NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE

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Side-by-Side Comparison of House and Senate Healthcare Reform Proposals

On November 7, 2009, the U.S. House of Representatives passed the Affordable Health Care for America Act (HR 3962). On November 21, the Senate's proposal for healthcare reform, the Patient Protection and Affordable Care Act, was introduced on the Senate floor in the nature of a substitute amendment to a House-passed bill: HR 3590. This action signifies the initiation of Senate floor debate of healthcare reform. The following chart provides a side-by-side comparison of the major market reform, mental health and addiction provisions of the proposals being considered in Congress.

	House Bill: Affordable Health Care for America Act (HR 3962)	**Senate Bill: The Patient Protection and Affordable Care Act (HR 3590)**
INSURANCE MARKET REFORMS		
High Risk Pool	Sec. 101: Beginning Jan, 1, 2010, creates a temporary insurance program for those who have been uninsured for at least 6 months or due to pre-existing conditions. Funding capped at $5M – program will exist until funding runs out or when the Health Insurance Exchange is functional.	Sec. 1101: Enacts a temporary insurance program for those who have been uninsured for at least 6 months and has a pre-existing condition. Funding capped at $5M – program will terminate when the American Health Benefit Exchanges are operational in 2014.
Pre-Existing Conditions	Sec. 106: Pre-existing condition exclusions entirely prohibited beginning in 2013. Prior to that date, shortens the time that plans can look back for a pre-existing condition from 6 months to 30 days and shortens time plans may exclude coverage of certain benefits generally from 12 months to 3 months (Begins Jan 1, 2010). Also, See 'High Risk Pool.'	Sec. 2704: No group or individual plan may discriminate against pre-existing conditions or against those that have been sick in the past.

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Coverage of Young Adults	Sec. 105: Young adults covered through parents' health insurance through age 26. (Begins Jan 1, 2010)	Sec. 2714: Young adults permitted to remain on their parents' health insurance until age 26 (Begins 6 months after enactment). Sec. 2004: Allows all young adults below age 25 who were formerly in foster care to be eligible for Medicaid and all its benefits, including EPSDT.
Lifetime and Annual Limits	Sec. 109: Prohibits use of lifetime limits. (Begins Jan 1, 2010)	Sec. 2711: Prohibits all plans from establishing lifetime or unreasonable annual limits on benefits (Begins 6 months after enactment).
Mental Health & Addiction Parity	Sec. 214: Applies 2008 Wellstone-Domenici MH/SA parity law to the individual and small group market	Sec. 1311(j) and 1562(c)(4): Applies mental health and substance abuse parity to all insurance plans
Public Health Insurance Option	Sec. 321: Requires the creation of a public health insurance option as a plan choice within the Exchange. It participates on a level playing field and must abide by all rules that apply to private plans. (Begins in 2013) Sec. 323: Secretary of HHS negotiates payments for providers, items and services (inc. prescription drugs).	Sec. 1322: Allows for the creation of non-profit, member-run co-operative health insurance programs. Sec. 1323: Requires the creation of a public health insurance option (called a "community health insurance option"), but allows states to pass a law to opt out of participating. Sec. 1324: Requires co-ops and the public option to abide by all federal and state laws that apply to private insurers.
Individual Responsibility	Sec. 401: Requires that either an individual has insurance or pays a 2.5% tax; based on modified adjusted gross income. (Amount of tax defined in Sec. 501) Sec. 501: Allows for hardship exemption.	Sec. 1501(5000A): Requires individuals to maintain minimum essential coverage beginning in 2014 or pay a penalty of $95 in 2014, $350 in 2015, $750 in 2016 and indexed thereafter. Penalties are reduced by half for those under age 18. Exemptions will be made for those who can't afford coverage, those under 100% of poverty, Indian tribes, and those who were uninsured for less than 3 months in a year.

