

Comparison of House and Senate Health Care Reform Legislation

This chart provides a side-by-side comparison of the major provisions in the health care reform bills passed by the House on November 7, 2009, and by the Senate on December 24, 2009. The conference committee to reconcile the two bills is scheduled to begin work in early January 2010. A detailed side-by-side comparison of the fraud/abuse provisions in the House and Senate legislation is available at www.skadden.com.

Provision	House	Senate
Individuals		
Individual Mandate	<ul style="list-style-type: none"> Individuals must have health insurance, with limited exemptions. Penalty is 2.5 percent Adjusted Gross Income (AGI) over threshold (\$9,350 for individuals, \$18,700 for couples), capped at the cost of the average national premium under a basic exchange plan. 	<ul style="list-style-type: none"> Individuals must have health insurance, with limited exemptions. After a phasing-in period, penalty will be the greater of 2 percent gross income or \$750 for each uninsured family member, up to a max of \$2,250.
Premium Tax Credits	<ul style="list-style-type: none"> These credits let the recipient pay only between 1.5-12 percent of income as premiums. For people under 400 percent Federal Poverty Level (FPL) who lack access to employer coverage or whose premiums exceed 12 percent of income. 	<ul style="list-style-type: none"> These credits let the recipient pay only between 2-9.8 percent of income as premiums. For people under 400 percent FPL who lack access to employer coverage, whose plan lacks an actuarial value of at least 60 percent, or whose premiums exceed 9.8 percent of income. Individuals whose employer-based premiums are between 8-9.8 percent of income receive a free-choice voucher from their employer, allowing them to purchase an exchange plan.
Cost-Sharing Tax Credits	<ul style="list-style-type: none"> These credits will result in 70-97 percent of a person's benefit costs being covered. Available to individuals under 400 percent FPL. 	<ul style="list-style-type: none"> These credits will result in 80-90 percent of a person's benefit costs being covered. Available to individuals under 200 percent FPL.
Changes to Personal Savings Accounts	<ul style="list-style-type: none"> Limits health Flexible Spending Account (FSA) contributions to \$2,500 per year. Increases tax on Health Savings Account (HSA) distributions not used for qualified medical expenses to 20 percent. Bars reimbursement of nonprescription drugs from an HRA, health FSA, HSA, or Archer MSA. All changes become effective 2011 except the health FSA contributions limit, which begins 2013. 	<ul style="list-style-type: none"> Limits health FSA contributions to \$2,500 per year. Increases tax on HSA and Archer MSA distributions not used for qualified medical expenses to 20 percent. Bars reimbursement of nonprescription drugs from an HRA or health FSA and taxes their reimbursement from HSA or Archer MSA. All changes become effective 2011.
Temporary Insurance for Individuals With Pre-Existing Conditions	<ul style="list-style-type: none"> Covers individuals and their spouses and dependents who were denied coverage, offered unaffordable coverage, have an eligible medical condition or have been uninsured at least six months. Premiums may not exceed 125 percent of state rate; age rating limited to 2:1. Deductibles limited to \$1,500 and cost-sharing to \$5,000 (for individuals). Effective 2010 until establishment of exchange. 	<ul style="list-style-type: none"> Covers individuals who were uninsured at least six months. Premiums established for a standard population and age rating limited to 4:1. Cost-sharing limit will track with the HSA limit. Effective within 90 days of enactment through 2013.

