spousal impoverishment rules to HCBS beneficiaries. (HR 3590, Sec. 2404).</p>
	<p><u>Funding to Expand ADRCs:</u> Appropriates \$10 million annually for FY 2010-2014 to the Secretary of Health</p>	<p><u>Funding to Expand ADRCs:</u> Appropriates \$10 million annually for FY 2010-2014 to the Secretary of Health</p>



**DRAFT**

**“Affordable Health Care for America Act”**  
House-Passed on Nov. 7, 2009  
(HR 3962)

**“Patient Protection and Affordable Care Act”**  
Senate-Passed on Dec. 24, 2009  
(HR 3590), including  
Manager’s Amendment (S.AMDT 3276)

**“Health Care and Education Reconciliation Act of 2010”**  
Senate-Passed on March 25, 2010  
House-Passed on March 25, 2010  
(HR 4872)

	and Human Services to carry out the Aging and Disability Resource Center provisions of the Older Americans Act.	and Human Services to carry out the Aging and Disability Resource Center provisions of the Older Americans Act. (HR 3590, Sec. 2405).
	<u>Sense of the Senate regarding Long-Term Care:</u> “It is the Sense of the Senate that during the 111 <sup>th</sup> Congress, Congress should address long-term services and supports in a comprehensive way that guarantees elderly and disabled individuals the care they need; and long-term services and supports should be made available in the community in addition to in institutions.”	<u>Sense of the Senate regarding Long-Term Care:</u> “It is the Sense of the Senate that during the 111 <sup>th</sup> Congress, Congress should address long-term services and supports in a comprehensive way that guarantees elderly and disabled individuals the care they need; and long-term services and supports should be made available in the community in addition to in institutions.” (HR 3590, Sec. 2406).
<b>PREVENTION</b>		
<u>National Prevention and Wellness Strategy:</u> Directs the Secretary to develop a national strategy to improve the nation’s health through evidence based clinical and community-based prevention and wellness activities. In so doing, the Secretary will consult with the heads of health agencies and other federal departments as necessary. The strategy will include specific goals and objectives, as well as national wellness and prevention priorities.	<u>National Prevention and Wellness Strategy:</u> The Senate bill establishes a National Prevention, Health Promotion and Public Health Council within HHS to develop a national prevention and health promotion strategy and to formulate interagency working relationships to implement the strategy. The strategy will set goals and objectives for specific health promotion and public health programs, as well as establish clear goals and benchmarks.	<u>National Prevention and Wellness Strategy:</u> The Reconciled Senate bill establishes a National Prevention, Health Promotion and Public Health Council within HHS to develop a national prevention and health promotion strategy and to formulate interagency working relationships to implement the strategy. The strategy will set goals and objectives for specific health promotion and public health programs, as well as establish clear goals and benchmarks. (HR 3590, Sec. 4001).
<u>Prevention and Public Health Fund:</u> Creates a fund,	<u>Prevention and Public Health Fund:</u> Creates a fund, to be	<u>Prevention and Public Health Fund:</u> Creates a fund, to be



**DRAFT**

**“Affordable Health Care for America Act”**

House-Passed on Nov. 7, 2009  
(HR 3962)

**“Patient Protection and Affordable Care Act”**

Senate-Passed on Dec. 24, 2009  
(HR 3590), including  
Manager’s Amendment (S.AMDT 3276)

**“Health Care and Education Reconciliation Act of 2010”**

Senate-Passed on March 25, 2010  
House-Passed on March 25, 2010  
(HR 4872)