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Employer Responsibility	Sec. 411: Beginning in 2014, if an employee chooses an insurance plan offered through the Exchange rather than a plan offered by the employer, the employer must make a contribution to the Exchange. Sec. 512: For employers who don't offer coverage, establishes a payroll tax of 8% of the wages of its employees. Small employers with annual payroll of $500,000 are exempt. Payroll tax phases in for small employers with annual payroll from $500,000-$750,000.	Sec. 1513: Requires employers with more than 50 full time employees who do not offer coverage and who have one or more employees receiving premium assistance to make a payment of $750 per employee. For employers with 50 or more FTEs who offer insurance but have at least one employee receiving premium assistance, the employer must pay the lesser of $3,000 for each employee receiving assistance or $750 for all full time employees.
Revenue	Sec. 551: Establishes a 5.4% tax on modified adjusted gross income in excess of $1M for joint tax returns ($500,000 for other tax returns). Sec. 552: 2.5% excise tax on medical devices sold for use in the U.S.	Sec. 9001: Levies an excise tax of 40% on insurance companies and plan administrators for any health coverage plan that is above the threshold of $8,500 for single coverage and $23,000 for family coverage. The tax would apply to the amount of the premium in excess of the threshold. Other revenue provisions include an annual flat fee on the health insurance, pharmaceu-tical & medical device sectors.
Community Living Assistance Services and Supports (CLASS Program)	Sec. 2581: Establishes a new, voluntary, public long-term care insurance program for the purchase of community living assistance services and supports by individuals with functional limitations. Provides cash benefit that is not less than an avg. of $50/day.	Sec. 8002: Establishes a new, voluntary, public long-term care insurance program for the purchase of community living assistance services and supports by individuals with functional limitations. Provides cash benefit that is not less than an avg. of $50/day.
Community-Based Collaborative Care Networks	Sec. 2534: Establishes a new program to support community-based collaborative care networks – a consortium of health care providers offering coordinated & integrated health services for low-income populations or medically-underserved communities.	[None.]

HEALTH INSURANCE EXCHANGES		
	HR 3962 (House bill)	HR 3590 (Senate bill)
Individual/Small Group Market for Health Insurance Plans (Exchanges)	Sec. 301: Establishes the Health Insurance Exchange which facilitates the offering of health insurance choices, including a public plan option. (See Public Health Insurance Option)	Sec. 1311: Requires the Secretary of HHS to award grants (available until 2015) to States to establish American Health Benefit Exchanges by 2014. Sec. 1321: Requires the Secretary to set standards for the Exchanges, qualified health plans, reinsurance, and risk adjustment. If the Secretary determines before 2013 that a State won't have an operational Exchange by 2014, the Secretary is authorized to operate an Exchange in that State.
Eligibility for Participation in the Exchange	Sec. 302: Beginning in Year 1 (defined in Sec. 100 (c) as 2013), individuals without insurance and small employers with 25 or fewer employees are allowed to participate in the Exchange. In 2014, employers with 50 or fewer employees can participate and in 2015, employers with 100 and fewer employees may participate with the ultimate goal of eventually allowing all employers to participate. **Medicaid-eligible individuals will be enrolled in Medicaid, not the Exchange.	Sec. 1312: Allows any individual who is lawfully residing within a State and who isn't incarcerated and small employers to participate in a State's Exchange. Beginning in 2017, large employers may participate as well.
Outreach & Enrollment Efforts	Sec. 305: Requires the Health Choices Commissioner (who oversees the Exchange) to conduct outreach and enrollment activities to ensure timely enrollment, including outreach to individuals with mental illness or cognitive impairments.	Sec. 2201: Allows individuals to apply for and enroll in Medicaid, CHIP, or the exchange through a state-run website.
Essential Benefits Package (For Plans in the Exchanges)	Sec. 222: Defines the services that must be offered by all plans within the Exchange. Includes rehabilitative and habilitative	Sec. 1302: Defines the services that must be offered by all plans within the Exchange. Includes rehabilitative and habilitative

Essential Benefits Package (cont.)	services; mental health and substance use disorder services, including behavioral health treatments. Requires that the Secretary of HHS consider adding domestic violence counseling to behavioral health or primary care visits.	services; mental health and substance use disorder services, including behavioral health treatments. Sec. 1311: Allows states to require benefits in addition to the essential health benefits.
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Cost-Sharing in the Exchange	Sec. 222: Annual cost-sharing cannot exceed $5,000 for an individual and $10,000 for a family. These limits include the cost of premiums.	Sec. 1302: Annual cost-sharing cannot exceed $5,000 for an individual and $10,000 for a family. These limits do not include the cost of premiums. Prohibits deductibles greater than $2,000 for individuals and $4000 for families enrolled in employer-sponsored plans.
Benefit Package Levels	Sec. 303: Plans must offer at least one basic plan in each service area they operate and have a choice to offer one enhanced and one premium plan. Differences between the three plan types are the levels of cost-sharing required, not the benefits covered. Variation in cost-sharing between plans cannot exceed 10%. Also creates a 4th plan tier: "premium-plus": plans may offer non-covered benefits at an additional cost to the consumer. States may apply state benefit mandates to all Exchange participating plans.	Sec. 1302: Differences between the types of plans are the levels of cost sharing required: Bronze (plan must pay for 60% of costs), Silver (70%), Gold (80%), and Platinum (90). In addition, a catastrophic plan may be offered to individuals under age 30 or individuals exempted from the mandate because of a hardship waiver. The catastrophic plan must cover essential health benefits and at least 3 primary care visits but may require higher cost sharing.
State Flexibility	Sec. 308: Permits states to offer their own Exchange or join with a group of states to create their own exchange.	Sec. 1332: Beginning in 2017, gives States the right to apply for a waiver for up to 5 years of requirements relating to the Exchanges, qualified health plans, and cost-sharing requirements. States must show that waivers will provide coverage that is at least as comprehensive and affordable to at least a comparable number of residents as the Exchange