Provision	House	Senate
Employers		
Mandated Coverage and Contributions for Employers	<ul style="list-style-type: none"> • Employers with payrolls of at least \$500,000 must provide employees with health insurance. Penalty for noncompliance depends on business size, ranging from 2-8 percent of payroll. • Employers must contribute 72.5 percent premium cost (individuals) and 65 percent (families) for lowest-cost plan that meets benefit requirements. Same penalties as for noncoverage. • If offered after a grace period, employers must cover preventive care at no cost to patient. 	<ul style="list-style-type: none"> • No mandated employer coverage. However, firms with at least 50 full-time employees are penalized for each employee obtaining subsidized coverage through an exchange. Penalty is the lesser of \$3,000 per employee receiving a credit or \$750 per employee (starts at a lower level before reaching this amount). • Firms this size are penalized \$600 per employee if they impose a mandatory waiting period over 60 days before employees can enroll in coverage.
Automatic Enrollment in Employer Coverage	<ul style="list-style-type: none"> • For any firm that offers coverage. • Must be the lowest-premium plan offered by employer. • Employees may opt out. 	<ul style="list-style-type: none"> • Only if firm has more than 200 employees. • Needn't necessarily be the lowest-premium plan offered by employer. • Employees may opt out.
Employer Tax Credits	<ul style="list-style-type: none"> • A tax credit is available to employers with fewer than 25 workers and average wages under \$40,000. • The max credit of up to 50 percent premium costs is available to employers with 10 or fewer employees and average wages of \$20,000 or less. Phases out as firm size and average wage increases. No credit for employees earning over \$80,000 per year. 	<ul style="list-style-type: none"> • A tax credit is available to employers with 25 or fewer workers and average wages under \$50,000. Employer must contribute at least 50 percent of premium costs. • The max credit of up to 50 percent premium costs is available to employers with 10 or fewer employees and average wages of \$25,000 or less. Phases out as firm size and average wage increases. • For 2010 to 2013, a credit of up to 35 percent is available for similarly situated employers that contribute at least 50 percent of premiums or 50 percent of a benchmark premium.
Temporary Reinsurance Program	<ul style="list-style-type: none"> • For employers that provide health benefits for Medicare-ineligible retirees over 55, the federal government will cover 80 percent of retiree's medical claims of more than \$15,000 and up to \$90,000. • Effective 90 days after enactment and is \$10 billion over 10 years. 	<ul style="list-style-type: none"> • For employers that provide health benefits for Medicare-ineligible retirees over 55, the federal government will cover 80 percent of retiree's medical claims of more than \$15,000 and up to \$90,000. • Effective 90 days after enactment and is \$5 billion through 2013.

Provision	House	Senate
Insurers		
Definition of Essential Benefits Package (Required for All Non-Grandfathered Qualified Plans)	<ul style="list-style-type: none"> • Provides comprehensive services, covers 70 percent of the value of benefits, limits annual cost-sharing to \$5,000 (individual) or \$10,000 (family), no cost-sharing for preventive services, no annual limits, no lifetime limits. • An essential benefits package for individuals and families below 350 percent FPL requires lower cost-sharing limits (e.g., for 133-150 percent FPL, the limits are \$500 for individuals and \$1,000 for families). • Requires reports due 2012 on covered services and cost-sharing levels and whether to include oral health in essential benefits package. • Starting 2010, Health and Human Services (HHS) will review insurers' justifications for premium increases prior to implementation. 	<ul style="list-style-type: none"> • Provides comprehensive services, covers at least 60 percent of the value of benefits, tracks annual cost-sharing limits with HSA limits. • HHS must define and annually update the benefit package.
Regulations on Insurers to Expand Coverage	<ul style="list-style-type: none"> • Bans rescission except in case of fraud and requires independent review of rescission, effective 2010. • Prohibits denying coverage based on pre-existing conditions. Limits such denials as a temporary measure starting in 2010. • Prohibits placing lifetime limits on benefits, effective six months after enactment. • Requires health plans to allow otherwise uncovered young people to remain on parents' insurance until 27th birthday, effective 2010. 	<ul style="list-style-type: none"> • Bans rescission except for fraud or intentional misrepresentation of material fact, effective 2010. • Prohibits denying coverage based on most pre-existing conditions. • Prohibits placing lifetime limits on benefits, effective six months after enactment. • Prohibits placing annual limits on benefits, except as allowed by HHS. • Requires health plans to allow otherwise uncovered young people to remain on parents' insurance until 26th birthday, effective six months after enactment. • Caps small group deductibles to \$2,000 (individuals) or \$4,000 (families) unless contributions are offered to offset exceeding deductible amounts.
Mandated Medical Loss Ratio (MLR)	<ul style="list-style-type: none"> • Requires MLR reporting by 2010. • When MLR reaches 85 percent, plans must provide rebates to consumers in the excess amount, until 2013. • Would also impose MLR limits on managed-care organizations and Medicare Advantage plans. 	<ul style="list-style-type: none"> • Requires MLR reporting by 2010. • When MLR reaches 85 percent (group) or 80 percent (individual), plans must provide rebates, through 2013.
Interstate Compacts and Nationwide Health Plans	<ul style="list-style-type: none"> • Allows states to form compacts to facilitate the purchase of individual insurance across state lines, effective 2015; states choose which state's laws to apply. 	<ul style="list-style-type: none"> • Allows states to form compacts to facilitate the purchase of individual insurance across states, effective 2016; insurers choose which state's laws to apply. • Allows insurers to offer nationwide plans, subject to one state's laws.

