

Comparing the House and Senate Health Care Reform Bills

Now that Democrats have lost their 60th vote in the U.S. Senate, the prospects for passing a comprehensive health care reform bill are unclear, and the same can be said for the process. However, the timetable is sure to be much slower, which gives all of us more time to review what was in the House and Senate packages and to share with lawmakers our opinions about the differences and similarities between the two versions of the bill.

The matrix on the following pages compares the two versions of the bill on many topics – focusing primarily on the differences, particularly with respect to the issue areas most relevant to coverage of children and families. However, even though the House and Senate bills differ in countless ways, the general outlines of the two plans are quite similar. For example, both bills would:

- Decrease the number of uninsured people nationally by at least 30 million.
- Create health insurance purchasing pools, called exchanges, which provide a mechanism for people to buy quality insurance through a regulated marketplace, and the bills would provide subsidies to help make coverage affordable for families and individuals with income below 400 percent of the federal poverty level.
- Expand Medicaid eligibility, thereby providing access to quality, affordable health care to millions of additional low-income parents and childless adults across the country; and in Wisconsin that change would provide a better benefits package for childless adults than the BadgerCare Plus Core Plan.
- Require employers, with exceptions for smaller businesses, to offer affordable coverage to their employees or pay a fee.
- Adopt insurance market reforms and consumer protections that would begin in 2010, including preventing insurance companies from denying coverage for people with preexisting conditions and chronic illnesses.
- Improve Medicare coverage for prescription drugs and preventive services.
- Implement initiatives to experiment with ways to slow the escalation of costs by changing the reimbursement system – putting more of an emphasis on rewarding quality of care and outcomes, rather than simply rewarding the number of procedures performed.
- Invest more than \$25 billion in community health centers, the public health workforce, and public health/wellness programs.
- They both contain sources of revenue and savings that are expected to more than offset the substantial costs, thereby causing a reduction in the federal deficit estimated to be at least \$130 billion over the next 10 years.

Side-by-Side Comparison of the House and Senate Health Care Reform Bills

	House (H.R. 3962)	Senate (H.R. 3590)
Medicaid (MA) related provisions		
Medicaid (MA) coverage – for children, adults & individuals with disabilities	Expands Medicaid to 150% of poverty in Jan. 2013, including new eligibility category for childless adults.	Expanded to 133% of poverty in Jan. 2014, including new coverage for childless adults. For most groups, it bases eligibility on modified gross income (w/o income disregards, assets or resource test).
MA maintenance of effort requirements for states	States may not reduce Medicaid eligibility. For WI that would mean not reducing eligibility of most kids under age 6 below 185 of poverty, or below 300% for infants less than age 1 and pregnant women.	States must maintain current MA coverage for kids until 2019, and they must maintain adult MA coverage until 2014, <u>unless</u> the state certifies it is experiencing a budget deficit or will experience one in the next year.
MA eligibility – state options	Allows states to: a) expand MA for family planning services; b) disregard income in providing continued MA coverage to individuals w. high drug costs; and c) provide MA coverage to low-income HIV-infected individuals	Allows states to expand MA coverage for family planning services.
MA benefit options and requirements	<ul style="list-style-type: none"> • Allows states to provide home visitation services for first-time pregnant women or kids under 2. • Allows coverage of therapeutic foster care. • Allows coverage of smoking cessation drugs. • Allows coverage for free-standing birth centers. • Requires coverage for certain preventive services (and vaccines) with no cost sharing. • Requires coverage of optometric and podiatrist services. • Extends to adults the enhanced CHIPRA match for translation services. 	<ul style="list-style-type: none"> • Funds states to develop maternal, infant and early childhood home visitation services. • Allows coverage of smoking cessation drugs. • Requires coverage for free-standing birth centers. • Provides a 1% increase in the federal match rate for coverage of certain preventive services and vaccines with no cost sharing. • Allows states to establish medical homes to provide coordinated care for people with chronic conditions. Community First Choice Option for people with disabilities (see financing section)
Transitional MA	No change	Extends it through 2012.