<p>derived from general revenues of the Treasury, including \$4.6 billion for FY 2011, \$5.6 billion for FY 2012, \$6.9 billion for FY 2013, \$7.8 billion for FY 2014 and \$9 billion for FY 2015. Included in these appropriations are funds for a Prevention and Wellness Trust, community health centers, and health workforce programs.</p>	<p>administered through the Office of the HHS Secretary, to improve health and to help restrain rate of growth in private and public sector health cost. It will fund those activities authorized by Public Health Service Act. Funding levels are authorized to be appropriated to include \$500 million for FY 2010, \$750 million for FY 2011, \$1 billion for FY 2012, \$1.25 billion for FY 2013, \$1.5 billion for FY 2014, and \$2 billion for FY 2015 and each subsequent fiscal year.</p>	<p>administered through the Office of the HHS Secretary, to improve health and to help restrain rate of growth in private and public sector health cost. It will fund those activities authorized by Public Health Service Act. Funding levels are authorized to be appropriated to include \$500 million for FY 2010, \$750 million for FY 2011, \$1 billion for FY 2012, \$1.25 billion for FY 2013, \$1.5 billion for FY 2014, and \$2 billion for FY 2015 and each subsequent fiscal year. (HR 3590, Sec. 4002).</p>
<p><u>Coverage of Preventive Services:</u> Only proven preventive services will be covered and cost-sharing for preventive services in Medicare and Medicaid will be eliminated. Medicare payments for certain preventive services will be increased to 100percent.</p>	<p><u>Coverage of Preventive Services:</u> Coverage will be provided and cost-sharing will be eliminated for qualifying, evidence-based preventive services.</p> <p>Medicare beneficiaries will have access to an annual wellness visit, including a comprehensive health risk assessment and personalized prevention</p> <p>Medicare payments for certain preventive services furnished on or after January 1, 2011, will be increased to 100 percent of actual charges or fee schedule rates</p> <p>As of January 1, 2013, states providing medical assistance under Medicaid for qualifying preventive services and prohibiting cost-sharing for these services will receive a one percentage point FMAP increase in respect to the medical assistance furnished for these services</p>	<p><u>Coverage of Preventive Services:</u> Coverage will be provided and cost-sharing will be eliminated for qualifying, evidence-based preventive services. (HR 3590, Sec. 2713).</p> <p>Medicare beneficiaries will have access to an annual wellness visit, including a comprehensive health risk assessment and personalized prevention plan (HR 3590, Sec. 4103).</p> <p>Medicare payments for certain preventive services furnished on or after January 1, 2011, will be increased to 100 percent of actual charges or fee schedule rates (HR 3590, Sec. 4103).</p> <p>As of January 1, 2013, states providing medical assistance under Medicaid for qualifying preventive services and prohibiting cost-sharing for these services will receive a one percentage point FMAP increase in respect to the medical assistance furnished for these</p>



**DRAFT**

**“Affordable Health Care for America Act”**

House-Passed on Nov. 7, 2009  
(HR 3962)

**“Patient Protection and Affordable Care Act”**

Senate-Passed on Dec. 24, 2009  
(HR 3590), including  
Manager’s Amendment (S.AMDT 3276)

**“Health Care and Education Reconciliation Act of 2010”**

Senate-Passed on March 25, 2010  
House-Passed on March 25, 2010  
(HR 4872)

		services (HR 3590, Sec. 4106).
<u>Health Research:</u> Research on prevention or wellness will be coordinated with the Director of the CDC and the Director of the NIH.	<u>Health Research:</u> The Secretary, through the CDC Director, will fund public health services and systems research. This research will examine best practices for prevention, focusing on the areas identified by the Secretary in the National Prevention Strategy or Healthy People 2020.	<u>Health Research:</u> The Secretary, through the CDC Director, will fund public health services and systems research. This research will examine best practices for prevention, focusing on the areas identified by the Secretary in the National Prevention Strategy or Healthy People 2020. (HR 3590, Sec. 4301).
<u>Public Health Workforce:</u> Creates a Public Health Workforce Corps to eliminate workforce shortages. The Secretary will determine the assignment of participants, which may be within state, local and tribal health departments.	<u>Public Health Workforce:</u> Creates a public health workforce loan repayment program to eliminate workforce shortages. Individuals agreeing to work for at least three years in either a federal, state, local or tribal public health agency will receive funds. In FY 2010, \$195 million is authorized to be appropriated, along with such sums as necessary in FY 2011 – 2015.	<u>Public Health Workforce:</u> Creates a public health workforce loan repayment program to eliminate workforce shortages. Individuals agreeing to work for at least three years in either a federal, state, local or tribal public health agency will receive funds. In FY 2010, \$195 million is authorized to be appropriated, along with such sums as necessary in FY 2011 – 2015. (HR 3590, Sec. 5204).
<u>Preventive Services Task Force:</u> Transforms the current U.S. Preventive Task Force into the Task Force on Clinical Preventive Services. The new Task Force will review data to determine the most effective clinical preventive services.  The existing Task Force on Community Preventive Services will review data to determine the most effective community preventive services.	<u>Preventive Services Task Force:</u> Expands efforts of, and coordination between, the U.S. Preventive Services Task Force and the Community Preventive Services Task Force.	<u>Preventive Services Task Force:</u> Expands efforts of, and coordination between, the U.S. Preventive Services Task Force and the Community Preventive Services Task Force. (HR 3590, Sec. 4003).