Provision	House	Senate
Insurers (continued)		
Abortion	<ul style="list-style-type: none"> Private plans may choose whether to cover elective abortion. People receiving premium subsidies may not choose a health plan that covers elective abortion. They may purchase supplemental abortion coverage entirely with their own money. Each insurer that offers a plan covering elective abortion on the exchange would have to offer an identical plan without elective abortion coverage. The public plan would not cover elective abortion. 	<ul style="list-style-type: none"> Private plans may choose whether to cover elective abortion. People receiving premium or cost-sharing subsidies may choose a health plan that covers elective abortion, but the federal subsidy funds cannot be used to purchase the coverage and must be kept segregated. States may pass laws prohibiting exchange plans from covering elective abortion.
Antitrust Exemption	<ul style="list-style-type: none"> Ended for insurers, effective upon enactment. 	<ul style="list-style-type: none"> Retained for insurers.
Health Insurance Exchanges		
Structure of Exchanges	<ul style="list-style-type: none"> One national exchange. Allows states to operate state exchanges if they meet operating requirements and the federal government approves. 	<ul style="list-style-type: none"> Two types of state exchanges in each state: individual and small business. States may merge these. Funding is available for creating the exchanges within one year of enactment and through 2014. Requires exchanges to submit financial reports to HHS and comply with oversight investigations.
Access to Exchanges	<ul style="list-style-type: none"> Open to people without qualifying coverage through an employer or public plan. Small businesses may let their employees get exchange insurance. In the first year, this will be allowed for businesses with 25 or fewer employees, with the max increasing to 100 in the third year. Undocumented immigrants may purchase insurance on the exchange if they are unsubsidized. 	<ul style="list-style-type: none"> Open to people without qualifying coverage through an employer or public plan. Small businesses with 50 or fewer employees may let their employees get exchange insurance. States may raise this max up to 100 through 2016. Starting in 2017, states may raise the max higher. Undocumented immigrants may not purchase insurance on exchanges.
Benefits to Be Offered Through Exchanges	<ul style="list-style-type: none"> Four suites, all of which include essential benefits package and which cover 70-95 percent of benefit costs. 	<ul style="list-style-type: none"> Four suites, all but one of which include essential benefits package and which cover 60-90 percent of benefit costs. On the individual exchanges, a catastrophic plan lacks essential benefits package. Generally, out-of-pocket limits track with HSA limits.
Out-of-Pocket Limits on Exchanges	<ul style="list-style-type: none"> Has lower out-of-pocket limits for people under 400 percent FPL, whether or not they have an exchange plan. 	<ul style="list-style-type: none"> Has lower out-of-pocket limits for people up to 400 percent FPL, ranging from one-third to two-thirds of HSA limits.
Regulations on Insurers Participating in Exchanges	<ul style="list-style-type: none"> Requires guaranteed issue and renewability. Allows premium variation only for age (max 2:1 ratio), premium rating area and family enrollment. Requires exchange plans to provide people with end-of-life planning information. 	<ul style="list-style-type: none"> Requires guaranteed issue and renewability. Allows premium variation only for age (max 3:1 ratio), premium rating area, family composition and tobacco use (max 1.5:1 ratio).