State Flexibility (cont.)		would provide and must also show that the waiver would not increase the Federal deficit. Sec. 1332: By July 1, 2013, requires the Secretary to issue regulations for interstate health care choice compacts (which can begin in 2016). Under these compacts, qualified health plans can be offered in all participating States but insurers would still be subject to each State's consumer protection and other laws.
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Affordability Credits for Exchange-Participating Plans	Sec. 341: Creates affordability credits for people with incomes up to 400% of poverty. For 2013-2014, credits can only be used to purchase the Basic plan, after which they can be used to purchase other plans. Sec. 343: At 133% of poverty, credits will cover premium costs that exceed 1.5% of the individual's or family's income. Premium credits are calculated on a sliding scale, phasing out at 400% of poverty, where they cover costs exceeding 12% of the individual's or family's income. Caps on out-of-pocket payments for those receiving credits range from $500 for an individual and $1000 for a family at the lowest income tier to $5000 for an individual and $10,000 for a family at highest income tier.	Sec. 1401(36B): Creates premium assistance credits for people with incomes up to 400% of poverty. For individuals or families at 100% of poverty, the credits cover premium costs that exceed 2% of income. Premium assistance credits are calculated on a sliding scale, phasing out at 400% of poverty, where they cover premium costs that exceed 9.8% of the individual's or family's income. Sec. 1402: The standard cap on out-of-pocket payments is $5,950 for individuals and $11,900 for families. For those receiving credits, the caps on out-of-pocket spending are reduced to one third of the standard level for those between 100-200% of poverty, one half of the standard level for those between 200-300% of poverty, and two thirds of the standard level for those between 300-400% of poverty.
MEDICAID/CHIP		
Medicaid Expansion	Sec. 1701: Requires states to cover children, parents, individuals with	Sec. 2001: Requires states to cover all non-elderly, non-pregnant

Medicaid Expansion (cont.)	disabilities, and non-disabled childless adults under age 65 who are not eligible for Medicare and who have incomes at or below 150% of FPL. For individuals that fall into these categories and with incomes between the levels in effect in the state as of June 16, 2009 and 150% of FPL, the federal gov't would pay 100% of the costs of Medicaid coverage in 2013 and 2014 and 91% in 2015 and beyond. Sec. 1703: Prohibits states from adopting eligibility standards, methodologies, or procedures in their Medicaid programs that are more restrictive than those in effect as of June 16, 2009.	individuals who are not entitled to Medicare up to 133% of poverty beginning in 2014. From 2014 to 2016, the federal government will pay 100% of the cost of covering newly eligible individuals. From 2017 to 2019, federal support is phased down, and from 2019 onward, states will receive an FMAP increase of 32.3 percentage points for covering these individuals. States must maintain the same income eligibility levels through 2013, but may be exempt if they are experiencing a budget deficit. For children, states must maintain current eligibility levels through Sept. 2019.
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CHIP	Sec. 1703: Prohibits states from adopting eligibility standards, methodologies, or procedures in their CHIP programs that are more restrictive than those in effect as of June 16, 2009. This maintenance of eligibility ends upon expiration of the CHIP program on Dec. 31, 2013.	Sec. 2101: Requires states to maintain current eligibility levels for CHIP through Sept. 2019. From 2014 to 2019, states will receive a 23 percentage point increase in the CHIP match rate. There is no provision to reauthorize CHIP after 2019.
Medicaid Medical Home Pilot	Sec. 1722: Establishes a 5-year pilot program to test the medical home concept with Medicaid beneficiaries. Specifically names the inclusion of medically fragile children and high-risk pregnant women. The federal government would match the costs of community care workers at 90% for the first 2 years and 75% for the next 3 years. The total funding provided for this project is $1.235B.	Sec. 2703: Provides states the option of enrolling Medicaid beneficiaries with chronic conditions, including serious and persistent mental illness, into a health home. Grants of up to $25 million are provided for planning and implementing the pilot projects.
Therapeutic Foster Care	Sec. 1727: Clarifies that federal Medicaid law does not prohibit State Medicaid programs from covering TFC for children in out-of-home placements.	[None.]

