NASMD

National Association of State Medicaid Directors

an affiliate of the American Public Human Services Association

Health Reform Bills Side by Side
(10/05/09 Draft)

Bill Provision Description	Senate HELP Committee	HR 3200 as passed by the Energy and Commerce with Medicaid Amendments (7/31/09)	Senate Finance Mark, with Amendments (10/05/09)
Basic Approach to Medicaid	Requires all individuals to have health insurance. Creates a Gateway similar to the Massachusetts model.	Requires all individuals to have health insurance. Creates an Exchange which requires employers to either provide coverage or pay into the Health Insurance Exchange Trust Fund. Expands Medicaid to individuals up to 133% FPL.	Requires all individuals to have health insurance. States must create exchange(s) for individual market and small group market. Requires all employers to provide coverage or pay a penalty. Expands Medicaid to individuals up to 133 % FPL.
INSURANCE REFORM			
Grandfather current coverage for individuals	yes	Yes, with conditions	Individuals with plans equal in value to young invincible coverage could keep that coverage and it would be considered creditable coverage for purposes of the personal responsibility requirement. Beginning July 1, 2013, Federal

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			rating rules would be phased in for grandfathered policies in the small group market, over a period of up to five years, as determined by the state with approval from the Secretary.
National Plans			Uniform packages can be offered across state lines but the plans must be licensed in every state they operate and they will be regulated accordingly by each state's laws and regulations. States are permitted to opt –out of the national plan. Legislative action must be taken at the state level in order for a state to opt-out. A state that opts-out can take legislative action opt back into the national plan.
State Opt-out			Beginning in 2015, States may request a waiver to opt-out of certain aspects of the Act through a process similar to CHIP and Medicaid waivers. To receive the waiver, the state must demonstrate: 1. the state plan provides comprehensive coverage as

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			required under an exchange plan with citizen input through a referenda or similar means; 2. the state plan will ensure all residents have coverage; 3. the state submits an application in the manner described by the Secy and 4. the state submits a 10 year budget that is budget neutral to the federal govt.
State Option for a basic health plan			States would have an opportunity to establish a state plan for people with incomes above Medicaid eligibility but below 200% of FPL. The federal government would provide funds to participating states to allow the provision of affordable health care through private health care systems under contract. Eligible individuals and families would have access to several affordable plans rather than through the exchange. Funding would be based on the value of individual tax credits and

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			subsidies that would otherwise been made based on enrollment in the state.
Limited premium variation permitted	Yes 2:1 maximum	yes	Yes based on tobacco use, age, and family composition; may vary based on geographic differences, but not within the same rating area. Premiums may not vary by more than 6:1
Provider networks	Secretary directed to include "wide choice of providers" requirement in certification regulations	Yes, Commission established requirements	
Cost Sharing Limits		$5,000 for individual; $10,000 for family; increased annually by CPI; Copayment should be used instead of coinsurance;	Out of pocket limits would be tied to varying percentages of current Health Saving Account limits
No cost share for preventive services	yes	Yes	Yes, except for value-based insurance designed plans
Dependent coverage up to age 26	yes		
No exclusion of pre-existing conditions	yes	yes	yes
Eligibility for Exchange	Individuals without insurance	Individuals without insurance.	Individuals and small employers; larger employers phased-in.
No annual or lifetime limits	yes	yes	yes

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Individual Mandate to obtain health insurance	Yes, but not applied to Native American, citizens in states who are not participating, and where affordable insurance is not available	Yes, except in cases of hardship. Those who don't obtain coverage will pay a penalty not to exceed the premium. Additional tax of 2.5% if an individual does not obtain acceptable coverage.	Yes, in 2013 all citizens and legal residents will be required to purchase health insurance or have health coverage through an employer, public program, or other source that meets the requirements. Hardships and exemptions will be granted when appropriate. (premium exceeds 8% of income)
Return of Profit	Profitable plans must return part of their profit to policy holders as rebates	Any QHBP with a medical loss ratio defined by the commission must provide a rebate to enrollees to reach the medical loss ratio	
Rebalancing of Risk Factors	States assess fees on plans with low enrollee risk factors and provide payment to plans with high enrollee risk factors	The commissioner of the exchange establishes mechanisms to adjust premium amounts based on risk factors to prevent adverse selection	All plans in the individual and small group markets would be subject to the same system of risk adjustment. The secretary would define qualified risk adjustment models.
Parity in Mental health and substance abuse benefit disorders		Yes, benefits must include mental health and substance abuse treatment services.	Yes, benefits must include mental health and substance abuse treatment services.
Coverage requirements	Disease management, medication and care compliance programs, and activities to	Hospitalization, outpatient hospital and outpatient clinic (including ER), professional	Preventive and primary care, emergency services, hospitalization, physician

