An Overview of Major Health Information Technology, Public Health, Medicaid, and COBRA Provisions of the American Recovery and Reinvestment Act of 2009

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
Health Information Technology, Health Care Quality, and Health Information Privacy			
General Approach	Establishes a program in Health Information Technology and Quality (HITECH); establishes a program of comparative effectiveness; revises Medicare and Medicaid policy to finance HIT adoption and use; amends federal privacy law.	Establishes HITECH; establishes a program of comparative effectiveness research; revises Medicare and Medicaid policy to finance HIT adoption and use; amends federal privacy law.	Establishes HITECH; establishes a program of comparative effectiveness research; revises Medicare and Medicaid policy to finance HIT adoption and use; amends federal privacy law.
	Total spending for these activities: ~$20 billion	Total spending for these activities: ~$16 billion	Total spending: ~$19 billion
Federal Program in Health Information Technology	HITECH, creating the Office of the National Coordinator for Health Information Technology (ONCHIT) and establishing duties and powers of the office under the Public Health Service Act.	HITECH Act, substantially similar. Amends Public Health Service Act. Codifies ONCHIT into statute. Appropriates $3B to ONCHIT, $20M to the Director of NIST for continued work on advancing health care information enterprise integration.	Codifies ONCHIT into PHSA. Appropriates $2B to ONCHIT; $20M to the Director of NIST for continued work on advancing health care information enterprise integration; $300M to support regional or sub-national efforts toward health information exchange. 0.25 percent set-aside of funds for management and oversight activities; funds available only upon submission by Secretary of operating plan and twice

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
			yearly reports on actual obligations, expenditures, and unobligated balances for each major set of activities.
Federal HIT Program Definitions	*Certified EHR technology:* "a qualified electronic health record that is certified pursuant to the Act as meeting standards developed under the act that are applicable to the types of records involved."	Definition substantially similar.	Follows House and Senate approach.
	Enterprise integration: "the electronic linkage of health care providers, health plans, the governments, and other interested parties, to enable the electronic exchange and use of health information among all components in the health care infrastructure."	Definition substantially similar.	Follows House and Senate approach.
	Health care provider: "a hospital, skilled nursing facility, nursing facility, home health entity, long term care facility, health care clinic, FQHC, group practice [as defined in Medicare], a practitioner [as defined in Medicare], a provider operated by, or under contract with, the IHS or tribal organization, urban Indian	Definition substantially similar, but includes a pharmacist, pharmacy, and laboratory.	Definition includes all entities listed in both House and Senate bills and also includes a community mental health center, renal dialysis facility, blood center, emergency service provider, "physician," rural health clinic, group practice, and therapist. However, a later "miscellaneous" provision of the HITECH Act specifically authorizes the Secretary, in

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
	organization, rural health clinic, a 340B covered entity (discount drug-eligible providers), ambulatory surgical center, and other category of facility or clinicians determined appropriate by the Secretary."		administering the law, to omit any of the listed entities from the definition of "health care provider."
	Health Information: uses the HIPAA definition, §1171(4) of the SSA (42 U.S.C. §1320d(4)): "any information, whether oral or recorded in any form or medium, that-- (A) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (B) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual."	Definition substantially similar	Follows House and Senate approach.
	Individually identifiable information: Uses HIPAA definition, 1171(6) of the SSA (42 U.S.C. §1320d(6)):	Definition substantially similar	Follows House and Senate approach.

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
	Qualified electronic health record: "an electronic record of health related information on an individual that (A) includes patient demographic and clinical health information such as medical history and problem lists; and (B) has the capacity to provide clinical decision support, to support physician order entry, to capture and query information relevant to health care quality, and to exchange electronic health information with, and integrate such information from other sources.	Definition substantially similar	Follows House and Senate approach.
Mission of ONCHIT	To develop a "nationwide health information technology infrastructure" that allows for electronic health information use and exchange and that ensures that the following elements are part of that infrastructure.	Mission substantially similar	Follows House and Senate approach.
Required Elements of Nationwide Health Information Technology Infrastructure	Ensure that each patient's health information is secure and protected.	Element substantially similar.	Follows House and Senate approach.
	Improve health care quality, reduces medical errors, reduces health	Element substantially similar.	Follows House and Senate approach but uses term

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
	disparities, and advances the delivery of patient centered care.		"patient-centered medical care."
	Reduce health care costs from inefficiency, medical error, in appropriate care, duplicative care, and incomplete information.	Element substantially similar.	Follows House and Senate approach.
	Provide appropriate information to help guide decision-making at the "time and place" of care.	Element substantially similar.	Follows House and Senate approach but uses phrase "help guide medical decisions."
	Ensure meaningful public input into infrastructure development.	Element substantially similar.	Follows House and Senate approach.
	Improves coordination of care and information among hospitals, laboratories, physician offices, and other entities "through an effective infrastructure for the secure and authorized exchange of health care information."	Element substantially similar.	Follows House and Senate approach.
	Improve public health activities and facilitates the early identification and	Element substantially similar.	Follows House and Senate approach.

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
	rapid response to public health threats and emergencies, including bioterrorism and infectious disease outbreaks.		
	Facilitate health and clinical research and quality.	Element substantially similar.	Follows House and Senate approach.
	Promote prevention of chronic diseases.	Element substantially similar.	Follows House and Senate approach.
	Promote a more effective marketplace, greater competition, greater systems analysis, increased consumer choice, and improved outcomes in health care services.	Element substantially similar.	Follows House and Senate approach.
	Improve efforts to reduce health disparities.	Element substantially similar.	Follows House and Senate approach.
Key Coordinator Duties	Review standards, implementation criteria, and certification criteria for information exchange that is recommended by the HIT Standards Committee.	Duty substantially similar.	Follows House and Senate approach.

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
	Coordinate HIT policy across the Department and "other relevant executive branch agencies."	Duty substantially similar.	Follows House and Senate approach.
	Oversee both HIT policy committee and HIT standards committee.	Duty substantially similar.	Follows House and Senate approach and provides that National Coordinator shall be a leading member in the establishment and operations of the HIT Policy Committee and the HIT Standards Committee and shall serve as a liaison among those two committees and the federal government.
	Update the Federal Health IT Strategic Plan, an annual operating plan to the appropriations committees that describes how expenditures are aligned with objectives, milestones, and metrics,, describes how funds will be allocated to HHS agencies, and identifies programs and activities to be supported. Annual reports required thereafter. Plan must use measurable outcome goals.	Duty substantially similar.	Follows House and Senate approach.
	Produce reports on: additional funding or authority needed; implementation report; impact of HIT on communities	Similar, but Senate bill requires that report on impact on vulnerable communities identify practices to increase the use of health information technology	Follows House and Senate approach. In addition, for report on resource requirements, requires assessment of resources needed to establish a

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
	with health disparities and uninsured, underinsured, and medically underserved areas; benefits and costs of the electronic use and exchange of health information; and resource requirements.	to reduce and better manage chronic diseases.	sufficient health information technology workforce.
	Establish governance mechanism for the network.	Duty substantially similar.	Follows House and Senate approach.
HIT Policy Committee	Establishes HIT Policy Committee to make policy recommendations to the National Coordinator relating to the implementation of a nationwide health information technology infrastructure.	Provision substantially similar.	Follows House and Senate approach.
Required Recommendations from HIT Policy Committee	Privacy and security technology "including for the segmentation and protection from disclosure of specific and sensitive individually identifiable health information with the goal of minimizing the reluctance of patients to seek care (or disclose information about a condition) because of privacy concerns."	Provision substantially similar.	Follows House and Senate approach.