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Suspension of Medicaid Eligibility for Justice-Involved Youth	Sec. 1729: Requires States to suspend, not terminate, eligibility for beneficiaries under age 19 who are incarcerated in a public institution during period of incarceration.	[None.]
Medicaid Accountable Care Organization Pilot Program	Sec. 1730A: Allows State Medicaid programs to pilot one or more of the models used in the Medicare Accountable Care Organization Pilot Program established in HR. 3962. Admin costs would be matched at 90% in the first 2 years and 75% in the last 5 years.	Sec. 2706: Establishes a demonstration project that allows qualified pediatric providers to be recognized and receive payments as ACOs under Medicaid. ACOs that meet quality standards and provide services at a lower cost can share in the savings that result.
Extension of Medicaid FMAP Increase	Sec. 1749: Extends the Medicaid FMAP increase originally authorized in the American Recovery & Reinvestment Act through June 2011.	[None.]
Medicaid Emergency Psychiatric Demonstration Project	Sec. 1787: Requires HHS to establish a 3-year Medicaid demonstration project to reimburse certain institutions for mental disease for services provided to Medicaid beneficiaries between the ages of 21 and 65 who are in need of medical assistance to stabilize an emergency psychiatric condition. Provides $75 million for the demonstration project.	Sec. 2707: Requires HHS to establish a 3-year Medicaid demonstration project to reimburse certain institutions for mental disease for services provided to Medicaid beneficiaries between the ages of 21 and 65 who are in need of medical assistance to stabilize an emergency psychiatric condition. Provides $75 million for the demonstration project.
Community Services	[None.]	Sec. 2401. Establishes an optional Medicaid benefit through which states could offer community-based attendant services and supports to Medicaid beneficiaries who would otherwise require the level of care offered in a hospital, nursing facility, or intermediate care facility for the mentally retarded. Sec. 2402: Removes barriers to providing HCBS by giving states the option to provide more types of

Community Services (cont.)		HCBS through a state plan amendment to individuals with higher levels of need, rather than through a waiver, and to extend full Medicaid benefits to individuals receiving HCBS under a state plan amendment.
MEDICARE		
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Medicare Part D	Sec. 1181: Eliminates the Part D coverage gap – or donut hole – beginning with a $500 reduction in 2010 and completing phase out by 2019. Sec. 1182: Provides discounts of 50% to brand-name drugs offered in the donut hole (Beginning in 2010). Sec. 1185: Prevents Part D plans from making any formulary changes that reduce coverage (inc. increased cost-sharing) in any way once the plan marketing period begins. Sec. 1202: Eliminates cost-sharing for ppl receiving care under a HCBS waiver who would otherwise require institutional care.	Sec. 3301: Requires drug manufacturers to provide a 50% discount to Part D beneficiaries for brand-name drugs and biologics purchased in the donut hole beginning July 1, 2010. Sec. 3305: Requires HHS to transmit formulary and coverage information to LIS beneficiaries who have been automatically reassigned to new Part D plans. Sec. 3307: Codifies the current six classes of clinical concern. Sec. 3309: Eliminates cost sharing for beneficiaries receiving care under a HCBS program who would otherwise require institutional care.
Specialized Medicare Advantage Plans for Special Needs Individuals	Sec. 1177: Extends the Special Needs Plan (SNP) program through 2012, and extends certain fully integrated dual eligible SNPs through 2015. Also extends the moratorium on service area expansion for dual eligible SNPs that do not meet certain requirements until 2012. Sec. 1178: Extends SNPs that serve residents in continuing care retirement communities through 2012.	Sec. 3205: Extends the Special Needs Plan (SNP) program through 2013 and requires SNPs to be approved by the National Committee for Quality Assurance. Allows HHS to apply a frailty payment adjustment to fully-integrated, dual-eligible SNPs that enroll frail populations. Requires HHS to transition beneficiaries enrolled in SNPs that do not meet statutory target definitions. Requires dual-eligible SNPs to contract with state Medicaid programs beginning

