

**Health Care Reform Proposals: H.R. 3962 and H.R. 3590**  
**“A Comparison”**  
**Jan. 12, 2010**

This document contains a brief comparison of the two health reform proposals, H.R. 3962, the Affordable Health Care for America Act in the House, and H.R. 3590, the Patient Protection and Affordable Care Act in the Senate. The House passed its bill, H.R. 3962, on Nov. 7, 2009 and the Senate passed its version, H.R. 3590, on Dec. 24, 2009. This analysis reflects key issues within the bills that are of importance to ACP and compares them to College policy.

Key Issues	H.R. 3962 (House)	H.R. 3590 (Senate)	ACP Policy
<b>COVERAGE</b>			
<b>Medicaid expanded to cover the poor (133% of FPL)</b>	Yes. Medicaid eligibility is increased to 150% FPL. Some Medicaid-eligible individuals can receive exchange-based coverage during “transition periods.”	Yes. Medicaid eligibility is increased to 133% FPL starting in 2014.	ACP’s own coverage proposal calls for expanding Medicaid to 100% of FPL, but we have since expressed support for expanding Medicaid to 133% of FPL. We have not taken a specific position on expanding Medicaid to 150% of FPL as in H.R. 3962 but such an expansion is generally consistent with ACP’s support for converting Medicaid from a categorical program to one that covers the poor and near-poor.
<b>Sliding scale tax credits</b>	Yes. Premium assistance available for qualified legal resident individuals with incomes between 133-400% FPL. Cost-sharing credits and out-of-pocket limits are also in the bill.	Yes. Premium assistance credits available for qualified legal resident individuals with incomes between 133-400% FPL (in some cases credits will be given to those with incomes between 100-133%). Cost-sharing credits and out-of-pocket limits are also in the bill.	ACP supports premium credits for the purchase of qualified health insurance. The premium credits outlined in the Senate bill seem to be more generous for those with incomes between 300-400%, capping premiums at 2% for those at 100% FPL to 9.8% for those at 400%. The House bill would cap premiums at 3% for incomes at 150% and below to 12% for incomes up to 400% FPL. The premium credits and cost-sharing assistance in the House bill better reflect ACP policy since they are more generous for those with incomes between 100-200% FPL,
<b>People can keep own insurance or buy coverage through an exchange</b>	Yes. Individual market health insurance purchased before 2013 is considered acceptable. After 5 year period beginning 2013, employment-based insurance operating prior to enactment must meet requirements relating to insurance reforms and minimum benefits. Uninsured (or underinsured) individuals and some small businesses permitted to purchase coverage in an insurance exchange.	Yes. Existing plans are grandfathered. Secretary will provide financial assistance to states to establish health insurance exchanges for qualified individuals and small businesses to facilitate purchase of qualified health insurance plans.	ACP supports establishing exchanges to facilitate the purchase of insurance. The House bill would establish a national exchange that would negotiate on behalf of consumers, thus spreading risk evenly and potentially lowering premium costs. To its credit, the Senate bill would require insurers to pool individual market and small group market plans regardless of whether they are purchased in Exchange, which would

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			spread risk. However, since the House would permit the negotiation of insurance contracts, better spread risk, and facilitate consumer purchase of coverage, it is more closely aligned with ACP policy.
<b>Health plans must cover people with pre-existing conditions, guarantee renewability, not vary premiums based on health</b>	Yes. Qualified health plans (QHP) cannot exclude coverage based on pre-existing conditions nor can they rescind coverage. All insurance plans must abide by guaranteed issue and renewal requirements. Premium rates for QHPs can vary only by age (2 to 1), geographic area, family enrollment.	Yes. Guaranteed issue and renewability required. Health insurer offering group or individual plan is prohibited from imposing preexisting conditions exclusion. Premiums in individual and small group market can only be adjusted based on age (3 to 1), tobacco use (1.5 to 1), family composition, and rating area. Large group market plans would have to abide by rating rules if purchased through the Exchange.	Both bills align with ACP's position on insurance reform. ACP prefers the House language since it would initiate reforms in 2013 rather than 2014, as outlined in the Senate bill.