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
	A nationwide technology infrastructure that allows for electronic use and accurate exchange of health information."	Provision substantially similar.	Follows House and Senate approach.
	Technologies that "allow individually identifiable health information to be rendered unusable, unreadable, or indecipherable to unauthorized individuals when such information is transmitted in the nationwide health information network or physically transported outside of the secured, physical perimeter of a health care provider, health plan, or health care clearinghouse."	This duty not specifically required of the HIT Policy Committee, however, Secretary is charged with a similar duty under the privacy provisions of the bill.	Adopts House provision.
	Use of EHRs by all persons in the U.S. by 2014.	Provision substantially similar.	Follows House and Senate approach.
	Technologies that can account for disclosures by covered entities under HIPAA for purposes of treatment, payment, and health information.	Provision substantially similar.	Follows House and Senate approach.

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
	Technologies to improve the quality of care through coordination, continuity, reduction of medical errors, improving population health, reducing population disparities, advancing research and education.	Provision substantially similar.	Follows House and Senate approach.
	No similar provision.	Use of electronic systems to ensure the comprehensive collection of patient demographic data, including, at a minimum, race, ethnicity, primary language, and gender information.	Adopts Senate provision.
	No similar provision.	Technologies and design features that address the needs of children and other vulnerable populations.	Adopts Senate provision.
Optional Recommendations from HIT Policy Committee.	Collection of quality data and public reporting.	Provision substantially similar.	Follows House and Senate approach.
	Public health and bio-surveillance.	Provision substantially similar.	Follows House and Senate approach.
	Various specialized technologies, including telemedicine, self service, home health care, medical error reduction, care continuity, meeting the	Provision substantially similar.	Follows House and Senate approach.

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
	needs of diverse population and any other technology that the HIT policy committee finds "to be among the technologies with the greatest potential to improve the quality and efficiency of health care."		
	No similar provision.	Methods to facilitate secure access by an individual to such individual's protected health information.	Adopts Senate provision.
	No similar provision.	Methods, guidelines, and safeguards to facilitate secure access to patient information by a family member, caregiver, or guardian acting on behalf of a patient.	Adopts Senate provision.
	No similar provision.	No similar provision.	Final law adds medical and clinical research as optional area for consideration in making recommendations to the Coordinator.
	No similar provision.	No similar provision.	Final law adds drug safety as optional area for consideration in making recommendations to the Coordinator.
Membership in the HIT Policy	Basic membership requirements enumerated. Committee membership	Much more specific and elaborate membership and operations requirements, including how members	Adopts Senate provision, but also specifies that National Coordinator shall take a leading position in

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
Committee	beyond the federal agencies includes the normal range of stakeholders.	are appointed, group representation (patients/consumers, health care providers, labor, privacy expertise, expertise in improving health of vulnerable populations, etc.).	the establishment and operations of the HIT Policy Committee.
HIT Standards Committee	Establishment of an HIT Standards Committee to make recommendations to the National Coordinator relating to standards, implementation specifications, and certification criteria.	Provision substantially similar.	Follows House and Senate approach.
Required Recommendations from HIT Standards Committee	Develop, harmonize, or recognize standards, implementation specifications, and certification criteria, consistent with the latest recommendations made by the HIT Policy Committee.	Provision substantially similar.	Follows House and Senate approach.
	Pilot testing of standards and implementation specifications.	Provision substantially similar.	Follows House and Senate approach.
	Assuring consistency with existing standards.	Provision substantially similar.	Follows House and Senate approach.

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
Additional Required Tasks for HIT Standards Committee	Serve as a forum to bring broad groups of stakeholders together.	Provision substantially similar.	Follows House and Senate approach.
	Establish a schedule for assessment of recommendations of Policy committee, not later than 90 days after enactment.	Provision substantially similar.	Follows House and Senate approach.
	Conduct public hearings and solicit public input.	Provision substantially similar.	Follows House and Senate approach.
Membership in the HIT Standards Committee	Broad public and private participation of stakeholders, including providers, ancillary health care workers, consumers, purchasers, health plans, technology vendors, researchers, relevant federal agencies, and individuals with technical expertise on health care quality, privacy and security, and on the electronic exchange and use of health information.	Substantially similar membership requirements. Senate bill also has many specific provisions for transparency and public participation.	Follows House and Senate approach.
Timeline for Adoption of Standards	Not later than 90 days after the Secretary receives the recommended standards, implementation specifications, or certification criteria, the	Provision substantially similar.	Follows House and Senate approach.

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
	Secretary and representatives of relevant Federal agencies shall jointly review and the Secretary shall determine whether to propose adoption of such standards and criteria. Adoption will be accomplished through regulation, whereas a decision by the Secretary not to adopt would have to be conveyed in writing to the National Coordinator and the HIT Standard Committee. The Secretary would be required to adopt an initial set of standards by December 31, 2009.		
Application to Private Entities	The Act provides that the standards are voluntary for private entities, but only for their non-contract work. However, federal agencies "shall require in contracts or agreements with health care providers, health plans, or health insurance issuers that as each provider, plan, or issuer implements, acquires, or upgrades health information technology systems, it shall utilize, where available, health information technology systems and products that meet the standards and implementation specifications adopted under" the Act.	Substantially similar, but the Senate bill does not specifically state that standards are voluntary for non-contract activities.	Adopts House provisions.

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
Federal HIT Development and Certification	Requires National Coordinator to support the development, routine updating, and provision of qualified EHR technology unless Secretary and Policy Committee determine that needs and demands of providers are being substantially and adequately met through the marketplace. Secretary shall certify such technology and may charge a nominal fee. Nothing requires federal or private entities to use such technology.	Provision substantially similar.	Adopts House and Senate provisions, but specifies that Secretary alone would make determination that needs and demands of providers are being met through the marketplace. In addition, National Coordinator (not Secretary) shall ensure certification of technology and charge nominal fee.
Miscellaneous Provisions – "Flexibility"	No similar provision.	No similar provision.	Specifically authorizes the Secretary, in administering the law, to omit any of the listed entities from the definition of "health care provider."
Coordination among Federal Agencies	As federal agencies implement, acquire, or upgrade health information technology systems used for the exchange of individually identifiable health information, they must adhere to HIT standards of this Act.	Provision substantially similar.	Follows House and Senate approach.
Reimbursement Incentive Study and	Secretary of HHS required to study and submit a report to Congress within 2	Provision substantially similar.	Follows House and Senate approach.