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	reduce medication errors	health services, services, equipment and supplies relating to health professional service, prescription drugs, rehabilitative and habilitative services, mental health and substance use disorder services, preventive services, maternity care, well baby and well child care and oral health, vision and hearing services, equipment and supplies for children under 21.	services, day surgery and related anesthesia, diagnostic imaging and screenings (including x-rays), maternity and newborn care, pediatric services (including dental and vision) medical/surgical care, prescription drugs, radiation and chemotherapy, and mental health and substance abuse services that at least meet minimum standards set by federal and state laws.
Rates	Must substantially reflect Medicare and CHIP policies	Based on Medicare parts A & B for similar services.	
Advisory Council	Establishes Medical Advisory Council to make recommendations regarding allowable benefits for federal reimbursement, "minimum qualifying coverage", and the definition of "affordable and available coverage".	Health Benefits Advisory Committee: Surgeon General shall chair this committee which will recommend benefit standards.	
Employer Responsibility		Employers are responsible for paying to the issuer of the coverage or required to make a contribution to the Health	Employers with more then 50 full time employees that do not offer health coverage must pay a fee for each employee who

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		Insurance Exchange.	receives the tax credit for health insurance through the exchange.
Revenue		A surcharge is imposed on the top 1.2% of earners with income greater than $350,000 for married couples and $280,000 for singles. Imposed at progressive rates.	An excise tax is imposed on insurers if the aggregate value of employer-sponsored coverage exceeds $8,000 for an individual or $21,000 for a family. The tax would entail 40% of the funds above the individual/family limit.
Affordability Credits/Individual Subsidies	Provided based upon a person's income, and the ratio of premiums to income. Up to 500% FPL would pay no more than 10% of income, Under 150% would be required to pay no more than 1% of income. Secretary directed to develop graduations for the FPL % between.	Medicaid agencies are required to repay their state share of the affordability credits for those Medicaid eligible individuals who receive insurance through the Exchange. Provide affordability premium credits to individuals and families with incomes up to 400% FPL to purchase insurance through the Health Insurance Exchange. The premium credits will be based on the average cost of	Tax credits available on a sliding scale basis for individuals and families between 134-300% of poverty to help offset the cost of private health insurance premiums. Beginning 2014 the credits are also available to individuals and families between 100-133%.

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		the three lowest cost basic health plans in the area and will be set on a sliding scale such that the premium contribution is no more than 1% of income for individuals with income at or below 133% FPL and no more than 11% (initial) and 12 % (final) of income for individuals with income at 400% FPL. Provide affordability cost-sharing credits to individuals and families with incomes up to 400% FPL. The cost-sharing credits are offered on a sliding scale basis such that the cost-sharing limit for those with income at or below 133% FPL is $250 per individual and $500 per family and for those with income at 400% FPL is $5,000 per individual and $10,000 per family.	

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MEDICAID MODIFICATIONS			
Medicaid Eligibility			
All individuals currently eligible will remain eligible for Medicaid		yes	yes
Mandatory eligibility level		133% for those under age 65 New eligibles would be paid at 100% FMAP; 90% FMAP beginning 2015. All individuals who are eligible under 1115 waivers and are below 133% FPL would get 100% FMAP. 100% FMAP (90% in 2015) for certain traditional Medicaid eligible individuals – individuals who have income less than 133% FPL and otherwise would be eligible under the state plan but for income as of June 16, 2009. 100% FMAP (90% in 2015) for temporary coverage of certain newborns.	On 1/2011, States would be provided the option to cover childless adults under a SPA at current FMAP. Effective 1/2014 eligibility for parents, children age 6 and older, and all childless adults otherwise ineligible for Medicaid would increase to 133% of FPL. During 2013, the penalty for failing to comply with the individual responsibility to obtain insurance would not apply to individuals at or below 133% of FPL. These individuals would not be eligible for tax credits in the exchange. All newly eligible non pregnant adults would be guaranteed a benchmark benefit package consistent with section 1937 of

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		A state cannot require a non-traditional eligible individual in managed care unless the state demonstrates to the Secretary that there is adequate capacity of the network to meet health, mental health and substance abuse needs of the individuals.	SSA. Medicaid cost sharing rules and out-of –pocket limit of 5% of family income would continue to apply to children. States would be able to provide Medicaid coverage to individuals with MGI above 133% FPL through traditional Medicaid or in the form of supplemental wrap benefits. Individuals above 133 who receive only a benefit wrap may be eligible for tax credits in the state exchange. States would be required to report on changes in Medicaid enrollment. From 2014 – 2019, States would receive an FMAP increase of 0.15%.
Coverage of Newborns		Non-traditional Medicaid enrollees and elected Medicaid; after 1 year deemed traditional Medicaid unless	