MA eligibility changes for children, and for young adults exiting foster care	<ul style="list-style-type: none"> • Extends MA eligibility for 60 days to any newborn who does not have acceptable coverage, and the child is deemed eligible if there is no MA determination at the end of 60 days. • Preserves MA eligibility for youths upon release from public institutions. 	Beginning in 2014, requires states to extend MA coverage for young adults under 25 who age out of foster care when they turn 18.
Medicaid rates for primary care providers	Would phase in increased rates for primary care providers to 100% of Medicare rates by 2012, and provides full fed. funding of those rate increases until 2015, and 91% of cost after 2015	No similar provisions
Children's Health Insurance Program (CHIP)		
CHIP's future	CHIP would be eliminated at the end of 2013, and kids over 150% of poverty would be transitioned to the new exchange	CHIP would be continued through 2019, and the funding is extended for two years.
CHIP maintenance of effort (MOE), & transition requirements	Requires states to maintain current CHIP coverage through Dec. 2013, and indefinitely for coverage in Medicaid expansions funded with CHIP dollars. Requires the HHS Secretary to submit a CHIP transition report that compares benefits under an average CHIP plan to the benefit standards in the Exchange.	CHIP-eligible kids who can't enroll because of federal funding caps must be screened to see if they are eligible for Medicaid, or for tax credits in an Exchange plan certified by the HHS Secretary to be comparable to CHIP.
CHIP requirements and options for states	Requires 12-month continuous eligibility for children. Precludes waiting periods for kids under age 2.	Creates a new option for states to provide CHIP coverage to certain children of state employees.
Federal Financing for MA, CHIP and DSH		
MA financing for the expanded coverage of adults	100% fed. funding for the 1 st two years, including certain parents and childless adults already covered (via state waivers), then decreasing to 91% fed. funding in 2015.	100% federal funding of the expanded coverage for the first 3 years, <u>excluding adults already covered</u> , then dropping in 2017 into a range of 82%-95%.
CHIP financing	No change.	Funding extended by 2 years, through 2015 (except for the CHIPRA bonus funding now available for states with large MA enrollment increases). Also, starting Oct. 1, 2015, states would receive an increase of 23 percentage points in their CHIP match rate
Extension of ARRA MA match increase	Extended six months, until June 30, 2011.	Not extended (ends on Dec. 31, 2010).

Funding for MA primary provider increases	As noted above, the bill increases MA rates for primary providers, and it funds those rate increases until 2015, and 91% of cost after 2015.	No provision
Funding for Disproportionate Share Hospitals (DSH)	Cuts \$20 billion -- \$10 billion from Medicare and \$10 billion from MA. Imposes largest reductions in states with the lowest uninsured rates and in states that don't target DSH \$s.	Cuts \$43 billion -- \$24.4 billion from Medicare and \$18.5 billion from MA. Imposes smaller reductions in low DSH states (like WI).
Outreach funding	No change.	Includes \$40 million for an additional 2 years of funding for MA & CHIP enrollment and renewal activities.
Funding for home visiting services and therapeutic foster care	Authorizes \$750 million over 5 years for these programs.	Provides funding for states to develop maternal, infant and early childhood home visitation services.
Community First Choice Option	No provision	For the next 5 years, provides states an enhanced MA match for attendants and community based supports for individuals with disabilities who need an institutional level of care.
Health Insurance Exchange(s)		
Health insurance exchange	Effective Jan. 1, 2013, creates a single nationwide health exchange for individuals and families over the new 150% Medicaid ceiling. States could offer their own Exchange with federal approval.	Effective Jan. 1, 2014, creates 50 state-level exchanges for individuals and families over 100% of poverty. To be administered by each state, or they can join to form regional Exchanges.
State block grant option	No provision	States may apply for a block grant to provide coverage for people below 200% of poverty, rather than permitting those individuals & families from receiving subsidized coverage in the Exchanges.
The "basic plan"	Would cover 70% of the cost of benefits, & would limit out-of-pocket spending to \$5,000/yr for individuals & \$10,000 for families (with lower limits for people below 400% of poverty).	Would cover 60% of the cost of benefits, & would limit out-of-pocket spending to \$5,950/yr for individuals & \$11,900 for families (with lower limits for people below 400% of poverty).
Other benefit plans	The Exchange would offer 3 other plans, covering up to 95% of costs.	Would offer 3 other plans, covering 70% to 90% of costs. Also, a plan for catastrophic coverage would be available for people up to age 30 and those exempt from the mandate to have insurance.