**“Affordable Health Care for America Act”**

House-Passed on Nov. 7, 2009  
(HR 3962)

**“Patient Protection and Affordable Care Act”**

Senate-Passed on Dec. 24, 2009  
(HR 3590), including  
Manager’s Amendment (S.AMDT 3276)

**“Health Care and Education Reconciliation Act of 2010”**

Senate-Passed on March 25, 2010  
House-Passed on March 25, 2010  
(HR 4872)

<p><u>Wellness Programs:</u> Grants lasting up to three years will be provided to small employers to provide up to 50 percent of the costs incurred for offering a qualified wellness program.</p>	<p><u>Wellness Programs:</u> Grants lasting up to five years will be provided to small employers that establish wellness programs. There will be a technical assistance and evaluation systems to assess employer based health policies and programs. Employers may offer premium discounts, cost sharing waivers or benefits to employees participating in a wellness program and meeting certain health related standards.</p> <p>Establishes ten state pilot programs for states to participate in a similar rewards program as incentivized in the individual market.</p> <p>The Secretary will establish a pilot program to examine the impact of individual wellness plans designed to reduce risk factors for preventable conditions on at risk populations who utilize community health centers.</p>	<p><u>Wellness Programs:</u> Grants lasting up to five years will be provided to small employers that establish wellness programs. There will be a technical assistance and evaluation systems to assess employer based health policies and programs. Employers may offer premium discounts, cost sharing waivers or benefits to employees participating in a wellness program and meeting certain health related standards. (HR 3590, Sec. 10408).</p> <p>Establishes ten state pilot programs for states to participate in a similar rewards program as incentivized in the individual market. (HR 3590, Sec. 2705).</p> <p>The Secretary will establish a pilot program to examine the impact of individual wellness plans designed to reduce risk factors for preventable conditions on at risk populations who utilize community health centers. (HR 3590, Sec. 4206).</p>
<p><u>Community Transformation Grants:</u> The Secretary, acting through the CDC director, will establish a program to award grants to provide evidence-based community prevention and wellness services in priority areas identified by the Secretary in the national strategy, or to such services.</p>	<p><u>Community Transformation Grants:</u> These competitive grants will be awarded through the CDC to state and local governmental agencies and community based organizations for the purpose of developing programs aimed towards promoting individual and community health while preventing the incidence of chronic disease, including obesity, tobacco use, or mental illness. Funds are authorized to be appropriated to carry out this section for each of fiscal years 2010 – 2014.</p>	<p><u>Community Transformation Grants:</u> These competitive grants will be awarded through the CDC to state and local governmental agencies and community based organizations for the purpose of developing programs aimed towards promoting individual and community health while preventing the incidence of chronic disease, including obesity, tobacco use, or mental illness. . Funds are authorized to be appropriated to carry out this section for each of fiscal years 2010 – 2014. (HR 3590, Sec. 4201).</p>



**DRAFT**

**“Affordable Health Care for America Act”**

House-Passed on Nov. 7, 2009  
(HR 3962)

**“Patient Protection and Affordable Care Act”**

Senate-Passed on Dec. 24, 2009  
(HR 3590), including  
Manager’s Amendment (S.AMDT 3276)

**“Health Care and Education Reconciliation Act of 2010”**

Senate-Passed on March 25, 2010  
House-Passed on March 25, 2010  
(HR 4872)