Provision	House	Senate
Providers		
Nonprofit Hospital Obligations	<ul style="list-style-type: none"> No provision. 	<ul style="list-style-type: none"> Requires nonprofit hospitals to conduct a community needs assessment and adopt an implementation strategy every three years and limit collection from needy patients, with a \$50,000 penalty tax for noncompliance.
Physician-Owned Hospitals	<ul style="list-style-type: none"> Prohibits physician-owned hospitals that lack a provider agreement from participating in Medicare. Those with a provider agreement could participate under certain conditions. 	<ul style="list-style-type: none"> Prohibits physician-owned hospitals that lack a provider agreement from participating in Medicare. Those with a provider agreement could participate under certain conditions. Existing physician-owned hospitals are subject to grandfather provisions.
Compliance Programs	<ul style="list-style-type: none"> Requires Medicare and Medicaid providers and suppliers to establish compliance programs. 	<ul style="list-style-type: none"> Requires Medicare and Medicaid providers and suppliers to establish compliance programs.
Professional Training	<ul style="list-style-type: none"> Redistributes residency positions and promotes outpatient training to increase the number of primary care providers, effective 2011. Provides loans and scholarships for aspiring public health, primary care and other professionals, effective 2011. Funds nursing training. 	<ul style="list-style-type: none"> Redistributes residency positions to increase the number of primary care providers and general surgeons, effective 2011, and promotes outpatient training, effective 2010. Provides loans and scholarships for aspiring public health, primary care and other professionals, effective 2010. Funds nursing training, effective 2010.
Medical Malpractice Tort Reform	<ul style="list-style-type: none"> Establishes voluntary grant program to incentivize states to implement litigation alternatives, effective immediately. 	<ul style="list-style-type: none"> Establishes voluntary grant program to incentivize states to implement litigation alternatives, from 2011 to 2016 only.
Drug and Device Manufacturers		
Closing the Part D Coverage Gap	<ul style="list-style-type: none"> Reduces doughnut hole by \$500 in 2010: seniors continue to get subsidized until their out-of-pocket drug costs exceed \$3200 per year. Starting 2010, 50 percent discount for brand-name drugs for seniors who are in the doughnut hole. Eliminates doughnut hole entirely by 2019. Funded by requiring drug manufacturers to provide Medicaid rebates for drugs used by full dual-eligibles and, after 2015, low-income subsidy recipients. 	<ul style="list-style-type: none"> Reduces doughnut hole by \$500 in 2010: seniors continue to get subsidized until their out-of-pocket drug costs exceed \$3200 per year. Starting 2010, 50 percent discount for brand-name drugs for seniors who are in the doughnut hole.
HHS Negotiation of Drug Prices	<ul style="list-style-type: none"> Requires HHS to negotiate drug prices on behalf of Medicare beneficiaries. 	<ul style="list-style-type: none"> No provision.
Medicaid Drug Reimbursement	<ul style="list-style-type: none"> Extends current rules through 2010, then limits Medicaid pharmacy multi-source payments to 130 percent weighted AMP. Increases the ceiling on payments for generics to 130 percent. 	<ul style="list-style-type: none"> Requires HHS to calculate reimbursement to pharmacists for multi-source drugs at a level no higher than 175 percent weighted AMP.