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
Report	years on "methods to create efficient reimbursement incentives for improving health care quality in Federally qualified health centers, rural health clinics, and free clinics."		
Capital Investment for HIT, Including Direct Federal Investment, Grants to States, and Investment in Safety Net Providers	Establishes grant, loan, and demonstration programs and provides funding to strengthen the HIT infrastructure. Also allocates funding directly to certain agencies for HIT development (HRSA, AHRQ, the IHS, and ONCHIT).	Provision substantially similar.	Follows House and Senate approach.
Support for Health Information Exchanges	$300 million to support regional and sub-national efforts at HIE.	Provision substantially similar.	Follows House and Senate approach.
Immediate Funding to Support HIT Infrastructure	HIT investments must be "necessary to allow for and promote the electronic exchange and use of health information for each individual in the U.S." consistent with the ONCHIT strategic plan. To the greatest extent practicable, the Secretary shall ensure that any appropriated funds are used for the	Provision substantially similar.	Adopts House and Senate provisions. Provides $2B in immediate funding for health information technology infrastructure, training, dissemination of best practices, telemedicine, inclusion of health information technology in clinical education, and state grants to promote health information technology.

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
	acquisition of HIT that meets ONCHIT standards.		
Certain Specified Minimum Investment Areas	HIT architecture that will support "nationwide electronic exchange and use of health information in a secure, private and accurate manner, including connecting health information exchanges."	Provision substantially similar.	Follows House and Senate approach.
	Development and adoption of appropriate certified EHR for categories of providers not eligible for support under Medicare and Medicaid.	Provision substantially similar.	Follows House and Senate approach.
	Integration of HIT, including electronic medical records, into initial and ongoing training of health professionals and others "who would be instrumental to improving the quality of healthcare through the smooth and accurate electronic use and exchange of health information, as determined by the Secretary."	Provision substantially similar.	No provision.

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
	Training on and dissemination of information on best practices to integrate HIT including electronic records, into a provider's delivery of care, including health centers and providers participating in Medicare, Medicaid, and SCHIP.	Provision substantially similar.	Follows House and Senate approach.
	Infrastructure and tools for the promotion of telemedicine.	Provision substantially similar.	Follows House and Senate approach.
	Promotion of clinical data repository or registry interoperability.	Provision substantially similar.	Follows House and Senate approach.
	No provision.	No provision.	Promotion of technologies and best practices that enhance the protection of health information by all holders of individually identifiable health information.
	The use of HIT by public health agencies.	Provision substantially similar.	Follows House and Senate approach.
Technology Centers	The act establishes a national HIT research center and regional extension centers to promote HIT adoption and	Provision substantially similar.	Follows House and Senate approach.

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
	provide technical assistance.		
State Grants to Promote HIT	Secretary authorized to award planning grants to states.	Provision substantially similar.	Follows House and Senate approach.
	Secretary authorized to award implementation grants; once approved, these grants can be used for activities "to facilitate and expand the electronic movement and use of health information among organizations according to nationally recognized standards."	Provision substantially similar.	Follows House and Senate approach.
Possible Implementation Grant Activities	Enhancing broad and varied participation in the authorized and secure use and exchange of information.	Provision substantially similar.	Follows House and Senate approach.
	Identifying State or local resources available for nationwide HIT promotion.	Provision substantially similar.	Follows House and Senate approach.
	Complementing other federal grants and programs.	Provision substantially similar.	Follows House and Senate approach.
	Providing technical assistance (TA) to	Provision substantially similar.	Follows House and Senate approach.

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
	reduce barriers.		
	Promoting effective strategies to adopt and utilize HIT in medically underserved communities.	Provision substantially similar.	Follows House and Senate approach.
	Assisting patients in utilizing health information.	Provision substantially similar.	Follows House and Senate approach.
	Encouraging providers to use TA.	Provision substantially similar.	Follows House and Senate approach.
	Supporting public health agencies.	Provision substantially similar.	Follows House and Senate approach.
	Promoting use of EHR for quality improvement efforts, including through quality measures reporting.	Provision substantially similar.	Follows House and Senate approach.
	No provision.	Establishing and supporting health record banking models to further consumer-based consent models that promote lifetime access to qualified health records.	No provision.
Qualified Recipients of State	Grants flow to qualified entities, as identified by states. The entity must be	Provision substantially similar.	Follows House and Senate approach.

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
Grants	designated as eligible to receive awards and must be a not for profit entity with broad stakeholder representation. The entity must "demonstrate that one of its principal goals is to use information technology to improve health care quality and efficiency through the authorized and secure electronic exchange and use of health information." The entity must meet other governance requirements.		
State Matching for Grants to Promote HIT	State match required but not until FY 2011 (1:10 ratio in 2011; 1:7 ratio in 2012, finally 1:3 in 2013 and thereafter).	Provision substantially similar.	Follows House and Senate approach, but gives Secretary the authority to decide to what extent, if any, State matching will be required before FY 2011.

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
Competitive Grants to States and Tribes for the Development of Loan Programs	Special competitive grant program for states or tribes to develop loan programs to achieve widespread HIT adoption. Eligible entities (the states or tribes) are authorized to provide loans for providers to purchase, use, upgrade, or improve use of HIT. Loan recipients must agree to (1) submit reports on certain quality measures; (2) demonstrate that the technology purchased will improve health care quality (e.g., care coordination); and (3) have a maintenance and support plan. The Act spells out duties of entities managing loan funds, allows private contributions under certain circumstances into loan funds, and requires guidance on loan funds.	Provision substantially similar.	Follows House and Senate approach.
Clinical Education Demonstration	Program to integrate certified EHR technology into community-based clinical education.	Provision substantially similar.	Follows House and Senate approach.
Support for Higher Education Programs	Secretary shall support health informatics programs at higher education institutions.	Provision substantially similar.	Follows House and Senate approach.