Medicare Advantage Special Needs Plans (cont.)		in 2013. Requires an evaluation of Medicare Advantage risk adjustment for chronically ill populations.
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Medicare Accountable Care Organizations	Sec. 1301: Creates a $20M pilot program that supports an alternative payment model within fee-for-service Medicare to reward physician-led organizations that take responsibility for the costs and quality of care received by their patients over time. ACOs can include groups of physicians organized around a common delivery system, an independent practice association, a group practice, or other practice organizations. Nothing in this provision prohibits the inclusion of other provider types or health organizations. ACOs that achieve quality and cost benchmarks are rewarded with a share of programmatic savings. (Begins Jan. 1, 2012)	Sec. 3022: Allows ACOs that meet quality of care targets and reduce costs to share in a portion of their savings to the Medicare program.
Medicare Medical Home Pilot Program	Sec. 1302: Expands pre-existing Medicare medical home demo and allots approx. $1.8B for the pilot programs.	Sec. 3502: Creates a program to establish and fund the development of community health teams to support the development of medical homes by increasing access to comprehensive, community based, coordinated care.
Medicare Payment for LMFT/LPC Services	Sec. 1308: Adds state-licensed or certified MFTs and LPCs as Medicare providers and pays them at the same rate as social workers.	[None.]
WORKFORCE		
Co-location of Primary and Specialty Care in	[None.]	Sec. 5604: Authorizes $50 million in grants for coordinated and integrated services through the co-location of

Community-Based Mental Health Settings		primary and specialty care in community-based mental and behavioral health settings.
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National Health Service Corps	Sec. 2201: Increases loan repayment benefits for each Corps member to a max of $50,000/year. Allows fulfillment of Corps service obligation through part-time service and clinical teaching (for up to 20% of the period of obligated service). Sec. 2202: Authorizes an add'l $1.8B between FY2011-FY2015) to the NHSC.	Sec. 5208: Provides specific funding amounts for the National Health Service Corps, increasing funding from $320,461,632 in 2010 to $1,154,510,336 in 2016, and adjusted each year thereafter "by the product of ''(A) one plus the average percentage increase in the costs of health professions education during the prior fiscal year; and (B) one plus the average percentage change in the number of individuals residing in health professions shortage areas designated under section 333 during the prior fiscal year, relative to the number of individuals residing in such areas during the previous fiscal year.''
Training for Behavioral Health Professionals	Sec. 2522: Establishes a new training program for mental and behavioral health professionals (including those specializing in substance abuse counseling and addiction medicine) to promote interdisciplinary training and coordination of the delivery of health care. Authorizes $60M for each of FY2011-FY2015 to carry out the program. Requires that no less than 15% of funds to be used for training programs in psychology.	Sec. 5306: Awards grants to schools for the development, expansion, or enhancement of training programs in social work, graduate psychology, professional training in child and adolescent mental health, and pre-service or in-service training to paraprofessionals in child and adolescent mental health.
Training Activities Related to Autism and Other Developmental Disabilities	Sec. 2527: Establishes a new $17M program to support training activities to address the unmet needs of kids and adults with autism and related DDs.	[None.]
Indian Health – Behavioral Health Training	Sec. 125: Allows the Secretary of HHS to enter into contracts and/or make grants to tribal colleges to	[None.]

Indian Health – Behavioral Health Training (cont.)	establish demonstration programs developing educational curricula for substance abuse counseling. Sec. 126: Improves access to behavioral health services through training and education programs.	
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Indian Health – Behavioral Health Treatment, Prevention, and Education	Secs. 701- 715: Requires that the Secretary of HHS implements various treatment and prevention strategies and pilot programs and authorizes an annual appropriation of such sums as necessary.	[None.]
Loan repayment for pediatric mental health specialists in underserved areas	[None.]	Sec. 5203. Establishes and funds a Pediatric Specialty Loan Repayment Program for individuals employed in health professional shortage area or medically underserved area for at least 2 years, who provide pediatric medical subspecialty, pediatric surgical specialty, or child and adolescent mental and behavioral health care, including SA prevention and treatment services."
Educating Primary Care Providers about Mental Health	[None.]	Sec. 5405: Establishes a Primary Care Extension Program to educate primary care providers about preventive medicine, chronic disease management, mental and behavioral health services (including substance abuse prevention and treatment services), and evidence-based and evidence-informed therapies and techniques.
MISCELLANEOUS		
340B Program	Sec. 2501: Expands the 340 Drug Discount Program to other entities, including those that provide community mental health or addictions services.	Sec. 7101: Extension of 340B drug pricing <u>does not</u> include community mental health or addictions centers.

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Federally-Qualified Behavioral Health Centers FQBHCs (cont.)	Sec. 2513: Sets forth criteria for the certification of FQBHCs and recognizes the role of such centers as safety net providers for individuals with behavioral, mental health, and substance use disorders.	[None.]
Community Transformation Grants	[None.]	Sec. 4201: Authorizes competitive grants to eligible entities for programs that promote individual & community health & prevent the incidence of chronic disease, incl. programs to prevent or reduce the incidence of mental illness.