Provision	House	Senate
Drug and Device Manufacturers (continued)		
Medicaid Drug Rebates	<ul style="list-style-type: none"> • Increases minimum manufacturer rebate for brand-name drugs purchased through Medicaid from 15.1 percent AMP to 23.1 percent AMP. Extends rebates to new formulations of brand-name drugs. Effective 2010. • Extends rebates to Medicaid managed-care organizations, effective 2010. 	<ul style="list-style-type: none"> • Increases flat rebate for single-source and innovator multi-source drugs purchased through Medicaid to 23.1 percent AMP, except for clotting factors and exclusively pediatric drugs, which go to 17.1 percent. Increases basic rebate for non-innovator multi-source drugs from 11 percent to 13 percent. Effective 2010. • Extends rebates to Medicaid managed-care organizations, effective 2010.
Section 340B Program	<ul style="list-style-type: none"> • Extends participation to additional hospitals and centers. • Requires drug makers to submit 340B reports and authorizes HHS to publicize prices. Secretary may establish penalties. 	<ul style="list-style-type: none"> • Extends discounts to inpatient drugs; extends participation to additional hospitals and centers. • Requires drug makers to submit 340B reports and authorizes HHS publicize prices. Secretary may establish penalties.
Part D Formulary Regulations	<ul style="list-style-type: none"> • Prevents Part D plans from making formulary changes that increase cost-sharing or otherwise reduce coverage once plan's marketing period begins. 	<ul style="list-style-type: none"> • Codifies the current six classes of clinical concern, removes current criteria used to identify protected classes of drugs and gives HHS authority to identify classes of clinical concern through rules.
Sunshine on Manufacturer Payments	<ul style="list-style-type: none"> • Requires manufacturers and distributors to report payments or other transfers of value made to covered persons, including a range of providers and patient advocacy groups. • Exceptions for <i>de minimis</i> transfers, short-term loans of some devices, discounts and rebates, in-kind items for charity care and goods/services under a contractual warranty. • Would preempt state laws, except certain requirements that go beyond the bill. • Effective 2011; information reported to the public 2011. Payments made under a clinical trial are delayed until product approval or two years, whichever is first. 	<ul style="list-style-type: none"> • Requires manufacturers and distributors to report payments or other transfers of value made to covered persons, including doctors and teaching hospitals. • Exceptions for <i>de minimis</i> transfers, short-term loans of some devices, discounts and rebates, samples intended for patients and patient educational materials. • Would preempt state laws, except state laws that go beyond the bill. • Effective 2011; information reported to public 2013. Payments made under a product development agreement or clinical trial are delayed until product approval or four years, whichever is first.
Other Transparency Provisions	<ul style="list-style-type: none"> • Drug and device makers and group purchasing organizations (as well as providers) required to report physician-ownership interest and investment data. • Requires HHS to study the use of prescriber information in manufacturer sales and marketing practices and make recommendations. • Requires any PBM that manages the drug benefit for an exchange plan to disclose information about rebates and concessions to the exchange commissioner. 	<ul style="list-style-type: none"> • Drug and device makers and group purchasing organizations required to report physician-ownership interest and investment data. • Requires drug makers and distributors to report information about drug samples to HHS. • Requires any PBM that manages the drug benefit for a Part D or exchange plan to disclose information about rebates and concessions to HHS.

Provision	House	Senate
Drug and Device Manufacturers (continued)		
Biosimilars	<ul style="list-style-type: none"> Establishes a licensure pathway for biosimilars, effective immediately. Biologic must have no clinically meaningful difference in safety, purity or potency from the reference product and may not be licensed for 12 years after the licensing of the reference product. 	<ul style="list-style-type: none"> Establishes a licensure pathway for biosimilars, effective immediately. Biologic must have no clinically meaningful difference in safety, purity or potency from the reference product and may not be licensed for 12 years after the licensing of the reference product.
Medicare and Medicaid		
Medicare Delivery and Payment Reform	<ul style="list-style-type: none"> Reduces market basket updates and adjusts for productivity. Expands productivity adjustments to Medicare providers that receive consumer price index (CPI) updates like ambulatory surgical centers, ambulances, clinical labs, and non-competitive-bid DME. Reduces Medicare Disproportionate Share Hospital (DSH) payments to account for reductions in uninsured, effective 2017. Requires Institute of Medicine to recommend changing payment system to reward value and quality, not volume. Recommendation becomes law without joint resolution of disapproval. 	<ul style="list-style-type: none"> Reduces market basket updates and adjusts for productivity. Begins process of applying value-based purchasing toward other providers (e.g., hospices and in-patient rehab facilities). Reduces Medicare DSH payments by 75 percent, effective 2015, and more depending on reductions in uninsured. Requires study of Medicare doctors' utilization patterns and establishes a values-based payment modifier to increase reimbursements for doctors that deliver high-quality care at low cost (and decrease reimbursements for low-value doctors). This will be budget-neutral.
Changes in Medicare Provider Reimbursement	<ul style="list-style-type: none"> Provides a 5 percent bonus for reimbursing Medicare primary care, effective 2011. Requires Institute of Medicine to report on validity of geographic adjusters that apply to Medicare physician and hospital payments and recommend improvements. Recommendations become law unless both houses of Congress disapprove by resolution. 	<ul style="list-style-type: none"> Provides a 10 percent bonus for reimbursing some Medicare primary care and major surgery in low-doctor areas, effective from 2011 to 2016. Increases reimbursements for certain imaging services, like bone density scans.
Extracting Savings from Medicare	<ul style="list-style-type: none"> Creates demonstration program to reimburse providers for coordinating home-based care for chronically ill seniors, effective 2012. Requires HHS to reform Medicare payments for post-acute services, including bundled payments, effective 2011. Creates pilot to test accountable-care organizations, effective 2012. 	<ul style="list-style-type: none"> Creates demonstration program to reimburse providers for coordinating home-based care for chronically ill seniors, effective 2012. Creates pilot to test payment-bundling arrangements, effective 2013. Allows accountable-care organizations to share in savings they produce, effective 2012.
Cuts to Medicare Advantage (MA)	<ul style="list-style-type: none"> Reduces MA payments by \$170 billion over 10 years to correct perceived disparity with traditional Medicare, beginning 2011. 	<ul style="list-style-type: none"> Applies benchmark and reduces MA payments by \$118 billion over 10 years, beginning 2012.