<b>Employers required to fund health insurance coverage</b>	Yes. Employers must either provide coverage to employees or pay a fee to the Health Insurance Exchange Trust Fund based on the amount of average wages paid by employer. Fee is capped at amount equal to 8% of average wage. Businesses with annual payroll of under \$500,000 are exempt from fee. Fee is phased in for applicable businesses.	Somewhat. Large employers whose employees acquire premium credits for the purchase of coverage through the exchange (either because employer fails to offer coverage or offers expensive coverage) will be required to pay a fee to the Secretary. Large employers are those with at least 50 full-time employees. Fine is capped at \$750 per employee per year.	ACP supports an employer mandate to provide coverage for employees once it's made affordable. The House bill has a stronger employer mandate; therefore, it better reflects ACP's position.
<b>Individuals required to have coverage</b>	Yes. Individuals who do not acquire acceptable coverage must pay a fee of 2.5% of taxpayer's modified adjusted gross income for taxable year beyond the filing threshold. Tax is capped at level of national average premium. Exceptions made for nonresident aliens, dependents, religious objectors, etc.	Yes. Beginning in 2014, individuals are required to maintain minimum essential coverage. The penalty for non-compliance is either based on a flat-dollar amount capped at \$750 per year (phased in starting at \$95 in 2014) and up to 2% of income or the cost of national average premium for a qualified bronze level coverage. Penalty will not be imposed on individuals who cannot afford coverage.	ACP supports an individual mandate if coverage is made affordable, a hardship exemption is included, and an employer mandate is established, among other issues to ensure that coverage is affordable.
<b>Plans must provide essential benefits, including preventive services; no cost-sharing for preventive services</b>	Yes. QHP must provide coverage of essential benefits package which includes among other things hospitalization, outpatient/emergency dept. care, physician care, and preventive care including services recommended w/ grade A or B by Task Force on Clinical Preventive Services and vaccines. No cost-sharing for preventive and well-child/baby care.	Yes. Effective upon enactment, group and individual plans must cover evidence-based preventive services with grade A or B from US Preventive Services Task Force as well as immunizations and certain procedures for women that may not have received an A or B from USPSTF but meet	ACP supports establishing a minimum benefit standard for qualified health plans, including coverage of evidence-based primary care services. Both bills would establish a minimum benefit package. The House bill states that at a minimum, preventive services in the essential benefits package must include

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	<p>Cost-sharing on the package is also limited. A Health Benefits Advisory Committee, chaired by the Surgeon General, would be established to recommend essential services. The Secretary would adopt or reject such recommendations.</p>	<p>guidelines established by HRSA. Cost-sharing requirements would not be imposed for these services. Beginning 2014, the Secretary will determine an essential benefits package for qualified health plans (e.g. Exchange-based coverage) to include at a minimum, preventive, wellness, disease management, hospitalization, etc. services.</p>	<p>those rated A or B by the Task Force on Clinical Preventive Services, ensuring that additional services may be provided.</p> <p>The Senate bill would immediately require all plans to cover at a minimum preventive services rated A or B by the USPSTF (among other categories of preventive services such as vaccinations) without cost-sharing. The Senate's essential benefit package, effective in 2014, would include, at a minimum, preventive services.</p> <p>ACP proposes that an expert Commission be established to recommend, among other things, essential evidence-based benefits. The House legislation would establish a Health Benefits Advisory Committee (which would include a practicing physician or other health practitioner among its membership) to determine essential benefit package based on the requirements outlined in the bill as well as certain cost-sharing limits. The Secretary of HHS would approve or reject the Advisory Committee's recommendations. Under the Senate bill, the Secretary would define the essential benefit package based on criteria established in the bill.</p>