<u>Positive Behavior Grants:</u> The Secretary will award grants aiming to promote positive behavior in medically underserved communities through the use of community health workers.	<u>Positive Behavior Grants:</u> The Director of the CDC will award grants aiming to promote positive behavior in medically underserved communities through the use of community health workers.	<u>Positive Behavior Grants:</u> The Director of the CDC will award grants aiming to promote positive behavior in medically underserved communities through the use of community health workers. (HR 3950, Sec. 399V).
<u>Preventive Medicine and Public Health Training Grant Program:</u> The Secretary will enter into contracts with, or award grants to, eligible entities to providing training to medical residents in preventive medicine specialties.	<u>Preventive Medicine and Public Health Training Grant Program:</u> The Secretary will enter into contracts with, or award grants to, eligible entities to providing training to medical residents in preventive medicine specialties.	<u>Preventive Medicine and Public Health Training Grant Program:</u> The Secretary will enter into contracts with, or award grants to, eligible entities to providing training to medical residents in preventive medicine specialties. (HR 3590, Sec. 768).
<u>Public Health Infrastructure Grants:</u> The Secretary, acting through the CDC Director, will award grants to health departments to address public health infrastructure needs.		
	<u>Healthy Aging, Living Well:</u> The Secretary, through the CDC, will award grants to state or local health departments, or Indian tribes, to carry out five year pilot programs to evaluate risk, conduct interviews, and provide clinical referrals for those who are between 55 and 64 years of age.	<u>Healthy Aging, Living Well:</u> The Secretary, through the CDC, will award grants to state or local health departments, or Indian tribes, to carry out five year pilot programs to evaluate risk, conduct interviews, and provide clinical referrals for those who are between 55 and 64 years of age. (HR 3590, Sec. 4202).
	<u>Incentives for Prevention of Chronic Diseases in Medicaid:</u> This grant program appropriates \$100 million	<u>Incentives for Prevention of Chronic Diseases in Medicaid:</u> This grant program appropriates \$100 million

**“Affordable Health Care for America Act”**

House-Passed on Nov. 7, 2009  
(HR 3962)

**“Patient Protection and Affordable Care Act”**

Senate-Passed on Dec. 24, 2009  
(HR 3590), including  
Manager’s Amendment (S.AMDT 3276)

**“Health Care and Education Reconciliation Act of 2010”**

Senate-Passed on March 25, 2010  
House-Passed on March 25, 2010  
(HR 4872)

	for the Secretary to award to states to provide incentives to Medicaid beneficiaries who successfully complete healthy lifestyle programs.	for the Secretary to award to states to provide incentives to Medicaid beneficiaries who successfully complete healthy lifestyle programs. (HR 3590, Sec. 4108).
<u>Non-emergency Transportation</u> : Requires Medicaid to cover non-emergency transportation consistent with federal regulations 42 CFR 431.54, as of June 1, 2008.		
	<u>Hospital Readmissions Reduction Program</u> : This provision directs CMS to track national and hospital-specific data on the readmission rates of Medicare participating hospitals for certain high-cost conditions that have high rates of potentially avoidable hospital readmissions.	<u>Hospital Readmissions Reduction Program</u> : This provision directs CMS to track national and hospital-specific data on the readmission rates of Medicare participating hospitals for certain high-cost conditions that have high rates of potentially avoidable hospital readmissions. (HR 3590, Sec. 3025, as amended by Sec. 10309).
<a href="http://thomas.loc.gov/cgi-bin/query/D?c111:3:./temp/~c111hrBfn9::">http://thomas.loc.gov/cgi-bin/query/D?c111:3:./temp/~c111hrBfn9::</a>	<a href="http://thomas.loc.gov/cgi-bin/query/D?c111:6:./temp/~c111LzSH53::">http://thomas.loc.gov/cgi-bin/query/D?c111:6:./temp/~c111LzSH53::</a>	<a href="http://thomas.loc.gov/cgi-bin/query/D?c111:2:./temp/~c111iYHVGD::">http://thomas.loc.gov/cgi-bin/query/D?c111:2:./temp/~c111iYHVGD::</a>

\* Please note that the italicized text in the table above reflects the changes made to the Patient Protection and Affordable Care Act (HR 3590) by the Health Care and Education Reconciliation Act of 2010 (HR 4872). The currently enacted health reform law (PL 111-148) is comprised of both bills, and therefore incorporates the changes made to HR 3590 by HR 4872.