Provision	House	Senate
Medicare and Medicaid (continued)		
Expanding Medicaid	<ul style="list-style-type: none"> • Expands coverage to 150 percent FPL. • Federal government would pay all costs for the newly eligible for the first two years and 91 percent afterward. • Physicians must be paid for Medicaid primary care at 100 percent of Medicare rates, effective 2012. Federal government will pay all extra costs through 2014, then 90 percent. • No co-pays for preventive care; states receive regular federal matching rate. 	<ul style="list-style-type: none"> • Expands coverage to 133 percent FPL. • Federal government would pay all costs for the newly eligible for the first three years and, subsequently, maintain the federal share of spending at significantly higher levels. • Requires that states offer premium assistance to any Medicaid beneficiary with access to employer insurance, if cost-effective for state. • Starting 2017, Nebraska will get a greater percentage of federal funds.
Extracting Savings From Medicaid	<ul style="list-style-type: none"> • Reduces Medicaid DSH payments by \$10 billion from 2017 to 2019. 	<ul style="list-style-type: none"> • Reduces Medicaid DSH payments by 25-50 percent, depending on the state. • Creates demonstration program to test payment bundling from 2012 to 2016. • Creates demonstration program to allow pediatric accountable care organizations to share in cost savings from 2012 to 2016.
Medicare and Medicaid Anti-Fraud, Waste and Abuse Provisions	<ul style="list-style-type: none"> • Increases funding to fight fraud by \$100 million per year. • Changes incentives to discourage preventable hospital readmissions. 	<ul style="list-style-type: none"> • Increases funding to fight fraud by \$10 million per year. • Changes incentives to discourage preventable hospital readmissions.
New Medicare and Medicaid Institutions	<ul style="list-style-type: none"> • Creates innovation center to test payment reforms at cost of \$1 billion per year. HHS may expand any pilot that actuaries certify will reduce long-term spending. 	<ul style="list-style-type: none"> • Creates advisory board to offer cost-saving proposals when Medicare spending rises too fast. Doctors, hospitals, and hospices would be exempt from board's recommendations until 2019. • Creates innovation center to test payment reforms at cost of \$1 billion per year. HHS may expand any pilot that actuaries certify will reduce long-term spending.
Screening Medicare and Medicaid Providers	<ul style="list-style-type: none"> • Requires HHS to establish screening procedures. Permits screening to vary according to the level of risk for each category of provider or supplier. 	<ul style="list-style-type: none"> • Requires HHS to establish screening procedures. Screening would vary according to the level of risk of provider or supplier.