<p><b>Offers a public plan to compete on level playing field with private insurers</b></p>	<p>Yes. Beginning in Y1, public plan will be established as an exchange-participating health plan. Premiums would be set at level sufficient to fully fund costs of health benefits provided and admin costs. Public plan will receive \$2 million in start-up funds but will be required to pay back that amount. Federal bail-out is prohibited.</p>	<p>Not applicable. The Senate-passed legislation does not include a public option.</p> <p>The bill would direct the Director of the Office of Personnel Management to contract with health insurers to offer multi-state health plans, requiring that at least 2 plans (including one non-profit plan) operate in each state's Exchange. Contracts will be at least 1 year duration. Administration will be similar to that of the Federal Employees Health Benefits Program (FEHBP) regarding</p>	<p>ACP supports a public plan as long as it competes on a level playing field with private plans in the Exchange, that providers are not required to participate and if reimbursement rates are based on negotiations with providers rather than on Medicare rates.</p> <p>Regarding the multi-state plans established in the Senate bill, the College has recommended that insurance exchanges permit the offering of FEHBP-participating national indemnity plans to eligible individuals providing</p>

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		<p>medical loss ratio, profit margin, premiums, etc. Benefits must be uniform in each state, include bronze, silver, etc. level plans. States can require additional benefits beyond essential benefits package (however, states must assume cost). Premium and cost-sharing credits are available in manner similar to other Exchange plans. The multi-state plans will be offered separate from FEHBP plans.</p>	<p>they receive separate funding and exist in a risk pool apart from the FEHBP program.</p>
<p><b>Physician participation is voluntary—not mandated if you also accept Medicare</b></p>	<p>Yes. Medicare-participating physicians are considered public plan-participating unless they opt-out. Sec. 325 states that the Secretary shall establish conditions of participation for providers under public plan.</p>	<p>Not applicable. The Senate bill does not include a public plan option.</p>	<p>The House bill would make public plan participation voluntary.</p>
<p><b>Secretary shall negotiate rates with providers. Not based on Medicare rates</b></p>	<p>Yes. The Secretary will negotiate rates for physicians and other providers and services (incl. prescription drugs). Negotiated rates cannot be lower than Medicare or higher than average rates of other QHPs. The Secretary is authorized to pay for innovative delivery services such as PCMH and cost-sharing and payment rates may be modified to encourage their use.</p> <p>Sec. 325 establishes payment terms for preferred physicians (those who accept public plan rates) and non-preferred physicians (those who balance bill based on Medicare policy). Negotiated payments will be reduced for non-preferred physicians. Non-preferred physician providers are required to accept negotiated rates as payment in full.</p>	<p>Not applicable. The Senate bill does not include a public plan option.</p>	<p>The House bill would negotiate rates rather than offer Medicare reimbursement rates.</p>
<p><b>DELIVERY AND PAYMENT SYSTEM REFORM</b></p>			
<p><b>Eliminates current Sustainable Growth Rate and accumulated cost</b></p>	<p>Addressed in separate bill, H.R. 3961, the Medicare Physician Payment Reform Act of 2009. The House passed H.R. 3961 on Nov. 19 by a vote of 243 to 183. In December 2009, Congress passed and the President signed into law a temporary measure to keep the 2009 rates in effect until March 1, 2010, thereby preventing a 21% cut that was set to go into effect on January 1.</p>	<p>No. Contains no provision addressing the SGR issue.</p>	<p>ACP strongly supports a separate House bill, H.R. 3961, which was passed by the House of Representatives. It is preferable in that it would:</p> <ul style="list-style-type: none"> <li>-Repeal the SGR.</li> <li>-Eliminate the scheduled 21% fee cut, and all accumulated debt, with a 2010 payment update that is based on the</li> </ul>

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			<p>Medicare economic index (medical inflation index) while a new payment system is being put in place.</p> <p>-Provide an additional growth allowance of per capita GDP plus 2% for primary care and preventive services and per capita GDP plus 1% for all other services. This will yield higher updates than the SGR, which limits spending on all services to only per capita GDP.</p>
<b>Higher updates for primary care (separate and higher spending target for primary care)</b>	Addressed in separate bill, HR3961, which calls for an alternative to current Sustainable Growth Rate (SGR) methodology	No.	Separate House bill, H.R. 3961, is preferable.
