

COMPARE Side-by-Side Comparison of Major Congressional Health Care Reform Proposals
(updated as of July 17, 2009)

Policy Option	Senate HELP Committee	Senate Finance Committee	House Tri-Committee
Status	The <i>Affordable Health Choices Act</i> was reported out of Committee on July 15, 2009.	<i>Health Care Reform: Draft Proposal</i> was made public on 6/19/09.	<i>America's Affordable Health Choices Act</i> (H.R. 3200) was introduced on July 14, 2009.
Summary	Establishes new health insurance market regulatory standards. Authorizes the establishment of a purchasing pool mechanism (Gateway) in each state, and authorizes the implementation of a public health insurance plan to be offered within the Gateway and subject to the same regulatory conditions as qualifying private plans. Provides sliding scale premium credits for individuals with incomes up to 400% FPL. Provides a tax credit to small business to subsidize coverage. Requires individuals to purchase health insurance that meets minimum standards. Requires employers (excluding certain small employers) who do not offer health coverage to employees to pay a fee. Creates a temporary reinsurance program to provide reimbursement to employers who provide health benefits to retirees and their dependents who live in states without established Gateways. Calls	Provisions of the draft proposal would reform the small and non-group market for health insurance in the states; create four benefit categories (bronze, silver, gold, platinum), with bronze as minimum creditable coverage, and require insurers to offer coverage in at least the silver and gold categories; permit value-based insurance design; permit states to establish self-sustaining state-based insurance exchanges; subsidize the purchase of health insurance with individual and small business tax credits; possibly create non-profit Consumer-Owned and Operated Plans (CO-OP) in lieu of access to a public option; mandate individuals to have coverage that meets minimum standards; possibly provide for "free rider" or "anti-crowd-out" provisions with respect to employers in lieu of an employer	Establishes new health insurance market standards and rules. Provides for additional consumer protections. Establishes a Health Insurance Exchange to encourage risk pooling and to facilitate the offering of qualified health insurance choices. Establishes minimum benefit package standards for all health plans and benefit requirements for qualified health plans participating in the Exchange. Creates a public option to be offered within the Exchange that would be subject to all regulations and standards applicable to private health insurance plans. Creates sliding scale affordability tax credits for individuals with incomes up to 400% FPL. Imposes a tax penalty on individuals without acceptable health care coverage (with certain exceptions). Requires employers who do not offer insurance to their