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
Medicare Payment Incentives for HIT Adoption and Use	Creates new payment incentives for eligible professionals (defined as physicians) and hospitals.	Provision substantially similar.	Follows House and Senate approach.
Medicare Payment Incentives - Physicians	Physician payment incentive begins in 2011 and applies to "covered professional services furnished by an eligible professional during a payment year" conditioned on evidence that the "eligible professional" is a "meaningful EHR user" during any particular "reporting period."	Similar approach, but with higher incentives for early adopters and earlier phase-out of incentive payments.	Adopts the Senate approach, with higher incentives for earlier adopters and prohibition against incentives after 2016. No incentive for physicians who adopt in 2015 or later.
	No special incentive payment for certain physicians.	25% increase for rural providers.	Additional 10% payment incentive but includes additional incentive of 10% for providers that "predominantly" furnish care in designated health professional shortage areas, regardless of urban or rural setting.
	Incentive payments are set at $15,000 for first payment year, phasing down to $0 by payment year 6. Adjustments are made for late adopters (after 2013); with elimination of payments for very late adopters after 2015.	Substantially similar, but further incentivizes early adopters with additional payments in initial years ($18,000 in 2011 and 2012). No incentives for providers who adopt EHR in 2015 or later.	Similar to Senate approach. Ends incentives for all adopters after 2016. Annual payments are capped, beginning at $15,000 in year 1 (with $18,000 in 2011 and 2012 for early adopters) and phased down to $0 by year 6. No incentives for adopters who begin after 2014 and no incentives after 2016.

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
	Incentive payments can be consolidated or periodic.	Provision substantially similar.	Follows House and Senate approach.
	Penalties are imposed beginning in 2016 in the case of professionals who are not meaningful EHR users. Secretary may grant up to a 5-year hardship exemption.	Penalties are imposed if professionals are not meaningful users of EHR technology during 2015 or later.	Adopts Senate provisions providing for penalty structure beginning in 2015 and later reporting years. For covered professional services furnished by an eligible professional during 2015 or any subsequent payment year, if the eligible professional is not a "meaningful EHR user" for a prior reporting period, the fee schedule amount would be reduced to 99% in 2015, 98% in 2016, and 97% in 2017 and in each subsequent year. Further penalties in 2018 if Secretary finds that less than 75% of eligible professionals are not meaningful EHR users. Penalty may not bring fees below 95% of applicable fee schedules. Secretary may grant up to a 5-year hardship exemption.
	Bars incentives for hospital based professionals who bill through the hospital.	Provision substantially similar.	Adopts House and Senate approach and clarifies that other health professionals who bill directly but furnish care in hospitals are not affected.
Medicare Payment Incentives – Medicare	MA plans would report professionals who attest to being meaningful users of EHR, and incentive payment system would apply. Eligible professionals are	Similar approach with lower service threshold (75%) and caps large MA organizations (no more than 5000 professionals can be counted).	Adopts the Senate approach but sets the service threshold at 80% in order to count the eligible professionals and removes the large organization

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
Advantage	those who are employed by the organization or a partner in an entity that contracts with the MA organization and furnishes at least 80% of the entity's services to MA enrollees.		payment cap.
Medicare Payment Incentives – Hospitals	Provides an incentive is a base payment beginning in 2011. Payment is a base fee plus a per-discharge amount, adjusted to reflect Medicare's share. Provides a 4-year transition schedule of payments, from 100% in first transition year to 25% by year 4. Hardship exemption included.	Similar to House, with different payment formula.	Follows House measure, with bonus payments to critical access hospitals that are meaningful users. Hardship exemption permitted.
Medicare - "Meaningful Use" of EHR Technology	Meaningful EHR user defined as: (1) meaningful use of certified EHR technology [*e.g.*, e-prescribing]; (2) EHR connection in accordance with prescribed standards for electronic exchange; (3) clinical quality and other performance reporting as prescribed by the Secretary. Secretary is expected to introduce "more stringent measures of meaningful use" over time; (4) Secretary required to post on CMS website list of meaningful EHR users and (as determined appropriate) group	Provision substantially similar.	Follows House and Senate approach.

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
	practices receiving incentive payments.		
Medicaid Payment Incentives for HIT Adoption and Use	Amends Medicaid federal payment provisions to establish a new program of EHR financing and incentive payments related to certain providers' net allowable costs related to adoption.	Provision substantially similar.	Follows House and Senate approach.
	Authorizes a 100% federal contribution for sums expended for payments to encourage meaningful adoption by certain providers who meet certain requirements. Payments must be made to the provider; costs must be associated with purchase, implementation, use and operation and maintenance, and provider must be certified as a meaningful user. Authorizes 90% federal match for state administrative costs related to EHR adoption.	Provision substantially similar.	Follows House and Senate approach.
	Defines providers as eligible professionals (physicians, nurse-midwives and nurse practitioners who are not hospital based and who have patient volumes at least 30% attributable	Similar approach with differences in allowable cost and payment limits that can be recognized.	Adopts House and Senate approach with modifications. Dentists are added. Pediatricians whose Medicaid practice volume is at least 20% of their patients are recognized (and subject to a lower payment cap). Recognizes physician assistants

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
	to Medicaid; children's hospitals; acute care hospitals whose Medicaid patients exceed 10% of total patient volume; and federally qualified health centers and rural health clinics (FQHCs and RHCs) and health professionals whose Medicaid patient caseloads exceed 30% of total patient volume). Health professionals receiving payment under Medicaid must waive their Medicare payment rights. Payments cannot exceed a defined threshold. Secretary to define net allowable costs related to technology adoption, use and maintenance.		practicing in physician assistant-led RHCs. Also recognizes FQHCs and RHCs whose Medicaid and "needy" patient volumes exceed 30% of total patient volume. "Needy" patients include Medicaid patients, SCHIP patients, persons receiving charity care, and persons receiving care for which payment is made on a prospective sliding fee basis.
	Payments can equal 85% of net allowable technology costs, with upper limits: $25,000 cap on purchase and initial implementation costs and $10,000 in annual operating costs. Five-year cap on total payments.	Provision substantially similar.	Adopts House approach. Separate payment limitations are provided for eligible hospitals.
	To qualify, state must show that providers are meaningful EHR users, that no rebates or deductions are imposed, that the provider systems are compatible with MIS, that the provider is	Substantially similar. Senate bill also emphasizes public reporting for special populations as evidence of meaningful use.	Adopts House and Senate provisions.

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
	responsible for payment and adoption costs, that use of funds is being tracked, and that there is oversight.		
Public reporting and transparency	Discretionary authority in the HIT Policy Committee to establish national public reporting standards.	HIT Policy Committee may consider as part of its standard-setting the collection of quality data and public reporting.	Adopts Senate provisions.
Race, ethnicity, primary language, and gender data reporting	No federal reporting requirements related to race, ethnicity, primary language, and gender. However, the definition of "qualified electronic health record" includes a requirement for the collection of "demographic" data, which remains undefined.	Senate bill requires HIT Policy Committee to develop recommendations regarding the use of electronic systems to ensure the comprehensive collection of patient demographic data, including, at a minimum, race, ethnicity, primary language, and gender information. Definition of qualified EHR includes a requirement for the collection of "demographic" data.	Adopts Senate provisions.
Public Health and Social Services Emergency Fund	Creates Public Health and Social Services Emergency Fund of $50M for improvements to HHS information technology security.	Similar in topics addressed but with much greater funding and broader in scope. Senate bill includes prevention and wellness funding within Public Health and Social Services Emergency Fund: $5.8B total funding for HHS IT security plus wide variety of public health activities, including public health workforce development, epidemiological screening, research, pandemic flu preparedness,	Adopts House provisions. $50M for improvements to HHS information technology security under Public Health and Social Services Emergency Fund.

