









Women's Priorities for the Best Combined Health Reform Bill






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Both the House and Senate health reform bills have the potential to improve women's access to health care. But, there are some significant differences between the two. **We need to press Congress to include the provisions that will be better for women in the final bill.** As the side-by-side comparison below shows, the House bill is better in most ways. But, there are some key exceptions. **Better provisions are checked (✓).** For a summary of provisions important to women that are included in both bills, see RWV's [What Health Reform Will Do for Women and Families](#).

COLUMN A – HOUSE BILL (H.R. 3962)	COLUMN B – SENATE BILL (H.R. 3590)
EFFECTIVE DATE 2013, UNLESS OTHERWISE NOTED	EFFECTIVE DATE 2014, UNLESS OTHERWISE NOTED
1. COVERING MORE PEOPLE	
✓ Covers 36 million currently uninsured people, bringing total of insured to 96% of legal U.S. residents under 65 by 2019	Covers 31 million currently uninsured people, bringing total of insured to 94% of legal U.S. residents under 65 by 2019
✓ Expands Medicaid eligibility up to 150% of the federal poverty line (\$33,075 for a family of 4)	Expands Medicaid eligibility up to 133% of the federal poverty line (\$29,327 for a family of 4)
✓ Provides 100% federal Medicaid match to states for first 2 years, then 91% federal match for all states	100% federal Medicaid match for first 2 years, then varying matches that penalize states already using state \$\$ to expand Medicaid enrollment (like NY) and reward states that have failed to do so
✓ Children eligible to stay on parents' coverage until age 27	Children eligible to stay on parents' coverage until age 26
✓ Requires most employers to offer coverage to their employees and pay fixed percentages of premium costs or pay a penalty of 8% of total payroll. <u>Stronger employer mandate than in Senate bill.</u>	Employers of more than 50 people face penalty of \$750 per full-time worker if they do not provide health coverage to their employees. Creates loop-hole by excluding part-time workers. <u>Not a real mandate.</u>
2. MAKING COVERAGE MORE AFFORDABLE	
✓ Anyone not already enrolled in qualified health plans can shop for health insurance in new national "exchange" or marketplace	U.S. citizens and legal immigrants who are not incarcerated can shop for health insurance on new state "exchanges"
Provides federal subsidies on sliding scale for people with incomes up to 400% of poverty (\$88,200 for a family of four) for insurance purchase through the exchange: Better subsidies for families earning less than 250% poverty ✓	Provides federal subsidies on sliding scale for people with incomes up to 400% of poverty (\$88,200 for a family of four) for insurance purchase through the exchanges: Better subsidies for families earning greater than 250% poverty ✓

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<p>✓ Undocumented immigrants can shop in the exchange, but are not eligible for subsidies. Legal immigrants may shop in the exchange and are eligible for subsidies.</p>	<p><u>Undocumented immigrants cannot shop in the exchanges, even with their own money.</u> Legal immigrants may shop in the exchange and are eligible for subsidies.</p>
<p>Limits out-of-pocket expenses for co-pays and deductibles: Better for families earning less than 250% of poverty than Senate bill ✓</p>	<p>Limits out-of-pocket expenses for co-pays and deductibles: Better for families earning greater than 250% of poverty than House bill ✓</p>
<p>✓ Includes public option in exchange that could compete with private insurers and lower prices</p>	<p>No public option. Insurers can offer multi-state plans under contract with U.S. personnel agency.</p>
<p>✓ Higher “actuarial value”* (minimum 70%) of insurance offered through exchange. Plan covers greater share of health costs.</p>	<p>Lower “actuarial value”* (minimum 60%) of insurance offered through exchange. Plan covers lower share of health costs.</p>
<p>✓ Prohibits insurers from placing annual limits on \$\$ value of coverage as of 2013.</p>	<p>Prohibits insurers from placing “unreasonable” annual limits as of 2014, with HHS secretary setting rules.</p>
<p>✓ Closes Medicare prescription drug donut hole by 2019</p>	<p>One-time, one-year \$500 reduction in donut hole in 2010. Relies on drug company discounts.</p>
<p>✓ Lifts insurers’ anti-trust exemption that limits competition and can cause premiums to rise</p>	<p>Does not lift insurers’ anti-trust exemption</p>
<p>Requires review of plans’ rate increases before they are implemented (effective upon enactment of bill)</p>	<p>✓ Requires establishment of process to review rate increases and require plans to justify increases. Plans could be excluded from exchange for unjustified rate increases. Provides grants to states to review and approve increases.</p>
3. MAKING COVERAGE FAIRER	
<p>✓ National health insurance exchange establishes consistent standards and stronger enforcement</p>	<p>State health insurance exchanges may lead to inconsistent standards and less rigorous enforcement in some states</p>
<p>✓ Ban on gender rating goes into effect 2013. Ban on coverage denials for pre-existing conditions goes into effect 2013.</p>	<p>✓ Ban on gender rating goes into effect 2014. Ban on coverage denials for pre-existing conditions goes into effect 6 months after enactment of law for children; 2014 for adults.</p>
<p>✓ Age rating limited to 2:1 ratio (The oldest people buying health insurance can be charged twice as much as the youngest people)</p>	<p>Age rating limited to 3:1 ratio (The oldest people buying health insurance can be charged three times as much as the youngest people)</p>
<p>✓ Ban on gender and age rating applies to everyone, regardless of whether they are buying an individual insurance policy or getting insurance from a small or large employer</p>	<p>Ban on gender and age rating does not apply to people who get insurance from a large employer unless the exchange is expanded to cover large groups</p>
<p>✓ Provides wellness grants for up to 3 years to small employers. <u>Does not</u> allow employers to tie premium discounts to employee health standards, which could prove discriminatory.</p>	<p>Allows employers to offer workers financial rewards (like premium discounts) for participating in wellness programs and meeting certain health standards</p>