<b>Bonus payments for primary care</b>	Yes. 5% for designated services, including office, nursing home, domiciliary, home, and hospital visits by primary care physicians, increased to 10% in health professional shortages areas; permanent beginning in 2011. Primary care physicians defined by specialty (general IM, pediatrics, family medicine, or geriatrics) and at least 50% of their allowed charges to Medicare must consist of the designated primary care services, which is defined very broadly as all evaluation and management services, including those conducted during hospital visits. Nurse-practitioners can also be eligible for the bonus if they meet the same billing threshold and are practicing within the limits of their licenses. The House bonus is funded totally out of new money.	Yes. Primary care physicians receive a 10% bonus for office, nursing facility, domiciliary, and home, services from 2011-2015. The bonus is funded with “new money.” Primary care physicians defined by specialty (general IM, pediatrics, family medicine, or geriatrics) and at least 60% of their allowed charges to Medicare must consist of the designated primary care services. The 60% threshold could exclude a significant number of primary care internists whose billing patterns include a larger proportion of services, such as hospital visits, that are not included as a designated primary care service as defined by the bill. Nurse-practitioners can also be eligible for the bonus if they meet the same billing threshold and are practicing within the limits of their licenses	House provision provides permanent bonus that would include most physicians practicing primary care and make bonus on more services including hospital visits. Senate bonus is larger for the designated primary care services (10% versus 5% in non-HPSAs) but because hospital visits are excluded from the Senate’s bonus, it is not clear if most internists would do better with a 5% bonus that includes hospital and other visits (House) or 10% on a more restricted designation of primary care services. The House bill’s eligibility criteria is preferable because most primary care internists would be able to meet the 50% billing threshold for designated primary care services needed to qualify. The Senate’s criteria—60% of billings for a more restricted designation of primary care services would likely result in a substantial number of general primary care internists being unable to qualify. The College is advocating for Congress to accept the House’s definition of designated primary care services, the 50% qualifying threshold for such services, and the permanent nature of the bonus payments, while increasing the bonus

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<p><b>Patient centered medical home to be tested on a national scale</b></p>	<p>Yes. Creates community-based pilot, and independent practice pilot. The Secretary, after evaluating the pilots, may issue regulations to expand the program if the CMS Chief Actuary determines that spending would not increase by doing so.</p> <p>The provision could be improved through:</p> <ul style="list-style-type: none"> <li>-Modifying the language to include a requirement that the pilots be designed to encourage the participation of physicians in practices with fewer than three full-time equivalent physicians to recognize the extent that small practices provide a significant amount of Medicare services.</li> <li>-Modifying the patient participation requirements under the Independent Practice Pilot to include a broader group of patients. More specifically, to replace the patient eligibility threshold that includes the sickest 50% of patients with the more inclusive threshold of “one or more chronic conditions” or all patients.</li> </ul>	<p>Yes, with reservation. The legislation includes a Center for Medicare and Medicaid Innovation to test new payment and service models to enhance quality and promote savings. Specifically mentions the medical home model ( for high need beneficiaries and to address women’s unique healthcare needs) and the community team medical home model as models that <u>may</u> be considered by the Secretary for testing—the College would prefer that the Center be mandated to test medical home models as in House bill. Allow the Secretary to expand project throughout system and projects are not required to be budget-neutral initially. The legislation, separate from the Center, does specifically call for an “Independence at Home” Medical Home demonstration and a State Medicaid health (medical) home option.</p>	<p>percentage to 10% as in the Senate bill.</p> <p>The House bill specifically includes the establishment of well funded, national medical home pilots. Such pilots are mentioned in the Senate bill as projects that <u>may</u> be chosen to be implemented under the Innovation Center. The specificity in the House bill is preferable, although the College also supports the establishment of a Center of Innovation to test new payment and service models.</p>
<p><b>Establishes Medicare Commission to recommend policies to achieve savings in Medicare with limited legislative review</b></p>	<p>Not in House bill.</p>	<p>ACP supports creation of an independent Medicare Commission but the Senate’s version does not meet key ACP conditions for support. The bill does create a commission to fast-track payment reform recommendations. However, it doesn’t ensure adequate primary care representation on the commission, does not provide Congress with acceptable ability (e.g. majority vote) to avoid implementation of recommendations, and the provision still excludes hospice and hospitals from being affected by savings over the first several years of Board consideration (leaving physicians excessively vulnerable to payment reductions to meet savings goals).</p>	<p>The broad Medicare Commission provision in the Senate bill, while promising in concept, does not meet critical aspects of College policy, as enumerated in the column to the left.</p>