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		eligible under the exchange. Initial Medicaid coverage is 60 days while a determination is completed to enroll the newborn in appropriate insurance.	
Unlawful residents		Nothing in the legislation shall change current prohibitions of payment under Medicaid or CHIP for individuals that are not lawfully present in the U.S.	Illegal immigrants are barred from participation; verification methods included to ensure exclusion.
Improvements to facilitate enrollment	yes	Yes, if approved by the Commissioner Medicaid can provide eligibility determinations through the Exchange.	State Medicaid programs would be required to operate a website that coordinates with state exchange websites for enrollment in Medicaid or the exchange.
Maintenance of effort for current Eligibility Categories		Yes, as of June 16, 2009 (also for CHIP, however, a state is not precluded from imposing limitations described in 2110(b)(5)(C)(i)(II) to limit expenditures under its annual allotment. Permits an exception to the maintenance of effort	States are not permitted to reduce income eligibility levels for Medicaid. This provision would expire when the state based exchanges become fully operational (expected 7/1/2013) except as it applies to coverage at income levels of 133% of poverty and below for which it would continue through 1/14.

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		requirement for certain populations who receive a premium or cost sharing subsidy for individual or group health coverage as of June 16, 2009, under section 1115 waivers. States must not apply any asset or resource test in determining eligibility beginning on or after Y1 of the America's Affordable Health Choices Act of 2009. Benchmark packages must meet the minimum benefits and cost sharing standards of a basic plan offered through the health exchange.	Between 1/1/11 and 1/1/14, a state is exempt from MOE for optional non-pregnant non-disabled adult pops. above 133% of the FPL if the state certifies that the state is currently experiencing a budget deficit or projects a budget deficit in the following SFY. On 1/1/14, income calculations for Medicaid and CHIP would change to Modified Gross Income (MGI), which is based on IRS Gross Income used in the state exchanges. Income disregards would not be allowed in Medicaid. An exception for the MGI rule would be made for the elderly and groups that are eligible for Medicaid, through another program, e.g., foster children, low income Medicare beneficiaries, SSI. The change to MGI would not apply to beneficiaries who were enrolled

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			in Medicaid on 1/1/14 until the later of 3/31/14 or their next redetermination date.
Eligibility Determinations	Criteria utilized to establish income levels for eligibility for premium credits in a gateway may also be used to determine eligibility for Medicaid/CHIP	If approved by the Commissioner, criteria utilized to establish income levels for eligibility premium credits in the Exchange may also be used to determine eligibility for Medicaid/CHIP.	State Medicaid programs would be required to operate a website that coordinates with state exchange websites for enrollment in Medicaid or the exchange.
Continuous Eligibility under CHIP		12 month continuous eligibility must be provided under CHIP for children with family income below 200% FPL. Prevents the application of a waiting period under CHIP for children under 2 who lost coverage or for whom health insurance is unaffordable.	
Expanded Outstationing		Expands requirements to receive and process applications at places such as DSH hospitals and FQHCs to all Medical Assistance Applications and affordability credits	Hospitals would have the option to make presumptive eligibility determinations, based on preliminary information, for any individual who may be eligible for Medicaid.

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Interaction with the Exchange		The Medicaid agencies must have an agreement with the Commissioner with regard to the enrollment of individuals in Exchange participating plans. States are required to accept individuals determined eligible for Medicaid through the exchange. Individuals in the exchange are eligible for wrap around benefits. Individuals who are Medicaid eligible and Exchange-eligible but have not elected to enroll in the Exchange will be automatically enrolled into Medicaid. A non-traditional Medicaid eligible as determined by the Commissioner will be accepted in Medicaid by the state without any further determination. The State will also accept without further determinations individuals	Individuals below 100 % FPL would be deemed ineligible for the exchange. Non-elderly non-pregnant adults between 100 and 133 % of FPL would be able to choose between Medicaid and subsidized coverage in the exchange. Children of parents who elect the exchange must continue to receive EPSDT. For every non-elderly, non-pregnant Medicaid eligible adult between 100% - 133% FPL that opts into the exchange, States would be required to pay an amount equal to the State's average cost of coverage for an individual in that same Medicaid eligibility category. The Mark provides for the availability of child-only health insurance coverage through the exchange and would direct the Secretary to determine whether alternative means – such as