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4. WOMEN'S HEALTH PROVISIONS	
<p> Protects victims of domestic violence and sexual assault from insurance denials for “pre-existing conditions”</p>	<p>No similar provision. Definition of “pre-existing conditions” does not explicitly include these.</p>
<p> Abortion coverage banned (except for cases of rape, incest or threat to the woman’s life) in any plan in the national insurance exchange that has even one policy holder receiving a federal subsidy. Abortion coverage only available as a rider on the basic insurance policy. <i>(Stupak amendment)</i></p>	<p> States can prohibit abortion coverage (except for cases of rape, incest or threat to the woman’s life) in state insurance exchanges. Insurers must segregate funds received for abortion coverage from other revenues to ensure no federal funds are used for that purpose. If abortion is covered, 2 separate premium payments are required: one for abortion coverage and one for everything else. <i>(Nelson amendment)</i></p>
<p>No co-pays or deductibles for preventive health services and screenings rated highly by the U.S. Preventive Health Services Task Force</p>	<p> No co-pays or deductibles for preventive health services and screenings rated highly by U.S. Preventive Health Services Task Force or for women’s health services and screenings included in other federal health guidelines (more expansive array of services)</p>
<p> Does not restore funding for abstinence education programs, which have not proven effective</p>	<p>Restores \$50 million in annual grants to states for unproven abstinence education programs, through FY 2014</p>
5. ADDRESSING HEALTH DISPARITIES	
<p> Improves access to care by increasing funding by \$12 billion over five years for community health centers; establish new programs to support school-based health centers (effective July 1, 2010) and nurse-managed health centers (effective 2011), and set criteria for the certification of federally qualified behavioral health centers</p>	<p>Improves access to care by increasing funding by \$10 billion for community health centers and the National Health Service Corps (effective fiscal year 2011); establishing new programs to support school-based health centers (effective fiscal year 2011) and nurse-managed health clinics (effective fiscal year 2010)</p>
<p> Gradually increases Medicaid payments up to Medicare levels, so more providers would accept Medicaid</p>	<p>No comparable provisions</p>
<p> Increases federal funding for translation services for adults in Medicaid</p>	<p>No comparable provision</p>
<p> Primary care providers get increased Medicaid payments and Medicare bonuses</p>	<p>Primary care providers get one-time 10% increase</p>
<p> Promotes training of diverse work force and promotes cultural and linguistics competence training for health care professionals</p>	<p>No comparable provision</p>

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6. CHILDREN'S HEALTH INSURANCE PROGRAM	
<p>Repeals Children's Health Insurance Program (CHIP) as of 2014 and moves children either into Medicaid or the insurance exchange</p>	<p> Maintains Children's Health Insurance Program (CHIP) through 2019, with better benefits and stronger out-of-pocket cost protections. Extends CHIP block grants thru 2015; assumes authorization of more funding at that time.</p>
7. INDIVIDUAL MANDATE PROVISIONS	
<p>Requires most individuals to have health insurance (individual mandate)</p>	<p> Requires most U.S. citizens and legal residents to have health insurance (individual mandate)</p>
<p> Penalty for violating individual mandate requirement is progressive (2.5% of income above a threshold amount), so less burdensome to low-income people</p>	<p>Penalty for violating individual mandate requirement is the <u>greater</u> of either: a) a flat amount starting at \$95 in 2014 and rising to \$750 in 2016, or b) a percentage of taxable income beginning at 0.5% in 2014 and rising to 2% in 2016</p>
<p>Mandate exemptions for financial hardship and religious objections. Undocumented immigrants not specifically exempted. They would have to apply for and secure a "hardship" waiver.</p>	<p> Mandate exemptions for people who cannot find affordable coverage, undocumented immigrants, American Indians, incarcerated individuals, religious objectors</p>
8. CONSUMER ASSISTANCE IN NAVIGATING HEALTH REFORM	
<p>No comparable provision. Relies on federal government outreach and assistance to consumers and employers, and establishes hotline and website</p>	<p> Immediate funding for states to create consumer assistance offices and navigators to help consumers use the new insurance exchanges</p>

*Source: Analysis by Community Catalyst, which explains that "actuarial value" is the percentage of the costs of covered services that the plan will pay for the typical enrollee. Higher "actuarial values" translate to lower out-of-pocket costs.

Comparisons drawn from RWV analysis and briefing documents prepared by Community Catalyst, Health Care for America Now, Center for American Progress, the Kaiser Family Foundation, the National Women's Law Center and the New York Immigration Coalition.