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
		etc.	
Prevention and Wellness Fund	Also creates Prevention and Wellness Fund of $1B: includes $650M for evidence-based clinical and community-based prevention and wellness strategies that deliver specific, measurable health outcomes that address chronic disease rates; $50M to States to implement healthcare-associated infections reduction strategies; and $300M for CDC immunization program.	No Prevention and Wellness Fund in Senate bill. Similar provisions in Senate bill under Public Health and Social Services Emergency Fund.	$1B for Prevention and Wellness Fund: includes $650M for evidence-based clinical and community-based prevention and wellness strategies that deliver specific, measurable health outcomes that address chronic disease rates; $50M to States to implement healthcare-associated infections reduction strategies; and $300M for CDC immunization program.
Community Health Centers	$1B for "renovation, repair" and "acquisition of HIT systems, providing a 180 day window for health center projects.	$1.87 B for "construction, renovation, and equipment" with funding available until September 30, 2010.	$1.5B for health center infrastructure needs including HIT, to be used for construction, renovation, equipment, and acquisition of HIT. HRSA given discretion to determine actual size of awards and types of eligible projects.
	$500M for "grants to health centers" ($250M available in FY 2009 and the remainder available after Oct. 1, 2009).	No other grants for health centers.	$500M for "grants to health centers authorized under Section 330 of the PHSA."
	Medicaid incentives for HIT adoption	Medicaid incentives for HIT adoption (see previous	Medicaid incentives for HIT Adoption (see previous

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
	(see previous discussion).	discussion).	discussion).
Primary Health Care Workforce	$600M in grants for "training of nurses and primary care physicians and dentists as authorized under Titles VII and VIII of the PHS Act" as well as for National Health Service Corps and Patient Navigator Program.	No provision.	$500M for primary care workforce, of which $300M is allocated to the National Health Service Corps program, with remaining funds for Titles VII and VIII training programs.
Privacy Reforms (including preemption)			
General Approach	HIT Policy Committee and HIT Standards Committee to develop standards, implementation specifications, and certification criteria.	Provision substantially similar.	Follows House and Senate approach.
Application of HIPAA to Business Associates	Applies HIPAA security provisions to business associates, as well as those provisions of the privacy rule that apply to them by virtue of their business associate contracts. Includes application of the civil and criminal penalties to business associates for violating HIPAA	Provision substantially similar.	Follows House and Senate approach.

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
	security and privacy standards.		
Business Associate Contracts Required for certain PHR vendors and other entities	Requires business associate contracts between covered entities and PHR vendors that contract with a covered entity to allow the covered entity to offer a PHR to patients as part of an electronic health record. Also requires business associate contracts between covered entities and Health Information Exchange Organizations, Regional Health Information Organizations, and E-prescribing Gateways.	Provision substantially similar.	Follows House and Senate approach. Provision applies to all entities that provide data transmission of PHI to a covered entity (or its business associate) that require access on a routine basis to such PHI. Provision also applies to all vendors that contract with a covered entity to allow that covered entity to offer a personal health record to patients as part of its electronic health record.
Notification of Breach	Imposes substantial new patient notification procedures in case of a breach of unsecured protected health information that is discovered by a covered entity; covered entity must notify individuals of breach and must notify HHS and the general public in certain cases; business associates must notify covered entity of breach and include the identification of each individual whose information was unlawfully released.	Provision substantially similar.	Follows House and Senate approach. Provision requires Secretary to issue interim final regulations to implement these requirements within 180 days of bill's enactment; provisions in this section apply to breaches discovered at least 30 days after publication of regulations.

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
Definition of Breach	Exempts from the definition of "breach" unintentional acquisition, access, use, or disclosure of PHI.	Provision substantially similar.	Final provision only exempts certain unintentional acquisitions, access, uses, or disclosures of PHI from the definition of breach. "Breach" does not include unintentional acquisition, access, use, or disclosure of PHI by an employee or individual acting under authority of a covered entity or business associate if such actions were in good faith and within the scope of employment of the employee or individual and the information was not further acquired, accessed, used or disclosed by any person. "Breach" also does not include an inadvertent disclosure from an individual otherwise authorized to access PHI at a facility operated by a covered entity or business associate to another similarly situated individual at the same facility and the PHI received is not further acquired, accessed, used, or disclosed without authorization by any person. All other unintentional breaches will still be considered within the definition of "beach."
Temporary Breach Notification Requirement for PHR Vendors and	Requires vendors of PHRs and non-HIPAA entities to notify each individual and the FTC of any breaches of security regarding unsecured PHI that is	Provision substantially similar.	Follows House and Senate approach. Provision requires Secretary to issue interim final regulations within 180 days of enactment. Applies to

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
Other Non-HIPAA entities	contained in a PHR maintained by the vendor or such entity. The FTC is required to notify the Secretary of such breaches. Requirement sunsets when FTC promulgates alternative requirements.		breaches discovered at least 30 days after regulations are published. "Vendor of personal health records'' is defined as an entity, other than a covered entity, that offers or maintains a personal health record. Provision applies to vendors of PHRs; entities that offer products or services through the website of a vendor that offers PHRs; non-covered entities that offer products or services through the websites of covered entities that offer PHRs, or that access or send information in a PHR; and third party service providers used by a vendor or other entity to assist in providing PHR products or services.
Privacy Education Program	Requires the designation of privacy advisors in each HHS regional office to offer guidance and education to covered entities, business associates and individuals on their rights and responsibilities. Also requires HHS's Office of Civil Rights to develop a national educational initiative to enhance public transparency regarding the uses of PHI.	Provision substantially similar.	Follows House and Senate approach.

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
Patient Control Over PHI Disclosures When the Item or Service Has Been Paid Out-of-Pocket in Full	If patient requests that provider not disclose PHI, provider must not disclose if: (1) disclosure is to health plan for payment or health care operation, not for treatment, unless disclosure required by law; and (2) PHI pertains to health care item or treatment for which provider was paid out-of-pocket in full. However, the use, disclosure, or request of deidentified PHI is specifically exempted from this provision.	Provision substantially similar.	Follows House and Senate approach.
Patient Control Over Obtaining and Directing the Transmittal of PHI in an EHR	Requires a covered entity that maintains an EHR containing an individual's PHI to provide to the individual upon request his or her record in an electronic format. Also permits the individual to direct the covered entity to transmit a copy of the record directly to another entity or person.	Provision substantially similar.	Follows House and Senate approach.
Disclosures Restricted to Limited Data Sets/Minimum Necessary	Limits disclosures of protected health information to the limited data set or the minimum necessary to accomplish the intended purpose, while giving the covered entity or business associate the discretion to determine what constitutes	Provision substantially similar.	Follows House and Senate approach. Provision requires the Secretary to issue guidance on what constitutes "minimum necessary" by July 17, 2010.