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<p><b>IOM study on Medicare geographic variation in Medicare payments and payment reform with fast-track implementation</b></p>	<p>Yes. The House bill includes a study by the IOM on ways to decrease variations in geographic service growth and spending to promote increased value throughout the healthcare system.</p> <p>The legislation instructs the Secretary to implement proposed Medicare payment policy changes, which are based on IOM findings and recommendations, unless Congress, under a fast-track, limited debate procedure, passes a joint resolution to disapprove the implementation.</p> <p>This provision meets most, but not all (e.g. assurance of adequate primary care representation) aspects of related College policy.</p>	<p>No, but the bill does contain a provision of concern on a related issue. It mandates that Medicare implement a separate payment modifier that would adjust payments based upon the quality of care provided relative to cost. The College believes that it is premature to make such a change in the Medicare fee schedule payment formula based upon a need for a better understanding of the reasons for such variations, and the development of appropriate measures to assess this “value” variable. In addition, there is concern that this measure would unfairly penalize solo and small practices.</p>	<p>The House IOM study provision addresses the limited issue of recommendations for payment reform to reduce geographic variation. It meets most relevant aspects of College policy.</p> <p>ACP would also support the expansion of the IOM study to address variations in quality relative to the cost of care provided.</p>
<p><b>Establishes Innovation Center to fast-track testing of new payment models</b></p>	<p>Yes. The legislation establishes a Center that tests payment models in the Medicare and Medicaid programs to determine the effect on the cost and quality in the respective program.</p> <p>In selecting models to test, the Secretary shall give preference to models determined by the CMS and by input from outside of CMS that the Secretary deems appropriate for which evidence shows focus on a population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures. The Secretary shall focus on models that are expected to reduce program costs while preserving or increasing quality.</p> <p>Allows the Secretary to expand project throughout the system and projects are not required to be budget-neutral initially. The Secretary shall not require that a test project be designed to be cost-neutral to be selected for testing.</p>	<p>Yes. The legislation includes a Center for Medicare and Medicaid Innovation to test new payment and service models to enhance quality and promote savings. Specifically mentions the medical home model (for high need beneficiaries and to address women’s unique healthcare needs) and the community team medical home model as models that may be considered by the Secretary for testing—the College would prefer that the Center be mandated to test medical home models as in House bill. Allow the Secretary to expand project throughout system and projects are not required to be budget-neutral initially.</p>	<p>Both bills create a Center for Innovation consistent with ACP policy. The House bill also includes the establishment of specific Medical Home pilots, in addition to establishing such a Center. Thus, the House approach is more consistent with ACP policy.</p>
<p><b>Improves PQRI and refrains from imposing punitive payment penalties</b></p>	<p>Yes. Extends the current 2% incentive payment for 2010, 2011, and 2012.</p> <p>By January 2011, the Secretary shall: make feedback reports to physicians that indicate reporting accuracy and projection toward qualifying for the bonus; and establish a mechanism by which physicians can appeal bonus</p>	<p>Extends bonus payment for successful reporting through performance year 2014. Assesses a payment penalty for failure to successfully participate in 2015 and beyond. Participation in Maintenance of Certification can be used to achieve successful reporting but</p>	<p>The House bill extends positive bonus payments through 2012, without shifting to payment penalties, as is directed in the Senate bill. The College is opposed to the use of penalties under the PQRI program. Since both bills contain the improvements of providing</p>

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	<p>payment determination.</p> <p>By January 2012, the Secretary shall develop a plan to integrate clinical reporting on quality measures with reporting requirements pertaining to meaningful use of EHRs.</p>	<p>through the registry reporting option only. Makes improvements by requiring timely feedback, establishing a successful reporting determination appeals process, and requiring that PQRI be consistent with EHR meaningful use reporting requirements.</p>	<p>more timely feedback, adding an appeals mechanism, and directing coordination with EHR meaningful use requirements, the College prefers the House bill. The House bill could be improved by adding the MOC option found in the Senate bill..</p>
<b>Misvalued Relative Value Units (RVUs)</b>	<p>Yes. Provides direction and discretion that allows review and adjustment of essentially any physician fee schedule service. Provides \$20 million in annual funding to carrying out these activities.</p>	<p>Yes. Provides direction and discretion that allows review and adjustment of essentially all physician fee schedule services. No funding is attached to these efforts.</p>	<p>The approach taken in both bills is similar and consistent with ACP policy. Neither approach precludes establishing an expert panel to advise CMS. The House provision is preferable, though, as it contains significant funding dedicated to these activities.</p>
