

Issue	House Health Reform Bill (HR 3962)	Senate Health Reform Bill (HR 3590)
<i>Private Insurance Market Reforms</i>		
Lifetime Caps	Eliminated in new & existing plans in 2010.	Eliminated in new plans 6 months after enactment; Existing plans allowed to have lifetime caps indefinitely.
Annual Limits	Eliminated in new plans in 2013 & existing plans by 2018.	Eliminated in new plans in 2014; Until 2014 "unreasonable" annual limits are prohibited; Existing plans allowed to have annual limits indefinitely.
Pre-Existing Conditions Exclusions	Eliminated in new plans in 2013 & existing plans by 2018; In 2010, limits the time that plans can look back for pre-existing conditions from 6 months to 30 days & shortens the time plans may exclude coverage of benefits generally from 12 months to 3 months.	As of 2014, no health plan can impose any pre-existing condition exclusion or discriminate against those who have been sick in the past; Pre-existing conditions exclusions for children are prohibited immediately.
Modified Community Rating	As of 2013, variation in premiums only based on age (limited to 2:1), family size & geography. Prohibits rating based on health status.	As of 2014, variation in premiums only by family structure, geography, actuarial value of the benefit, age (limited to 3:1) & tobacco use (limited to 1.5:1). Prohibits rating based on health status.
Rescissions	Eliminated in new & existing plans in 2010.	Eliminated in new plans in 2010.
Guaranteed Issue & Renewal	As of 2013, requires guaranteed issue (no one can be denied health insurance) & renewal of insurance policies (regardless of health status, utilization of health services or any other related factor).	As of 2014, guaranteed issue & renewal.
Extension of Dependent Coverage	Dependents can remain on their parents' insurance until age 27 as of 2010.	Dependents can remain on their parents' insurance until age 26 as of 2010.
Exchanges	Established in 2013, where individuals & small employers can purchase insurance; Creates affordability tax credits for individuals purchasing insurance through the Exchange from 100 to 400% of federal poverty level (FPL).	By 2014, each state will establish an Exchange to help individuals & small employers obtain coverage; Creates refundable tax credits providing premium assistance for health coverage in the Exchange; There is a sliding scale of credits from 100 to 400% of FPL.
Out-of-Pocket Caps	Sets maximum annual out-of-pocket expenses at \$5,000 for an individual & \$10,000 for a family; these levels are indexed to inflation. Those receiving affordability credits through the Exchange will have lower out-of-pocket caps.	Sets maximum out-of-pocket limits at \$5,950 for individuals & \$11,900 for families, which would be reduced for individuals receiving affordability credits through the Exchange (those below 400% of FPL).

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Essential Benefits Package	Plans offered through the Exchange must offer these benefits at minimum: Hospitalization; Outpatient hospital & outpatient clinic services, including ER services; Professional services of physicians & other health professionals; Such services, equipment, & supplies incident to the services of a physician's or a health professional's delivery of care in institutional settings, physician offices, patients' homes or place of residence, or other settings, as appropriate; Prescription drugs; Rehabilitative & habilitative services; Mental health & substance use disorder services, including behavioral health treatments; Preventive services, including those services recommended with a grade of A or B by the Task Force on Clinical Preventive Services & those vaccines recommended for use by the Director of the CDC; Maternity care; Well-baby & well-child care & oral health, vision, & hearing services, equipment, & supplies for children under age 21; Durable medical equipment, prosthetics, orthotics & related supplies.	Plans offered through the Exchange must offer (but are not limited to) these benefits: Ambulatory patient services; Emergency services; Hospitalization; Maternity & newborn care; Mental health & substance use disorder services, including behavioral health treatment; Prescription drugs; Rehabilitative & habilitative services & devices; Laboratory services; Preventive & wellness services & chronic disease management; Pediatric services, including oral & vision care.
Access to Specialists & Therapies	No provision.	Prevents the HHS Secretary from promulgating regulations limiting access to health care services.
<i>Public Programs</i>		
High Risk Pools	Creates a temporary National High Risk Pool Program for those who have been uninsured for several months or are denied a policy because of a pre-existing conditions; Provides up to \$5 billion for the program; Terminates when funds are exhausted or when the Health Insurance Exchange is operational in 2013.	Creates a temporary insurance program for those who have been uninsured for several months & have a pre-existing condition until the Exchanges are operational in 2014; Provides up to \$5 billion for the program.
Expansion of Medicaid	Expands eligibility to childless adults & children up to 150% of FPL; Allows State Medicaid programs to cover low-income individuals who are HIV positive up to 133% FPL through December 31, 2013, after which coverage will be available through the Exchange.	Expands eligibility to childless adults & children up to 133% of FPL.
Expansion of 340B	Extends the section 340B outpatient drug discounts to certain rural & other hospitals, including Critical Access Hospitals.	Expands 340B program to inpatient drugs; Expands 340B program to certain children's hospitals, cancer hospitals, critical access & sole community hospitals, & rural referral centers.

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Medicaid Rebate for Clotting Factor Therapies	Increases the minimum manufacturer rebate for brand-name drugs purchased by State Medicaid programs from 15.1% to 23.1% of AMP; effective 2010.	Exempts clotting factor from rebate increase to 23.1% of average manufacturer price; Sets rebate for clotting factor at 17.1%.
Medicare Donut Hole	Eliminates Part D donut hole, beginning with \$500 reduction in 2010 & completing phase-out by 2019; Provides 50% discount for drugs & biologics for Part D enrollees in coverage gap; Provides that drugs provided to patients by AIDS Drug Assistance Programs (ADAP) can count toward out-of-pocket costs allowing individuals to qualify for Part D catastrophic benefits.	Eliminates Part D donut hole; Discounts brand-name drugs & biologics by 50% for Part D beneficiaries during the coverage gap beginning July 1, 2010.
<i>Other</i>		
Biosimilars	Creates an FDA licensure pathway for "biosimilar" products, which are generic versions of biologic products such as clotting factor; biosimilar must have no clinically meaningful differences in safety, purity or potency from the reference product & may not be licensed until at least 12 years after the date that the brand name product was licensed.	Establishes process to approve biosimilars; Sets 12 years of data exclusivity; If FDA approves a biosimilar as interchangeable, HHS cannot determine that a second or subsequent biosimilar is interchangeable to same reference product until 1 year later.
Comparative Effectiveness Research	Creates a new Center at the Agency for Healthcare Research & Quality; Includes protections from mandating payment, coverage or reimbursement policies; Creates a rare disease advisory panel if research is proposed concerning a rare disease.	Establishes a non-profit entity, the Patient-Centered Outcomes Research Institute; Prohibits findings to be mandates on practice guidelines or coverage decisions.