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
	the minimum necessary disclosure. Exempts de-identified information from the disclosure limits.		
Restrictions on Marketing/Definition of "Health Care Operations"	Exempts from the definition of "health care operations" (thereby requiring patient consent) communications by a covered entity or business associate that encourage recipients of the communication to purchase or use a product or service (*i.e*., marketing cannot be considered a health care operation).	Provision substantially similar.	Follows House and Senate approach.
	Provision in House bill exempts from the marketing restrictions certain communications from pharmacists to patients intended to reduce medical errors or improve patient safety.	Amendment by Senator Harkin clarifies that pharmacies or other entities can contact or market to consumers who have used certain products without violating privacy standards.	Provides that communications are acceptable when the communication describes only a drug or biologic that is currently being prescribed for the recipient of the communication and any payment received by the covered entity in exchange for making the communication is reasonable in amount. (Not specifically limited to pharmacists but limited to communications about a drug or biologic.) In addition, providers may engage in fundraising activities using a patient's PHI, as long as any written fundraising provides an opportunity to opt out of future activities.

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
Accounting of Disclosures	Requires a detailed accounting of disclosures of health information made through HIT systems.	Provision substantially similar.	Follows House and Senate approach by providing that upon request, an individual can receive an accounting of disclosures made by a covered entity or a business associate through HIT systems for the three years prior to the date the accounting is requested. Provision applies to disclosures beginning January 1, 2011 or January 1, 2014, depending on the date of a provider's acquisition of an electronic health record. Secretary is required to issue regulations by July 17, 2010 on what information shall be collected about each disclosure.
Prohibition on Sale of PHI	Prohibits the sale of patients' PHI or use for marketing purposes without their consent.	Provision substantially similar.	Follows House and Senate approach by prohibiting the sale of patients' PHI without authorization, with certain exceptions allowing for remuneration in exchange for PHI for certain public health activities, research, or other activities as specified by the Secretary. Secretary required to issue regulations governing the sale of PHI by July 17, 2010.
De-identified Data	Requires the Secretary, within 18 months of enactment, to promulgate	Provision substantially similar.	No provision in final bill authorizing the Secretary to narrow or clarify the definition of health care

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
	regulations that eliminate from the definition of health care operations those activities that can reasonably and efficiently be accomplished through deidentified information or that should require a valid authorization for use or disclosure; in doing so, the Secretary may narrow or clarify the definition of health care operations.		operations with respect to deidentified information. Act requires that Secretary, in consultation with stakeholders, issue guidance on how best to implement HIPAA's requirements for the de-identification of PHI within 12 months after enactment.
Applicability to PHR Vendors and Other Non-HIPAA Entities	Requires business associate contracts between covered entities and PHR vendors that contract with a covered entity to allow the covered entity to offer a PHR to patients as part of an electronic health record. Also requires business associate contracts between covered entities and Health Information Exchange Organizations, Regional Health Information Organizations, and E-prescribing Gateways.	Provision substantially similar.	Follows House and Senate approach. Provision applies to all entities that provide data transmission of PHI to a covered entity (or its business associate) that require access on a routine basis to such PHI. Provision also applies to all vendors that contract with a covered entity to allow that covered entity to offer a personal health record to patients as part of its electronic health record.
	Requires vendors of PHRs and non-HIPAA entities to notify each individual and the FTC of any breaches of security regarding unsecured PHI that is contained in a PHR maintained by the vendor or such entity. The FTC is	Provision substantially similar.	Follows House and Senate approach. Provision requires Secretary to issue interim final regulations within 180 days of enactment. Applies to breaches discovered at least 30 days after

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
	required to notify the Secretary of such breaches. Requirement sunsets when FTC promulgates alternative requirements.		regulations are published. "Vendor of personal health records'' is defined as an entity, other than a covered entity, that offers or maintains a personal health record. Provision applies to vendors of PHRs; entities that offer products or services through the website of a vendor that offers PHRs; non-covered entities that offer products or services through the websites of covered entities that offer PHRs, or that access or send information in a PHR; and third party service providers used by a vendor or other entity to assist in providing PHR products or services.
Enforcement	Improves HIPAA privacy enforcement, including new enforcement approaches, tiered penalties, and empowerment of state attorneys general to bring civil suits in federal court to recover damages on behalf of states' citizens.	Provision substantially similar.	Follows House and Senate approach. Act amends HIPAA to increase penalties for violations by establishing tiers of penalties based upon the nature and extent of the violation and harm caused. Increased penalties for violations of HIPAA are effective immediately. Effective 24 months after enactment of the Act, violators of the Act are subject to its HIPAA criminal and civil provisions. Secretary is required to impose civil penalties for violations due to willful neglect and to conduct a

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
			formal investigation of any complaint if a preliminary investigation indicates willful neglect. The Act does not prevent OCR from pursuing corrective action without penalty in cases where the person did not know of the violation involved. Act amends HIPAA to permit OCR to pursue investigations against individuals for alleged criminal violations. Act requires that civil monetary penalties or monetary settlements collected with respect to a privacy or security-related HIPAA offense be transferred to OCR for use enforcing the new provisions of the Act and the HIPAA privacy and security rules. Act requires the Comptroller General to submit recommendations to Secretary within 18 months after enactment for giving a percentage of any civil monetary penalties collected to the individuals harmed. Act permits states' attorneys general to bring civil actions in federal court on behalf of the residents of their states who have been adversely affected by violations of HIPAA or the Act to enjoin further violations or to obtain statutory damages on behalf of the residents of the state. These provisions apply to violations occurring after the date of enactment

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
HIPAA Preemption	HIPAA preemption standard preserved, thereby necessitating HIT that can conform not only to national standards but where they exist, more stringent state standards.	Provision substantially similar.	Follows House and Senate approach.
Comparative Effectiveness Research			
Comparative Effectiveness Research	Establishes a Federal Coordinating Council for Comparative Effectiveness Research whose duties are to assist HHS, the VA, DOD and other federal agencies coordinate and conduct comparative effectiveness and related health services research. Members (at least half of whom must be clinicians) drawn from the federal agencies (AHRQ, CMS, NIH, ONCHIT, FDA, VA/Health, DOD/MHS). HHS Secretary chairs. Council to prepare a report by June 30, 2009 that describes comparative effectiveness activities and recommendations for further research. Annual reports required.	Senate bill includes the word "clinical" before every reference to comparative effectiveness research, in attempt to limit use of results in treatment or coverage decisions. Appropriates $1.1B to AHRQ, NIH and HHS to evaluate the relative effectiveness of different health care services and treatment options. $700M to fund immediate studies on the comparative effectiveness of various medical tests and treatments, $400M of which is directed to the Office of the Director of NIH. Additional $400M to be allocated at the discretion of the Secretary of HHS. Secretary to enter in contract with IOM for no more than $1.5M for report to Congress by June 30, 2009 with recommendations on national priorities for comparative clinical effectiveness research.	Follows House and Senate approach but eliminates "clinical" modifier from Senate bill. Funding levels same as Senate bill. Purpose of the Council to reduce duplication of federal comparative effectiveness research activities. Duties are: (1) foster coordination of research conducted; and (2) advise on strategies with respect to the infrastructure needs of comparative effectiveness research. Funding shall be used to (1) conduct or support research to evaluate and compare the clinical outcomes, effectiveness, risk, and benefits of medical treatments and services that address a particular medical condition; and (2) encourage the development and use of clinical registries, clinical data networks, and other forms of electronic health data that can be used to generate or obtain