Exchange subsidies	See affordability section (next page)	See affordability section (next page).
Individual & small group markets	Combines them into one insurance pool and one exchange.	Keeps separate insurance pools and separate exchanges in each state for the individual & small group markets.
Exchange subsidies for people w. access to private coverage	Exchange subsidies limited to people who aren't enrolled in qualified or grandfathered employer or individual coverage, and who don't have access to an employer plan with premiums costing less than 12% of their income.	Employees who are offered coverage by an employer aren't eligible for subsidies unless the premiums for the employer plan costs more than 9.8% of the employee's income or the plan pays less than 60% of actuarial value. Employees whose employer coverage would cost between 8% and 9.8% of their income can convert their employer contribution into a voucher that can be used to shop in an exchange.
Public option	Creates a public insurance option that would be available through the exchange. Providers would negotiate reimbursement rates with the government	Does not include a public option. Instead, private firms would be allowed to offer insurance policies across state lines, & Office of Personnel Management has obligation to ensure there are at least 2 qualified multi-state plans (at least one of which is non-profit) in each state.
Exchange coverage of undocumented immigrants	No affordability credits for undocumented immigrants; but they may purchase coverage through an exchange with their own funding.	No affordability credits for undocumented immigrants; and they may <u>not</u> purchase coverage through an Exchange with their own funding.
Employer requirements and options		
Employer mandate	Employers must pay 65% of family premiums (72.5% for individuals) and meet minimum benefit and consumer protection standards, or pay an 8% payroll tax. Small businesses with payrolls less than \$500,000 are exempt.	There isn't a mandate per se, but if a firm with more than 50 employees doesn't offer any coverage, it must pay \$750 per employee if even one employee receives a subsidy through the Exchanges. If the employer does offer some coverage, it could owe a penalty of up to \$3,000 per employee who goes into an exchange and gets a credit, if the employee share of premium costs is more than 9.8% of income.
Participation in exchanges	Limited to employers with not more than 25 employees the 1 st year, 50 or fewer the 2 nd year, & 100 or fewer the 3 rd year. Could be expanded to larger employers over time.	Limited initially to employers with 50 or fewer employees; but starting in 2017, states could allow employers with more than 100 employees to participate.