<b>Advanced Imaging Payment Modifications</b>	<p>Beginning January 1, 2011: Increases rate at which advanced imaging equipment is assumed to be used from 50% to 75%; and increases the technical component payment discount for advanced imaging on contiguous body parts from the current 25% to 50%.</p>	<p>Phases in an increase to the utilization rate for advanced imaging equipment from 50 % to 75 % from 2010-2014. Increases the technical component discount for advanced imaging on contiguous body parts from the current 25% to 50% beginning in July 2010. Requires a CMS study of estimated savings of these changes over 10-year period.</p>	<p>Provisions in both bills are similar and are generally consistent with ACP policy. The College is concerned that “savings” generated may not be used to improve payment for other physician services. It appears that savings would go back to the Treasury, as opposed to being distributed in the form of increased payment for other services within the fee schedule. CMS has already decided through the rule-making process to increase the assumed utilization rate to 90% beginning in 2010 and to redistributes the savings. The ideal scenario is Congress putting the CMS redistribution action into law (or not acting on the issue in deference to CMS) and including the 50% payment reduction for contiguous body part advanced imaging.</p>
<b>Funding for a transparent process to conduct Comparative Effectiveness Research (CER)</b>	<p>Yes. The Secretary shall establish within the Agency for Healthcare Research and Quality a Center for Comparative Effectiveness to conduct, support, and synthesize research with respect to the outcomes, effectiveness, and appropriateness of health care services and procedures in order to identify the manner in which diseases, disorders, and other health conditions can most effectively and appropriately be prevented, diagnosed, treated, and managed,</p>	<p>Yes. This legislation creates an independent, non-profit institute to provide for the conduct of comparative effectiveness research. The institute would be governed by a multi-stakeholder board that is appointed by the Comptroller General. Once fully implemented, the institute would be funded from multiple sources, including mandatory appropriations, the Medicare</p>	<p>The Comparative Effectiveness provisions in both bills generally meet College policy. College policy supports the use of cost-effectiveness research. The House bill is silent on the issue, while the Senate bill places specific limitations on its use.</p>

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	<p>clinically.</p> <p>This Center for Comparative Effectiveness, while established within AHRQ, has significant protections from undue government or private sector influence. These protections include an independent multi-stakeholder oversight commission, transparent operations, strong conflict of interest policy, and funding outside of the appropriations process. Mechanisms for prioritization and effective dissemination of information are also consistent with our policy. Funding is based on a fair share per capita assessment on government and private sector health plans. The Institute would not mandate coverage, reimbursement, or other policies for any public or private payer. The language makes no mention of cost effectiveness research, which is highlighted in ACP policy—the legislation is silent on this issue.</p>	<p>trust funds, and a fee on health plans.</p> <p>The Institute is to establish procedures to ensure transparency, credibility, and access through public comment periods, forums, public availability of information, and protocols for conflicts of interest.</p> <p>The Institute would not mandate coverage, reimbursement, or other policies for any public or private payer. Processes would allow stakeholders and other individuals to provide informed and relevant information with respect to the determination, to review draft proposals of the determination and to submit public comments with respect to draft proposals. Prohibits the Institute from using cost-effectiveness analyses (QALY) for establishing as a threshold what health care is cost-effective or recommended; and the Secretary shall not use such measure (or similar measure) as a threshold to determine coverage, reimbursement, or incentives programs.</p>	
<b>WORKFORCE</b>			
<p><b>Advisory council to recommend workforce goals</b></p>	<p>Yes. Establishes a permanent advisory committee, the Advisory Committee on Health Workforce Evaluation and Assessment, to assess, evaluate and advise on the appropriateness of the nation’s health workforce and make recommendations on policies to ensure that such workforce is meeting the nation’s needs.</p> <p>Advisory Committee will consist of 15 members with representatives of the health care workforce and health professionals, employers, third-party payers, labor unions, etc.</p> <p>Establishes the National Center for Health Care Workforce Analysis to collect, analyze and report data describing the health care workforce, develop and publish benchmarks for</p>	<p>Yes. Establishes a National Health Care Workforce Commission to develop and commission evaluations of education and training activities to determine whether the demand for health care workers is being met; to identify barriers to improved coordination at the federal, state, and local levels and recommend ways to address such barriers; and to encourage innovations to address population needs, constant changes in technology, and other environmental factors. One noteworthy priority for the Commission is to analyze and make recommendations for eliminating barriers to</p>	<p>The federal government should develop a national health care workforce policy to ensure an adequate supply and spectrum of primary care physicians trained to manage care for the whole patient; and establish a permanent national commission on the health care workforce to provide explicit planning at the federal level by setting specific targets for increasing primary care capacity.</p> <p>The provisions in both bills meet College policy. The Senate bill establishes state grants for workforce development, a provision the House does not include. Neither bill specifically calls</p>