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		determined to be traditional Medicaid eligible by the Commissioner. The state shall provide Medicaid available during presumptive eligibility periods. If the Commissioner determines the state has the capacity, the state will conduct eligibility determination for Affordability credits and the Commissioner will reimburse the state for the costs of doing the determinations. A non-traditional Medicaid eligible individual may be an Exchange eligible individual if the individual was enrolled in a qualified health benefits plan, grandfathered health insurance coverage, or current group health plan during the 6 months before the individual became a non-traditional	direct subsidies, and refinements to tax credit eligibility determinations, are necessary to provide support for the purchase of such coverage for children. Stand-alone dental plans also would be permitted to offer pediatric dental benefits directly and to offer coverage through the exchange. These plans must comply with all consumer protection requirements in order to participate in the exchange.

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		Medicaid eligible individual. All Medicaid eligibles can become Exchange eligible individuals in year 5 if the state requests such treatment for the group including such individual, the state shows they can provide wraparound services, and the Commissioner agrees. CHIP individuals considered exchange eligible unless eligible for Medicaid.	
Medicaid coverage			All newly eligible non-pregnant adults would be guaranteed a benchmark benefit package would have to meet the requirements for a Silver level plan in the exchange. Populations currently exempted from mandatory enrollment in a benchmark plan would continue to be exempted.

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Nurse Home Visitation Services		Provides for optional coverage and enhanced payment.	Under Title V of the SSA, would provide funding to states, tribes and territories to develop and implement one or more evidence based Maternal, Infant and Early Childhood Visitation models. Model options would be targeted at reducing infant and maternal mortality.
School Based Services		(Eliminates provision in draft that would have required States to furnish Medicaid eligible children in school based clinics.)	Establishes a grant program to be used to fund operating expenses for school-based health centers. Would appropriate $100 million in both FY 2010 and FY 2011, to remain available until expended for such program. The Secretary would be directed to give preference in awarding grants to school-based health centers serving a large population of children eligible for Medicaid or CHIP.
Coverage of Incarcerated Youth		The state must assure that a youth who was eligible for Medicaid upon being incarcerated must retain	

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		eligibility and receive benefits upon release. During incarceration, the state must establish a process that ensures that the state does not claim FFP for services excluded by 1905(a)(28)(A) and the youth receives services for which federal participation is available.	
Therapeutic Foster Care		Specifies that nothing in the title would prevent a state from covering therapeutic foster care for eligible children in out of home placements.	
Tobacco Cessation		Deletes tobacco cessation exclusion from covered outpatient drugs. Tobacco cessation counseling for pregnant women is a covered benefit.	States would be required to provide coverage under Medicaid for tobacco cessation services for pregnant women without cost-sharing.
Family Planning		State plan option to provide only family-planning services	State plan option for new categorical group for non-pregnant women up to highest level applicable to pregnant women under Medicaid or CHIP and at state option, individuals

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			eligible under standards and processes of existing 1115 family planning waivers. Benefits would be limited to family planning services and supplies and related medical diagnosis and treatment services. Presumptive eligibility would be permitted.
Optional coverage of low-income HIV infected individuals		State plan option to provide medical assistance to individuals with an HIV infection and income/resources below the maximum level set for mandatory eligibility categories for people with disabilities in the State; excludes this group from funding limitation for territories. This option sunsets on January 1, 2013, when broad based coverage will be available through the Exchange or expanded Medicaid.	
Birthing Center Coverage		Includes State-option coverage for "free standing birthing	Would identify free-standing birthing centers as Medicaid

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		centers"	providers
Hospice			Would allow Medicaid children as defined by the State to receive hospice services without forgoing any other service to which the child is entitled under Medicaid.
Vaccines for Children		Public health clinic is included under VFC program.	
Non-emergency transportation		Requires Medicaid coverage of non-emergency transportation consistent with federal regulations 42 CFR 431.53 as in effect as of June 1, 2008.	
Accountable Care Organization Pilot		Establishes an Accountable Care Organization Pilot under Medicaid.	Establishes a demonstration project which would allow pediatric medical providers who meet certain criteria to be recognized as accountable care organizations (ACOs). Participating providers would be eligible to share in the federal and state cost savings achieved for Medicaid and CHIP. States, in consultation with the Secretary, would establish a minimum level of savings that