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
			outcomes data. Subpopulations should be considered when research is conducted or supported with the funds provided. Council may not mandate coverage, reimbursement, or other policies for any public or private payer and its reports are not to be considered mandates.
Medicaid Provisions (Other than HIT Adoption-Related)			
Temporary FMAP Increase	Maintains higher FMAP in states that otherwise would experience declines in FMAP in FY 2009, 2010, or 2011.	Provision substantially similar.	Follows House and Senate approach.
	Provides a general 4.9 percentage point increase for each state during calendar quarters that occur during the "recession adjustment period" (10/1/2008-12/31/2010). Special assistance option for the territories equal to 4.9 percentage points plus a 10% increase in their caps or a 20% increase in their caps. High unemployment states would receive additional assistance.	Across the board increase of 7.6% for all states with same provision for the territories and a smaller unemployment increase. Territories spending caps increased by 15.2%.	Final across the board increase of 6.2% for states and territories. Funding available during quarters falling within the 27-month period beginning 10/1/2008 through 12/31/2010. For states that experience substantial increases in unemployment rates, the Act also includes significant reductions in state matching contributions, ranging from 5.5% to 11.5% additional reductions. The changes in the Medicaid matching rates do not apply to DSH payments or administrative costs.
	Maintenance of effort required and	Payments conditioned on adherence to prompt	Retains both MOE and prompt pay requirements;

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
	applicable to "eligibility standards, methodologies or procedures under [Medicaid] including states operating under §115 waivers.	payment of providers rules.	adds compliance grace period.
Disproportionate Share Hospitals	Increases state DSH allotments in 2009 and 2010.	Similar provision, using a different formulas and longer time period of increased payments.	Adopts the House provision.
Temporary Extension of Work Transition	Would extend the special transitional Medicaid assistance (TMA) through Dec. 31, 2010, for persons who leave welfare for work, providing up to one year of coverage as long as they are employed. Simplifies TMA administration at state option.	No provision.	Adopts the House provision.
Family Planning Services	New state option to provide extended family planning services to low income women otherwise ineligible for Medicaid, without the need for a §1115 waiver.	No provision.	No provision.
Medicaid for the Uninsured and Unemployed	Gives states the temporary option of covering certain unemployed and uninsured persons as well as spouses and dependents: (1) individuals receiving unemployment benefits or who	No provision.	No provision.

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
	have exhausted their benefits; (2) individuals who are receiving food stamps and are otherwise ineligible for Medicaid; and (3) individuals in families with gross incomes below 200% FPL who received or exhausted unemployment benefits between September 1, 2008, and December 31, 2010, or who were involuntarily separated from unemployment during this time period. 100% of costs of benefits and administration to be assumed by federal government during this time period.		
Medicaid Protections for American Indians	Prohibits cost sharing when Medicaid-eligible American Indians receive services from an Indian Health Care provider or contract services provider	No provision.	Adopts the House provision.
	Exempts tribal, religious, spiritual, or cultural property from being counted as assets.	No provision.	Adopts the House provision.
	Requires ongoing consultation between states and tribes on matters related to	No provision.	Adopts the House provision.

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
	Medicaid and CHIP.		
Moratorium on Regulations	Continues until June 30, 2009, the regulatory moratorium on 6 regulations (targeted case management, school based services, provider taxes, public provider cost limits, graduate medical education, and rehabilitative services) that would otherwise expire on March 31, 2009. Latter 3 regulations in proposed form or enjoined by court. New moratorium would also cover hospital outpatient regulations.	No provision.	Adopts the House provision with respect to final regulations (outpatient hospital services, school based services, provider taxes, and targeted case management). Includes sense of Congress resolution to withdraw proposed regulations addressing graduate medical education, cost limits for public providers, and rehabilitative services.
QI Coverage	No provision.	Would extend Medicaid payment of Medicare Part B premium for certain low income Medicare beneficiaries whose incomes slightly exceed that for Qualified Medicare Beneficiaries.	Adopts Senate provision.
Continuation of Health Coverage for the Unemployed (COBRA) Provisions			
Premium Assistance for COBRA Beneficiaries	Reduces COBRA premium payments for assistance eligible individuals in order to maintain health care coverage.	Provision substantially similar.	Follows House and Senate approach with $24.7B in funding.

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
Definition of "Assistance Eligible Individual"	Any qualified beneficiary if: (A) at any time during the period that begins with September 1, 2008, and ends with December 31, 2009, the qualified beneficiary is eligible for COBRA continuation coverage, (B) the qualified beneficiary elects coverage, and (C) the qualifying event is the involuntary termination of the covered employee's employment and occurred during such period.	Provision substantially similar.	Adopts House and Senate provisions, but limits eligibility for premium assistance to individuals with annual incomes below $125,000 (single) or $250,000 (couples).
	As under current law, coverage ends once qualified beneficiary covered by any other group health plan, (other than coverage consisting of only dental, vision, counseling, or referral services [or a combination thereof], coverage under a health reimbursement arrangement or a health flexible spending arrangement, or coverage of treatment that is furnished in an on-site medical facility maintained by the employer and that consists primarily of first-aid services, prevention and wellness care, or similar care [or a combination thereof]) or is eligible for benefits under title XVIII of the Social	Provision substantially similar.	Follows House and Senate approach.

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
	Security Act.		
Short-term Premium Assistance for COBRA Benefits	Qualified beneficiary who elects COBRA only has to pay 35% of required premium; balance of premium subsidized by the entity to which premiums are payable, but that amount is claimed as a credit against the payroll taxes owed by that entity. If the subsidy amounts exceed the payroll taxes due, the Secretary will pay the entity any excess amounts.	Substantially similar, except that qualified beneficiary must pay 50% of required premium.	Adopts House provision.
	Subsidy also available for continuation coverage mandated under state law (e.g., for employees of small employers not otherwise covered by COBRA).	Provision substantially similar.	Follows House and Senate approach.
	Amounts of premium assistance not included in individual's gross income.	Provision substantially similar.	Follows House and Senate approach.
Temporary, Optional Medicaid Coverage	Certain individuals who are within one or more of the categories described below and meet certain requirements and spouses and dependent children under age 19 of those individuals are eligible	No provision.	No provision.