Small business tax credits	Makes tax credits available to small businesses with fewer than 25 employees & average wages below \$40,000.	Makes tax credits available to small businesses with not more than 25 employees & average wages below \$50,000.
Wellness programs	Provide grants for up to 3 years to small employers for up to 50% of costs for a qualified wellness program.	Provide grants for up to 5 years to small employers that establish well-ness programs. Permit employers to offer rewards to employees for participation in qualified wellness programs.
Employer grandfather provisions		Permanently grandfathers existing employer plans that offer any level of coverage.
Affordability		
Medicaid expansion	By expanding Medicaid to 150%, low-income adults would have access to quality care with no premiums or deductibles and modest co-pays	Expansion of Medicaid to 133% would help some childless adults in WI, but fewer than in the House plan.
Tax credits	Would provide \$602 billion over 7 years (2013-2019) for affordability credits for people below 400% of poverty in the exchange.	Would provide tax credits of \$436 billion over 6 years (2014-2019) to subsidize coverage for people in the exchanges.
Premiums (in Medicaid and the exchanges)	The House bill provides much lower premiums for low-income individuals and families, ranging from zero for people below 150% of poverty and in Medicaid, to 3% percent of income at 150% of poverty, and 5.5% at 200% of poverty.	The Senate premiums would range from 4% of income at 134% of poverty, to 6.3% for families at 200% of poverty.
Cost-sharing subsidies	Provides subsidies (“affordability credits”) to help meet deductibles and co-pays for families up to 400% of poverty.	Provides smaller subsidies, which are only for people below 200% of FPL.
Limit on out-of-pocket spending in an “essential benefits package”	For the basic plan: \$5,000/yr for individuals & \$10,000 for families (with lower limits for people below 400% of poverty).	For the basic plan: \$5,950/yr for individuals & \$11,900 for families (with lower limits for people below 400% of poverty).
Cost-sharing restrictions on employer-based coverage of kids	May not charge any cost-sharing for preventive services for children or well-baby and well-child care.	Does not appear to have a similar restriction.

Miscellaneous provisions		
Individual mandate	The uninsured contribute 2.5% of income above the income tax filing threshold, capped at the amount of the average premium.	Phases in a penalty for the uninsured that in 2016 shall grow to up to \$750 per uninsured adult and \$2,250 per family, or 2% of family income, whichever is higher.
Medical homes	Establishes a 5-yr. medical home pilot program for MA eligibles. The pilot can waive state-wideness & comparability and the FMAP would be 90% for 2 years and 75% for the next 3 years. Provides up to \$1.235 billion.	Allows states to provide coordinated care through a medical home for individuals with chronic conditions, and provides \$25 million for planning grants.
Demonstrations, pilots and payment reforms	<ul style="list-style-type: none"> Establishes Center for Medicare and Medicaid Innovation to test payment & service delivery models to improve quality & efficiency. Establishes a medical home pilot project (see next item). 	<ul style="list-style-type: none"> Establishes CMS Innovation Center to test, evaluate & expand different Medicare, MA & CHIP payment structures to foster patient-centered care, improve quality & slow cost growth. Establishes MA & CHIP pilots to allow pediatric medical providers organized as “accountable care organizations” to share in cost savings Authorizes \$100 million in funding for grants for healthy lifestyle demonstration programs. Establishes a global payments demonstration project for large safety net hospital systems in up to 5 states, and a bundled payment demonstration program for up to 8 states.
Home visitation	No change	Allows & funds sates to develop early childhood home visitation programs.
Effect on insurance coverage	An estimated 36 million people would gain coverage, while 18 million would remain uninsured.	About 31 million would gain coverage, leaving 23 million uninsured.
Regulation of private insurance		
Requirements for private coverage of children	By 2018, all employer-based coverage must include an “essential benefits” for children, as well as well-baby and well-child care.	Requires that all health plans cover, at no cost, the preventive care and screenings identified in “Bright Futures” (the Amer. Academy of Pediatrics “gold standard” for preventive care.
Preexisting conditions	Insurers would be prohibited from denying coverage for pre-existing conditions in 2013.	Insurers would immediately be prohibited from denying coverage to kids for pre-existing conditions, and for adults beginning in 2014.