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	<p>performance for federal workforce programs, makes publicly available a national health workforce database.</p>	<p>entering and staying in careers in primary care including physician compensation. Composed of 15 members and shall include no less than one representative of the health care workforce and health professionals, employers, third-party payers, labor unions, etc. Establishes the National Center for Health Workforce Analysis to provide for the development of information describing and analyzing the health care workforce and workforce related issues. Also establishes a competitive health care workforce development grant program for the purpose of enabling state partnerships to complete comprehensive planning and to carry out activities leading to coherent and comprehensive health care workforce development strategies at the state and local levels.</p>	<p>for a representative of a primary care physician organization to serve on the council. ACP feels strongly that primary care should specifically be represented.</p>
<p><b>Scholarships and loan repayment programs for primary care physicians</b></p>	<p>Yes, includes increased funding for NHSC plus the option of part-time service in NHSC for half the reward amount. Full time awards increased from \$35k to \$50k. Also includes the Frontline Health Providers Loan Repayment Program for needed specialties including primary care that are not in HPSA's (90% of awards are for primary care providers). Faculty Loan Repayment awards increased from \$20k/year to \$35k/year. Includes primary care training and enhancement grants, and grants for interdisciplinary training under Title VII.</p>	<p>Yes. Permanently reauthorizes the National Health Service Corps program plus the option of part-time service in NHSC for half the reward amount or double the length of time for the full award amount; It also establishes the NHSC fund with dedicated mandatory funding for the program; provides state health professions loan repayment tax relief; reauthorizes Title VII programs, including Sec 747, Primary Care Training and Enhancement programs, and interdisciplinary training programs; reauthorizes and increases the Faculty Loan Repayment awards from \$20k/year to \$30k/year; reauthorizes Scholarships for Disadvantaged Students; but language reinstating the 20/220 pathway, as adopted during Committee mark-up, was dropped from H.R. 3590.</p>	<p>ACP supports increased funding for the NHSC and health professions training programs under Title VII in order to meet the demands of a high performing primary care workforce. ACP also supports the establishment of new award programs in exchange for service in areas of national need.</p> <p>Overall, ACP favors the House bill because of the establishment of the new Frontline Health Providers Loan Repayment Program, the new part-time option for NHSC, and the Public Health Investment Fund, which establishes an entitlement system for many of the health professions programs and sets baseline funding at the FY2008 levels. However, on a more nuanced level, there are differences in programs, authorization levels, and funding amounts to individuals; for instance, the House bill is more generous for NHSC and faculty loan repayment, the Senate bill is</p>

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			more generous for Sec 747 primary care training.
<b>Increased GME slots for primary care and increased training in ambulatory settings</b>	Yes, redistributes unused residency slots to hospitals that agree to maintain their current primary care levels and use the new slots only for primary care. Includes a demonstration program to direct GME funds directly to certain Teaching Health Centers to develop and operate primary care training programs rather than the hospital; eliminates barriers to ambulatory training and calls for an OIG study on the impact of changing these rules on increased ambulatory training. Also calls for a GAO study on evaluation of training programs, which ACP opposes.	Yes, redistributes unused residency slots to hospitals that agree to maintain their current primary care levels and use the new slots for primary care and general surgery. Eliminates barriers to training in ambulatory care settings. Establishes teaching health centers for the purpose of establishing new accredited or expanded primary care residency programs.	As a preliminary target, ACP recommends that the number of Medicare-funded graduate medical education positions available each year in adult primary care specialties be increased in order to graduate 3,000 additional primary care physicians each year for the next 15 years to meet the nation's anticipated health care needs. ACP supports training in ambulatory care settings and endorsed Sen. Bingaman's amendment to the SFC bill to establish teaching health centers.  The House language on redistribution of slots is more favorable as it is limited to primary care positions while the Senate language includes both primary care and general surgery. The House bill also requires that 90% of the slots go to primary care versus 65% in the Senate bill, and the House bill would allow for increased slots in urban and rural areas. For all these reasons, the House bill is preferable. However, the House bill includes a GAO study on the evaluation of training programs, which ACP opposes.