	<p>for establishing standards to ensure efficient use of health information technology for enrollment in qualified health plans. Creates a new national insurance program to help adults who have or develop functional impairments. Directs the Secretary of HHS to establish a national strategy and support infrastructure necessary to improve the quality of the U.S. health care system. Calls for the establishing an enhanced national strategy to prevent disease, promote health, and build the public health system, health promotion campaigns, and identification and promotion of disease prevention best practices. Calls for establishing programs intended to improve access to clinical preventive services for vulnerable populations. Provides supports for enhancing and increasing the supply of a qualified health care workforce (through enhanced workforce education and training and providing support to the existing health care workforce). Authorizes and provides for the enhanced implementation of activities and regulatory standards intended to combat health care fraud and abuse.</p>	<p>mandate; expand Medicaid eligibility; provide tax incentives for small business workplace wellness programs; establish Medicare personalized prevention plans; align Medicare coverage for preventive services with scientific evidence; create incentives in Medicare and Medicaid programs to encourage healthy behavior; give states the option to develop medical homes and improve care coordination and transitional care benefits within Medicaid programs; and require Medicaid coverage for tobacco cessation for pregnant women.</p>	<p>employees to pay a fee equal to 8 percent of employee wages (certain small employers are exempt). Provides for a sliding scale tax credit to small employers. Reforms Medicare payment rates for certain providers, and includes certain incentive payments to specified providers. Reforms Medicare Advantage plans to encourage quality improvement and cost reduction. Eliminates the Medicare Part D “donut hole” and makes other improvements to the Medicare program. Establishes an Accountable Care Organization (ACO) pilot program. Establishes a medical home pilot program in Medicare and Medicaid. Encourages the implementation of post-acute bundled payments and authorizes the Secretary to expand the existing Medicare Acute Care Episode demonstration. Improves Medicare payment rates for primary care providers. Extends certain Medicare coverage of preventive and mental health services. Establishes a Center for Comparative Effectiveness Research and a public/private stakeholder commission (the Comparative Effectiveness</p>
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<p>Individual Mandate</p>	<p>Individuals will be required to have health coverage that meets minimum standards and to report such coverage annually. Exemptions will be made for individuals unable to access affordable coverage. Coverage is determined to be unaffordable if the premium paid by the individual is greater than 12.5 percent of adjusted gross income. The minimum penalty will be no more than \$750 per year. Individuals deemed to lack availability to affordable coverage, Native Americans, individuals living in states where Gateways are not operational, and individuals without coverage for fewer than 90 days are exempt from the mandate and penalty.</p>	<p>All individuals are required to obtain health insurance coverage. There will be religious exemptions and exemptions for undocumented workers. The fine for non-compliance will be based on a percentage of the average cost of the lowest cost option available. Exemptions from the fine will be provided if coverage is unaffordable (the lowest cost premium exceeds 15% of income). There will also be exemptions for hardship, individuals below 100% FPL, and Native Americans. There will be a state option for auto enrollment. There will be mandatory enrollment for employers with more than 200 employees.</p>	<p>Imposes a tax equal to 2.5 percent of modified adjusted gross income above a specified income level on individuals without acceptable health care coverage. Acceptable coverage includes grandfathered individual and employer coverage, certain government coverage (e.g., Medicare, Medicaid, coverage provided to veterans, military employees, retirees, and their families), and coverage obtained pursuant to the Exchange or an employer offer of coverage. Authorizes the Department of Treasury and the Exchange to establish a hardship exemption from the additional tax. Provides exceptions depending on residency status and a religious exemption.</p>
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<p>Employer Mandate</p>	<p>Employers with more than 25 employees that do not offer qualifying coverage (or that pay less than 60 percent of their employees' monthly premiums) are subject to a \$750 annual fee per uninsured full-time employee and \$375 per uninsured part-time employee. For employers subject to the assessment, the first 25 workers will be exempted. Beginning in 2013, the penalty amounts will be adjusted using the Consumer Price Index for urban consumers. Employers with 25 or fewer employees are exempt from penalties and are eligible for program credits.</p>	<p>Employer responsibility is listed as an "open issue." In lieu of an employer mandate, the draft includes a "free rider" or "anti-crowd-out" approach – which would require employers to contribute 50% of the national average Medicaid costs for workers enrolled in Medicaid or 100% of the cost of the tax credit for workers receiving tax credits. Workers can only leave employer-sponsored coverage for the Exchange if the coverage offered is unaffordable (exceeding 12.5% of income). Medicaid-eligible employees can leave employer-sponsored coverage for Medicaid but the employer will have to contribute unless the coverage the employer was offering was unaffordable.</p> <p><i>The draft also includes a table with alternatives for an employer mandate:</i></p> <p><i>Option #1: Covering firms with more than 25 employees, qualified coverage equal to minimum creditable coverage; 50% premium contribution; non-offering firm pays penalty of \$2,400 per worker;</i></p>	<p>Requires employers to offer all of its employees the option of selecting individual or family health coverage. Provides that the minimum employer contribution in the case of an offering employer is 72.5 percent of the premium for individual coverage, and 65 percent of the premium for family coverage - or a proportional amount for non-fulltime employees. Family coverage for this purpose includes the employee's spouse and qualifying children. Requires an offering employer to contribute 8 percent of an employee's wages to the Exchange for each employee who declines the employer's coverage offer and obtains an affordability credit for coverage through the Exchange. Provides exemptions for certain small employers. Authorizes the creation of rules that would prohibit employers from engaging in practices that steer employees away from employer-offered coverage and into coverage offered under the Exchange.</p>
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treatment of subsidy eligible workers – firewall.