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
	for temporary Medicaid coverage.		
	The categories of individuals include individuals who are receiving unemployment compensation benefits, or who were receiving but have exhausted, unemployment compensation benefits on or after July 1, 2008, individuals who are involuntarily unemployed and were involuntarily separated from employment on or after September 1, 2008, and before January 1, 2011, whose family gross income does not exceed a percentage specified by the State (not to exceed 200 percent) of the FPL applicable to a family of the size involved, and who, but for subsection (a)(10)(A)(ii)(XX), are not eligible for medical assistance under this title or health assistance under title XXI, individuals who are involuntarily unemployed and were involuntarily separated from employment on or after September 1, 2008, and before January 1, 2011, who are members of households participating in the food stamps program, and who, but for subsection (a)(10)(A)(ii)(XX), are not	No provision.	No provision.

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
	eligible for medical assistance under this title or health assistance under title XXI.		
	100% Federal match is provided for states that allow these individuals to enroll in Medicaid during the period in which they are enrolled.	No provision.	No provision.
Duration of Coverage	Maximum of 12 months, followed by unsubsidized coverage for up to 6 additional months.	Maximum of 9 months, followed by unsubsidized coverage for up to 9 additional months.	Adopts Senate provision.
When Subsidy Begins	Subsidy is available for periods of coverage beginning on or after date of enactment.	Substantially similar to House bill, except that if any qualified beneficiaries have already elected and paid the full premium during the 60-day election period for periods when premium assistance are otherwise available for that period, a refund or credit will be given.	Adopts Senate provision.
Special Election Permitted for Those Eligible for Subsidy Who Have Not Elected COBRA Coverage.	Health plans and issuers are required to allow qualified beneficiaries eligible for the subsidy to have a 60-day period to elect COBRA coverage if not previously elected, but coverage is prospective only beginning on date of election.	Substantially similar.	Follows House and Senate approach.

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
Type of Coverage That Can Be Elected	Same as current law (generally can only continue previous coverage; some ability to elect only core coverage).	Any health plan option offered to active employees which has same or lower premium as previous coverage.	Adopts Senate provision.
Notice Required if Qualified Beneficiary No Longer Eligible for Premium Assistance	Qualified beneficiaries who are no longer eligible for premium assistance must notify the group health plan. Timing and content of notice to be prescribed by the Secretary of Labor.	Substantially similar.	Follows House and Senate approach.
	Penalty imposed for failure to notify the group health plan equal to 110 percent of the premium reduction, beginning on the date that eligibility terminates.	Substantially similar.	Follows House and Senate approach.
Extension of COBRA Coverage to Older or Long-Term Employees Who Lose Coverage Due to Termination of Employment or Reduction of Hours	Individuals who are 55 or older or have 10 years of service with an employer (or with 2 or more employers who contribute to the same multiemployer health plan) can elect COBRA coverage if they lose coverage as a result of a qualifying event that consists of termination of employment or reduction of hours. Coverage lasts until qualified beneficiary reaches Medicare eligibility age or is covered under another group health	No provision.	No provision.

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
	plan. Coverage is not subsidized.		
Notice and Reporting Requirements	Group health plans and issuers are subject to a variety of notice requirements.	Substantially similar.	Follows House and Senate approach.
Health Coverage Tax Credit (HCTC) Under the Trade Adjustment Assistance Act (TAA)			
Temporary Modification of the HCTC	No provision.	No provision.	Under the Trade Act of 2002, "eligible individuals" and their qualifying family members are eligible for a refundable tax credit equal to 6% of the health care premium they pay for "qualifying health insurance" during each month they are eligible. This credit is available on an advance basis. Provisions generally expire in 2011.
TAA HCTC Definitions	No provision.	No provision.	"Eligible individuals" include TAA recipients and individuals over 55 receiving pensions from the Pension Benefit Guaranty Corporation (PBGC) as long as the individuals do not have other specified health coverage (such as Medicare, Medicaid or SCHIP, or coverage as an employee under an employer-sponsored health plan where the employer provides at least a 50% subsidy).

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
	No provision.	No provision.	"Qualifying health insurance" includes COBRA continuation coverage, state-based continuation coverage, coverage under a state high risk pool, spousal coverage under an employer-sponsored plan and individual health insurance.
Temporary Increase in Percentage Amount of Credit	No provision.	No provision.	Amount of HCTC temporarily increased to 80% of the premium for eligible individuals and their qualifying family members (effective for first month beginning 60 days after date of enactment). Increased credit amount does not apply to months beginning after December 31, 2010.
Determining 63-day Lapse in Creditable Coverage for Health Insurance Continuation Purposes	No provision.	No provision.	The period between the date of TAA-loss of coverage and 7 days after Secretary of Labor determines TAA eligibility is not counted toward the 63-day period in determining whether there has been a break in coverage. This does not apply to plan years beginning after December 31, 2010.
Continued Qualification of Family Members for HCTC after Certain Events	No provision.	No provision.	Until 2011, family members of eligible individuals who have qualified for COBRA based on the eligible individual becoming entitled to Medicare, divorce or death, certain special rules apply. Qualifying family members are entitled to the HCTC for expenses paid in the 24 months after the eligible individual is eligible

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
			for Medicare. In the case of divorce, qualifying family members are entitled to the credit for expenses paid in the 24 months after the date of divorce. In the case of death, qualifying family members are entitled to the credit for expenses paid in the 24 months after the date of death. In each case, these rules only apply to individuals who were family members immediately before the qualifying event.
Alignment of COBRA Coverage with TAA – Maximum Period of COBRA Coverage	No provision.	No provision.	Until 2011, for individuals who qualify for COBRA based on termination of employment or reduction in hours and whose pensions are paid by PBGC, the maximum period of COBRA coverage ends on the date of death of the covered employee (or if the surviving spouse or dependent children of covered employee, maximum period of coverage ends not earlier than 24 months after the date of death of covered employee).
Expansion of definition of "qualified health insurance" eligible for the HCTC	No provision.	No provision.	Until 2011, qualified health insurance includes coverage under a VEBA (voluntary employees' beneficiary association) that is established pursuant to a bankruptcy court order (including under section 1114 of the Bankruptcy Code).
GAO Study	No provision.	No provision.	No later than March 31, 2010, the GAO must submit to Congress an analysis of (1) administrative costs to

Issue	House Bill (H.R.1)	Senate Amendments to H.R.1	American Recovery and Reinvestment Act of 2009
			Federal government of advance payment of refundable tax credit and the administrative costs to providers of qualified health insurance; (2) health status and relative risk of those receiving the HCTC; (3) participation rate of those eligible for HCTC; and (4) extent to which those eligible for HCTC obtained non-qualifying insurance or went without insurance.