<b>Non-Discrimination regarding Health Professionals</b>	Yes, Section 238 specifies that the bill does not supersede state laws prohibiting qualified health plans from discrimination against health care providers acting within scope of license and certification under state law; applies to participation, coverage, reimbursement and "related requirements."	Yes, Section 2706. Insurers are not allowed to discriminate regarding participation or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law; allows setting separate payment rates based on quality or performance measures.	Neither the House nor Senate provision is problematic. ACP policy on nurse practitioners calls for effective interdisciplinary collaboration of a health care team in the PCMH, recognizing complementary roles in the delivery of care, as defined through respective professional practice. ACP policy also allows for testing the effectiveness of nurse practitioner-led PCMH practices in accordance with existing state practice acts.
<b>ADMINISTRATIVE SIMPLIFICATION</b>			
<b>Standardize language and forms</b>	Yes.	Yes.	Provisions are similar. Both are generally acceptable.
<b>Establish standard</b>	Yes.	Yes.	Provisions are similar. Both

<b>Key Issues</b>	<b>H.R. 3962 (House)</b>	<b>H.R. 3590 (Senate)</b>	<b>ACP Policy</b>
<b>operating rules and companion guides for using and processing health care transactions</b>			are generally acceptable.
<b>Increase consistency of claims edits and code corrections</b>	Yes.	Yes.	Provisions are similar. Both are generally acceptable.
<b>Increase electronic exchange of administrative and clinical data</b>	Yes.	Yes.	Provisions are similar. Both are generally acceptable.
<b>Development of "smart card" technology</b>	Yes.	Yes.	Provisions are similar. Both are generally acceptable.
<b>Plans must publicly report their medical loss ratios.</b>	Yes. The medical loss ratios of managed care plans contracted by states must be publicly reported annually. Plans must also annually spend at least 85% of premium dollars on medical care, known as the medical loss ratio (the Secretary can set the required percentage but the minimum is 85%). Plans that spend less than the required minimum must provide rebates to enrollees that total the amount in which their medical care spending is deficient.	Unclear. Requires the establishment of minimum medical loss ratios only for plans established by states to provide coverage for low income individuals not covered by Medicaid. It is not clear if these ratios need to be publicly reported.	Both bills reflect medical loss ratios under limited conditions. College policy supports the disclosure of medical loss ratios by health plans. The House bill is consistent with this policy. The Senate bill is unclear. The College has no policy on the specific level of medical ratio that is preferred,
<b>MEDICAID ENHANCEMENTS</b>			
<b>Medicaid primary care pay increased to Medicare rates</b>	Yes. Medicaid primary care payments will increase to 80% of Medicare in 2010, 90% of Medicare in 2011, and 100% in 2012 and thereafter.	No.	ACP supports the House provision to increase Medicaid payments to Medicare rates for primary care services (evaluation and management services as defined by CPT code, not specialty—as a consequence, any physician billing for such codes would qualify for the bonus).
<b>MEDICAL LIABILITY REFORM</b>			
<b>Establishes caps on damages; provides alternative methods for resolving disputes</b>	Partially. States shall be given incentive payments if a state enacts an alternative medical liability law that allows for certificate of merit or early offer or both but the law cannot limit attorneys' fees or impose caps on damages. States can receive an incentive payment if caps are imposed on other issues/aspects (excluding any caps imposed on attorneys' fees or damages).	Partially. Authorizes \$50 million in demonstration grant money to States for the development, implementation, and evaluation of alternatives to current tort litigation.	ACP supports imposing caps on non-economic damages; and testing and funding new models—like health courts, which would have cases heard by an expert panel rather than by a lay jury. ACP continues to believe that Congress needs to do more to reform the medical liability system.