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			would need to be achieved by an ACO in order for it to share it the savings.
Transitional Medical Assistance		Extends TMA until December 31, 2012.	
Federal Payments	.	The federal government will pay 100% (90% beginning in 2015) matching to bring the eligibility levels to 133% for traditional and non-traditional eligibles. 100% FFP (90% beginning in 2015) for newly eligible enrollees Requires the Comptroller General to study the FMAP rate and the effect of removing the 50% floor and the 83% ceiling and report to Congress by February 15, 2011. Requires the Comptroller General to study Medicaid Administrative Costs and report to Congress by February 15, 2011. Establishes within CMS a Center for Medicare and Medicaid Payment	To defray the costs of new eligibles, additional Federal financial assistance will be provided to all states. Those states that do not currently cover the newly eligible populations will receive more assistance initially than those states that currently cover at least some non-elderly non pregnant individuals. Between 2014 and 2019, the additional assistance to the two types of states will be adjusted downward and upward, respectively, so that by 2019 all states will receive the same level of additional assistance for covering new eligible. (New eligibles are non-elderly non pregnant individuals below 133% of FPL who were not previously eligible for a full or

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		Innovation	benchmark benefit package, or who were eligible for such a package through a capped waiver but were not enrolled as of the date of enactment.) FMAP would be increased in 2014 by 27.3% for an expansion state 37.3% for a non-expansion state. In 2019, all states would receive 32.3 % increase. FMAP could not exceed 95% in any year. Additional assistance would be available to "high need states," which are defined as states the 1. have total Medicaid enrollment that is below the national average for Medicaid enrollment as a percent of state population as of the date of enactment; and 2, had seasonally adjusted unemployment rates of 12% or higher for August 2009. These states would receive full federal funding to newly eligibles for

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			the 5 year period of 2014 – 2018.
60 day rule on overpayments			Would extend from 60 days to one year for federal repayment of identified overpayments. In any case due to fraud, where the state is unable to recover because the amount has not been finally determined through the judicial process or the final judgment is under appeal, the state must repay the federal share within 30 days after the final judgment is made.
Preventive Services		Requires coverage of preventive services recommended with a grade of A or B by the Task Force for Clinical Preventive Services or vaccines recommended by the Director of CDC and appropriate for individuals entitle to Medicaid. Payment is at regular FMAP. Prohibits cost sharing for preventive services.	A state that opts to provide Medicaid coverage for all recommended preventive services and immunizations and removes cost-sharing for these services would receive a one percentage point increase in the federal share of its FMAP for those services.

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Maternity and adult quality measures		The Secretary must establish maternity care quality measures for use by State programs under Medicaid and CHIP and must collect data from managed care entities and providers. The Secretary must also establish adult care quality measures and develop a standardized reporting format.	The Secretary would create procedures to identify health care quality measurements for Medicaid-eligible adults similar to the procedures already underway for children. The Secretary would also establish procedures for and provide grants to states to collect and voluntarily report health care quality data for Medicaid-eligible adults. Also, the Secretary in consultation with states, would be required to identify specific preventable health care acquired conditions and would prohibit payments for services related to such conditions.
Changes to Medicaid best price for pharmacy	Yes, Secretary must develop a system to verify calculation of best price. Secretary must also develop regulations with standards and procedures for the calculation of best price, and conduct audit and spot check of prices. Department	Sets the Federal upper reimbursement limit at no less than 130% of Average manufacture prices	The federal upper limit would be changed to no less than 175% of the weighted average (determined on the basis of utilization) of the most recently reported monthly average manufactured price.

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	must establish an internet web site where prices are posted.		
Prescription drug rebates		Increases minimum rebate percentage for single-source drugs to 22.1 percent after December 31, 2009. Extends Medicaid prescription drug rebates to Medicaid managed care organizations. The manufacturers must make the rebate payments to the state Medicaid agencies rather than to the Medicaid Managed Care Organizations.	Would apply to managed care organizations. Drugs purchased through the 340(b) program would not be subject to rebates. The rebate amounts would be increased with the minimum rebate percentage for single source and innovator multiple source drugs going from 15.1% to 23.1% and from 11% to 13% for generic drugs. The federal upper limit would be changed to no less than 175% of the weighted average of the most recently reported monthly average manufacturer price.
DSH		Report to recommend what to do with DSH given the impact of health reform.Secretary of HHS must reduce the Medicaid DSH payments to states by $10 billion ($1.5 billion in Fy 2017; $2.5 billion in FY2008, and $6 billion in FY2019) using a method that	Reduced by 50% once the number of uninsured individuals in the state is reduced by 50%. Thereafter the state's DSH allotment would be reduced using a calculation based on further reduction in the rate of uninsured. A state's DSH allotment would not decrease by