Provision	House	Senate
Other Government Health Programs		
Public Plan	<ul style="list-style-type: none"> • Must meet same basic requirements as private plans. • Funded solely by beneficiary premiums, except \$2 billion in start-up money from the government. • The plan negotiates payment rates with providers so that they are not lower than Medicare rates but not higher than the average private rate. • Medicare providers are considered to be participating in the public plan unless they opt out. • Medicare's fraud and abuse protections apply to the public plan. 	<ul style="list-style-type: none"> • Does not include a public plan. Office of Personnel Management (OPM) will contract with private insurers to offer two multi-state plans, one of which must be non-profit and one of which cannot cover elective abortions (functions are not exclusive). OPM's role limited to negotiating and certifying plans that meet its qualifications with respect to MLR, profit margins, premiums and other terms and conditions.
Children's Health Insurance Program (CHIP)	<ul style="list-style-type: none"> • Ends CHIP. Former recipients either go to Medicaid or exchange. • Requires a report due 2011 ensuring exchange coverage is comparable to CHIP coverage and there will not be treatment interruptions. 	<ul style="list-style-type: none"> • Preserves CHIP. States will receive a 23 percent higher federal reimbursement rate. • Requires states to maintain current eligibility levels until 2019. Benefit and cost-sharing rules will continue. • CHIP-eligible children unable to enroll due to enrollment caps are eligible for exchange credits.
Insurance for the Severely Disabled	<ul style="list-style-type: none"> • Creates CLASS, a voluntary federal insurance program that provides long-term care and cash to people with severe disabilities. • Premiums would cover full cost of benefits, which would average at least \$50 per day. 	<ul style="list-style-type: none"> • Creates CLASS, a voluntary federal insurance program that provides long-term care and cash to people with severe disabilities. • Premiums would cover full cost of benefits, which would at least \$50 per day.
Co-ops	<ul style="list-style-type: none"> • Creates a program to facilitate nonprofit, member-run insurers. Effective six months after enactment. 	<ul style="list-style-type: none"> • Creates a program to facilitate, through loans and grants, creation of nonprofit, member-run insurers. \$6 billion will be available by 2013.
State Group Insurance	<ul style="list-style-type: none"> • No provision. 	<ul style="list-style-type: none"> • Permits states to create a basic health plan for people between 133-200 percent FPL. In such states, these people would not receive exchange subsidies. The program would be funded with 95 percent of the money the federal government would otherwise give as subsidies.
Alternative State Innovations	<ul style="list-style-type: none"> • No provision. 	<ul style="list-style-type: none"> • Starting in 2017, a state can waive some requirements and instead provide innovative health care using money otherwise spent on subsidies. Must be the same or greater coverage for the same or cheaper price.

Provision	House	Senate
Financing		
Start Year	<ul style="list-style-type: none"> • 2013 for most provisions. 	<ul style="list-style-type: none"> • 2014 for most provisions.
Overall Price Tag	<ul style="list-style-type: none"> • \$894 billion. Projected budget savings according to the Congressional Budget Office (CBO): \$104 billion for 10 years. 	<ul style="list-style-type: none"> • \$871 billion. Projected budget savings according to CBO: \$132 billion for 10 years.
Funding the Legislation: Taxes and Fees	<ul style="list-style-type: none"> • 5.4 percent surtax on individuals with AGI over \$500,000 and on families with AGI over \$1 million a year. Effective 2011. • Insurers must pay a fee, to be determined by HHS, to finance comparative effectiveness research fund. • 2.5 percent tax on device sales. Effective 2013. 	<ul style="list-style-type: none"> • 40 percent tax on high-end employer plans (aggregate value over \$8,500 if individual, \$23,000 if family). Higher thresholds in some cases. • 62 percent increase in Medicare Part A payroll tax rate for individuals making over \$200,000 a year or families making over \$250,000. • Annual fees, allocated by market share: beginning 2010, \$2.3 billion on drug makers for sales after 2008; beginning 2011, \$2 billion on device makers for sales after 2009 (increases to \$3 billion after 2017); and, beginning 2011, an increasing amount on insurers for sales after 2009 (starts at \$2 billion and ends up at \$10 billion after 2016). Nonprofit insurers with 90 percent or higher MLR are exempt. • 10 percent tax on indoor tanning salons, effective 2010.
Funding the Legislation: Changes to Tax Code	<ul style="list-style-type: none"> • Eliminates deduction for employers who receive a subsidy for providing retiree prescription drug coverage. 	<ul style="list-style-type: none"> • Eliminates deduction for employers who receive a subsidy for providing retiree prescription drug coverage, effective 2011. • Deductibility of employee compensation is capped at \$500,000 per individual for insurers that get at least 25 percent of gross premium income from minimal plans. • Increases threshold for itemized deduction for unreimbursed medical expenses from 7.5-10 percent of AGI, effective 2013; temporarily waived for seniors.

If you have any questions regarding the matters discussed in this memorandum, please contact the following attorneys or call your regular Skadden contact.

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