Rating reforms	Limits age rating so rates cannot vary by more than 2-1 between the oldest & youngest adults. Doesn't provide for tobacco ratings.	Allows age rating to vary by up to 3-1 between the oldest & youngest adults, and limits increased rates for smokers to be not more than 50%.
Dependent coverage of adult children	Provide dependent coverage for children up to age 27 for all individual and group policies.	Provide dependent coverage for children up to age 26 for all individual and group policies.
Medicare and Long-term care		
Medicare rate setting	Leaves it to Congress and the existing advisory panel to set Medicare reimbursement rates.	Creates a new independent commission to set Medicare rates and policies.
Medicare Advantage plans	Restructure payments – phasing down to fee-for-service levels by 2013.	Restructure payments – phasing down to base payments on the average of plan bids in each market, phased in over 4 years, starting in 2012.
Voluntary program to provide long-term care for people with disabilities	Would be financed with premiums paid by participants, through voluntary payroll deductions, with no fed. subsidy. People could qualify for lifetime benefits if they become disabled after paying premiums for at least 5 years and working for at least 3 of those years.	Same
Increased spending for public health and health care workforce		
Community health centers	\$12 billion over 5 years	\$8.5 billion over 5 years
Public health/wellness	\$16.9 billion over 5 years	\$15 billion over 10 years
Workforce	\$5 billion over 5 years	\$1.5 billion over 5 years
Federal financing and cost savings		
Total 10-year cost	Expected to cost \$1.05 trillion over the next 10 years, but new revenue and cost savings would reduce the federal deficit by \$139 billion.	Expected to cost about \$871 billion over the next 10 years, but would reduce the federal deficit by an estimated \$132 billion.
Medicare Advantage cost savings	Eliminates MA overpayments by phasing down payments over 3 years to ultimately achieve parity with traditional Medicare levels in the community. In conjunction with a “coding adjustment, this saves \$170 billion over 10 years..	Doesn't eliminate overpayments; establishes new competitive bidding approach under which private MA plans will continue to be paid more than Medicare levels in some communities & less than Medicare in others. Total savings: \$120 billion.

Net cost increases for MA and CHIP	MA/CHIP costs through 2019 estimated to increase by \$425 billion.	MA/CHIP costs through 2019 estimated to increase by \$395 billion.
Medicaid cost savings	Reduces payments for disproportionate share hospitals by \$10 billion over 10 years, and projects \$24.6 billion saved through pharmacy reimbursement and prescription drug rebate provisions.	Reduces payments for disproportionate share hospitals by \$18.5 billion over 10 years, and projects \$38.4 billion saved through pharmacy reimbursement and prescription drug rebate provisions.
High earners tax surcharge	A 5.4% surtax on couples with adjusted gross incomes of more than \$1 million a year and individuals over \$500,000 (starting in 2011). Generates \$460 billion.	No provision.
“Cadillac” health care tax	No provision.	40% excise tax on employer-sponsored group health plans with premiums over \$8,500 for individual coverage and \$23,000 for family. (Special dispensation for people working in dangerous professions, who have high premiums due to high risk.) Takes effect in 2013 and raises \$149 billion.
Increased Medicare payroll tax	No provision.	Increase Medicare payroll tax from 1.45% to 2.35% for individuals earning more than \$200,000/year and families earning more than \$250,000, starting in 2013. Raises \$86.8 billion.
Annual fee on health insurance providers	No provision.	Imposes fee based on proportion of market share, beginning in 2010, and generating \$2.3 billion per year.
Annual fee on manufacturers & importers of branded drugs	No provision.	Imposes fee based on proportion of market share, beginning in 2011. Raises \$59.6 billion over 10 years.
Increased floor on medical expense deduction	No provision.	Raise 7.5% adjusted gross income floor on medical expenses deduction to 10%, beginning in 2013. Generates \$15.2 billion over 10 years.
Total 10-year revenue increase	\$564.5 billion	\$460.3 billion

(continued)

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In compiling this information, we drew heavily from a number of other useful summary documents, particularly the following:

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- Kaiser Family Foundation, *Side-by-side Comparison of Major Health Care Reform Proposals*, Jan. 13, 2010. <http://www.kff.org/healthreform/sidebyside.cfm>
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- Tri-Committee House staff, *House-Senate Comparison of Key Provisions*, Dec. 29, 2009. http://energycommerce.house.gov/Press_111/health_care/HScomparison.pdf

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