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		includes the uninsurance rate in each state and the amount of uncompensated care provided by hospitals.	more than 65% of the allotment in 2012. Any portion of the state's DSH allotment that is currently being used to expand eligibility through a section 1115 waiver is exempt from the reductions.
Medicaid Rates		Medicaid rates are tied to Medicare Part B rates for primary care services: 80% Medicare in 2010 90% Medicare 2011 100% Medicare 2012 and beyond; This applies to both fee for service and managed care. Physicians will receive 100% of Medicare rates for primary care services and other primary care practitioners will receive the Medicare rate for their services (usually 85 % of the physician rate). The required increase in Medicaid payments are	

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		financed with 100% FMAP (90% beginning in 2015) up to 100% of Medicare. Requires the state to submit a plan amendment each year specifying the payment rates for services and additional data to assist the Secretary in evaluating the States compliance with the requirements including data on managed care organizations. Effective 2011. States must also report annually to CMS administrator information on the determination of rates including final rates; the methodologies and the justification for the rates and an explanation of the process used by the state to allow providers, beneficiaries and their representatives and other concerned parties a reasonable	

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		opportunity to review and comment.	
Medical Home		States may apply to the Secretary for a medical home pilot project. The Secretary shall conduct an evaluation of the pilot program.	Creates a new Medicaid state plan option under which Medicaid beneficiaries with chronic conditions could designate a medical home. Medicaid enrollees with at least one serious and persistent mental health condition qualify to receive services under this option.
Translation Services		Extends 75% matching rate for translation services from children to "other individuals" for whom English is not the primary language.	
Healthy Lifestyles			States could design a proposal and apply for funds to provide incentives to Medicaid enrollees who improve their health status and complete scientifically based healthy lifestyle programs.
Graduate Medical Education		Codifies that GME is an allowable cost under Medicaid. Establishes requirements for	

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		the payment of GME.	
Puerto Rico & Territories		Increases, but does not remove, the cap on Federal spending in the Territory Medicaid programs Residents of Micronesia not excluded from Medicaid by PRWORA.	FY2011 all territories FMAP rate would be increased from 50% to 55% and all spending caps would be increased by 30%.
Podiatrists		Includes podiatrists as a physician under Medicaid	
Managed Care provider tax		Extends the delay in managed care provider tax elimination to October 1, 2010.	
Optometrists		Requires Medicaid coverage of professional services of optometrists.	
Qualified Individuals		Extended for 2 years	
Dual eligibles			The bill would clarify the Medicaid demonstration authority for coordinating care for dual eligibles is as long as five years.
Cost Sharing for Certain Dual Eligibles			Medicare Part-D cost sharing for individuals receiving Medicaid HCBS under section 1915, 1932

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			or 1115 waivers would be equalized with cost-sharing for institutionalized individuals, effective January 2011.
Federal Coordinated Health Care Office			Would establish a new office in CMS, the Federal Coordinated Health Care Office for Dual Eligible Beneficiaries. The office would be tasked with improving programmatic and regulatory coordination between Medicare and Medicaid, improving access to services, and increasing dual eligible enrollee satisfaction.
Study on Coverage of Dual Eligibles			Would require HHS Secretary to monitor drug coverage and access of Part D beneficiaries in Medicare and Medicaid.
Community Living Assistance Services & Support (CLASS)	CLASS Act National voluntary insurance fund to cover long term care supports – Similar to Medicare trust fund, voluntary, but must opt out.	The Secretary will establish this national voluntary LTC insurance program. CLASS would provide individuals with support to live in the community. Funded by wage-based premiums.	

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Community First Choice Option			Establishes the Community First Choice Option, which would create a state plan option under section 1915 of the Social Security Act to provide community based attendant supports and services to individuals with disabilities who are Medicaid eligible and who require an institutional level of care. States choosing the Community First Choice Option would be eligible for increased FMAP of 6% for reimbursable expenses in the program. The option would sunset after five years.
Spousal Impoverishment			Would require states to extend nursing-home spousal impoverishment rules to individuals on home and community-based waivers. This requirement would sunset after 5 years.
Nursing Home Diversion			Offers FMAP increase to states that make structural reforms to Medicaid that promote HCBS

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			services over institutional care. Funding provided for 5 years, beginning in 2011.
Medicaid Improvement Fund			Rescinds $700 million available from 2014 – 2018 for "Medicaid Improvement" – including contractor oversight and demonstration project evaluation
INSURANCE EXCHANGE or GATEWAY			
Grants for connector/ exchange	yes		States would receive "start-up" money; exchanges expected to become self-sustaining.
Connector fee	Yes, surcharge of no more than 3% to shift money from low actuarial plans to high actuarial plans		
Certifies or Recertifies health plans	yes		
Provides consumers with information on the cost of premiums, and the availability of in and out of network providers	yes	Yes, the Commissioner is required to make this information available.	States must create a website that contains cost/quality information. Must also develop "rating system" to categorize plans by cost/quality.
Provides data on the use of preventative services in plans	yes		

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State Eligibility in Gateway	States may: Establish a gateway - Adopt the insurance reform provisions. -Agree to make employers who are state or local governments subject to sections 162 and 164. Request the Secretary operate a Gateway. -Adopt the insurance reform provisions. -Agree to make employers who are State or local governments subject to sections 162 and 164. States may elect not to take the actions described in I or II.	State Medicaid programs must accept Medicaid eligibility determinations done through the gateway. Medicaid programs can enter into an agreement to perform eligibility for premium assistance in the gateway. Under Medicaid, states must cover any newborn child born in the U.S. who is not otherwise covered. This initial Medicaid eligibility is up to 60 days while a determination is completed to enroll the newborn in appropriate insurance.	
Access to coverage: Exchange eligible individual		All individuals unless enrolled in another QHBP or other acceptable coverage	Initially limited to individuals and small employers, phasing in larger employers
Staggered participation of plans in exchange		Y1 – individuals/smallest employers Y2 – Above, plus small employers Y3 – Above, plus commission approved large employers .	Yes; in 2015 States must begin to accept businesses with up to 100 employees; beginning in 2017 States may allow businesses with more than 100 employees into the exchange

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Options for states to operate exchange		State or States may apply to Commission to operate exchange if approved by Commission per specified requirements.	States expected to establish and operate the exchanges; option to create "regional exchanges" across state lines.
Coordination of enrollment between Medicaid and Exchanges	Gateways must implement policies and procedures to identify individuals who lack qualifying coverage and assist them in enrolling in Medicare/Medicaid/CHIP or other Federal programs		Secretary of HHS required to issue guidance on best-practices to coordinate enrollment of venerable populations in CHIP. Allows a single form to apply for Medicaid, CHIP, or tax subsidies in the Gateways. Medicaid/CHIP/Gateways operate secure data systems to determine eligibility via the single form, and/or data exchange. Exchanges can enter into a contract with the State Medicaid agency to determine eligibility for the tax credits.
Individuals eligible for CHIP may elect to enroll in CHIP or in a qualified health plan	yes	CHIP individuals must enroll in a qualified health plan.	States must maintain their current eligibility levels through 2019, but could expand eligibility at any point before

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			then. Other aspects of CHIP remain the same, including the use of income disregards, benefit packages and cost-sharing. Beginning in 2014, the CHIP matching rate would increase by 23% points, up to a 100% maximum.
Gateway must consult with Medicaid offices in carrying out activities	yes		
Navigators	Grants to States to establish gateways and entitle navigators to assist in eligibility- duties: public education activities, distribute information, assist with enrollment, provide cultural and linguistic information		
Level of benefits	There will be three levels of benefits provided: A Tier – plans that cover no less than 76% of total costs B Tier – Tier A plans plus 8% C Tier – Tier A plans plus 17%	Four levels of benefits will be available basic, enhanced, premium, and premium plus. Premium plus is an optional level.	Four levels of benefits will be available bronze, silver, gold and platinum. A separate young invincible policy would be available for

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			those 25 years or younger. This plan would be a catastrophic only policy in which the catastrophic coverage level would be set at the HSA current law limit, but prevention benefits would be exempt from the deductible.
Affordability Credits/ Individual Tax Credits		Credit for premiums and cost sharing paid to QHBP by Commission State Medicaid Agency, if deemed capable, makes determination with respect to eligibility for credits. Commission pays Medicaid costs associated with determination. Y1 and Y2 credits may only go to basic plan Y3 for enhanced or premium plans below 400% FPL and not Medicaid eligible; Does not include employers	Refundable tax credit for individuals and families who purchase insurance through the exchange up to 300% of poverty. A cost sharing subsidy would be designed to buy out any difference in cost sharing between the insurance purchased and certain actuarial values based on income.

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		where employers offer employee coverage if the coverage and employer contribution meet requirements.	
Employer Credits	Small business will receive a credit if they offer health insurance. The credit shall be: ▪ $1,000 for each employee with individual coverage ▪ $2,000 for each employee with family coverage ▪ Up to $400 for each 10% of insurance expenses paid by the employer abut 60%	Provide small employers with fewer than 25 employees and average wages of less than $40,000 with a health coverage tax credit. The full credit of 50% of premium costs paid by employers is available to employers with 10 or fewer employees and average annual wages of $20,000 or less. The credit phases-out as firm size and average wage increases.	Provide small employers with fewer than 25 employees and average wages of less than $40,000 with a health coverage tax credit. The full credit of 50% of premium costs paid by employers is available to employers with 10 or fewer employees and average annual wages of $20,000 or less (Indexed to the Consumer Price Index beginning in 2014). The credit phases-out as firm size and average wage increases.
Treatment of State Mandated benefits		Benefits required if state enters into an agreement to reimburse Commission for additional costs	National plans operating in a State can opt-out of State mandated benefits in order to establish a uniform benefits package nationwide.
FQHCs	Additional funding; FQHCS will also be allowed to provide services in additional settings.		Insurers participating in the state exchanges would be required to provide payment for services

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	They will no longer have to operate in medically underserved locations. They will be allowed to operate in another FQHCs catchment area. FQHCs who fail "material" conditions will have a year to correct with out losing any funding. The legislation also requires HHS to redefine how medically underserved locations are determined.		furnished to enrollees of the insurer by any electing federally-qualified health center at levels no less than such center would receive under Section 1902(bb) of the Social Security Act for such services. Establishes a prospective payment system (PPS) for FQHCs under Medicare; extends the PPS to all insurers participating in the exchange.
Changes for Retirees	a temporary reinsurance program for employers who provide health insurance between the ages of 55-64 in states which are not participating in the Gateway	Allows a temporary reinsurance program for retirees 55 -65.	
Enrollment	HHS required to develop interoperable and secure standards to facilitate enrollment into HHS programs within 180 days.		
Medicare Advantage Plans		States with waiver programs to integrate Medicare and Medicaid benefits as of 2004	Rebases the calculation of MA benchmarks to the plan bids.

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		are extended through 2015.	
Health Care Quality	Development of quality measures, programs and reporting	Development of quality measures.	HHS directed to develop Medicaid quality measures.
Fraud, Waste and Abuse	Within HHS, a Dept of Health Care Fraud	There will be a Special Inspector General for the Health Insurance Exchange. If the Secretary determines there are certain risks related to certain providers the Secretary can apply enhanced screening and oversight and an enrollment moratorium against those types of providers. If the Secretary determines that previous affiliation of a provider poses an undue risk of fraud or abuse the Secretary may apply enhanced safeguards to reduce such a risk. Authorizes Medicaid to establish non-payment policies for health-care acquired conditions. Conduct evaluations and	Requires States to establish provider screening programs; provides FMAP reduction penalty for States that do not establish an acceptable program. Creates integrated database of claims and encounter data from Medicaid and Medicare as well as quality of care, certifications, reported abuse, and other integrity measures for the Federal government to use to identify fraud, waste and abuse. Extends Medicare Recovery Audit Contractors to Medicaid by the end of 2010.

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		submit an annual report to the Secretary. Places new requirements on providers and suppliers to establish compliance plans to combat waste and abuse. In terms of overpayments due to fraud, it gives an extra year for states to recover or attempt to recover the overpayment. Additionally, it allows for the adjustment in the federal payment to be made within 1 year in the case of overpayments due to fraud, whether or not the recovery was made.	
Health Care Acquired Conditions		Medicaid non-payment for certain health care acquired conditions. Also for CHIP.	Effective 7/1/11 would prohibit payments to states for Medicaid services related to health care acquired conditions.
Bundled payment demonstration			Would establish a bundled payment demonstration project under Medicaid in up to eight states. Up to 5 states could create a

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			global capitated, bundled payment system for a large safety-net Hospital system to evaluate changes in health care spending and outcomes.
Psychiatric Care Demonstration			Appropriates $75 million for demonstration project(s) in up to eight states to expand the number of emergency inpatient psychiatric care beds. States could receive federal Medicaid matching payments to demonstrate that covering patients in these hospitals will improve timely access to emergency psychiatric care, reduce the burden on overcrowded emergency rooms, and improve the efficiency and cost-effectiveness of inpatient psychiatric care.
Increasing Health Care Competition (Public Plan/CO-Op options)	States must include a public health insurance plan through state-operated gateway (exchange).	Provides for a public health insurance option through the Health Insurance Exchange. This option must comply with the requirements applicable to the other Exchange	Provides funding for the Consumer Operated and Oriented Plan program to foster the creation of nonprofit, member run health insurance companies that serve individuals

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		participating health benefit plans.	in one or more states. CO-Ops would compete in the reformed non-group and small group insurance market.