Option #2: Covering firms with more than 100 employees; qualified coverage equal to HIPAA creditable coverage; 50% premium contribution; non-offering firms face linear phase-up penalty starting at 1% of payroll for firms with more than \$750,000 in total annual payroll up to 11% for firms with \$10 million payroll; treatment of subsidy-eligible workers – firewall.

Option #3: Covering firms with more than 200 employees; qualified coverage equal to HIPAA creditable coverage; contribution N/A; penalty – non-offering firm pays \$295 per employee; treatment of subsidy-eligible workers – firewall for employees in firms over 200 employees – with partial firewall for firms below 200 employees (applies to FTE, affordability standard based on 12.5% of base salary for single coverage).

<p>Purchasing Pools</p>	<p>Authorizes the implementation of an Affordable Health Benefit Gateway in each state, established either by the state or by the Secretary of HHS, and that will be administered through a governmental agency or non-profit organization. Notwithstanding the establishment of Gateways, licensed health insurers will be able to sell - and any resident will be able to purchase - health insurance policies outside of the Gateway, including policies that do not meet standards to be a Gateway qualified health plan. States will regulate health insurance sold outside the Gateway.</p> <p>Risk pools within the Gateways will include all enrollees in an individual plan, a group health plan, or the newly established public health insurance plan that is offered through the Gateway. The Gateway will establish procedures to qualify interested insurers to offer policies through the Gateway. The Gateways will use risk adjustment mechanisms to remove incentives for plans to avoid offering coverage to those with serious health needs. Planning grants will be provided to each state to support the creation of state Gateways, but Gateways must become financially</p>	<p>State-based Exchanges will facilitate enrollment for individuals and small groups; provide standardized enrollment application, provide a format for insurance options and marketing; and provide call center support and customer service. There will be an option for states to contemplate multiple, competing Exchanges after 5 years if approved by the Secretary of HHS. Exchanges must be self-sustaining.</p>	<p>Establishes a Health Insurance Exchange under the purview of the Health Choices Administration – an independent executive branch agency to be headed by the Health Choices Commissioner – that will facilitate the offering of health insurance choices. The Commissioner carries out functions including: establishment of qualified plan standards and benefit levels, the establishment and operation of the Health Insurance Exchange, the administration of affordability credits, and additional functions. The Health Choices Commissioner must establish a process through which to obtain bids, negotiate and enter into contracts with qualified plans, and ensure that the different levels of benefits are offered with appropriate oversight and enforcement. The Commissioner also facilitates outreach and enrollment, creates and operates a risk pooling mechanism, and ensures consumer protections.</p> <p>Permits states to offer their own health Exchange or join with a group of states to create their own exchange, in lieu of the federal</p>
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	<p>self-sustaining through establishing a surcharge on participating health plans. The Gateway will establish procedures to qualify health plans to be offered through them, develop tools to enable consumers to obtain coverage, establish open enrollment periods, and assist consumers in the purchase of long term services and supports. The Secretary shall establish the essential health care benefit design.</p> <p>States will have three options with regard to Gateways: (1) proactively launching a Gateway; (2) requesting that the Secretary establish an initial Gateway once all necessary insurance market reforms have been enacted; or (3) not act to conform to the new requirements. If a state does not act to form a Gateway, the Secretary shall establish and operate a Gateway in the state after a period of six years. Until a state becomes either an establishing or participating state, the residents of that state will not be eligible for premium credits, an expanded Medicaid match, or small business credits. States may form regional Gateways operating in more than one state; states may establish subsidiary regional Gateways, as long as each Gateway serves a distinct region.</p>		<p>Exchange. Allows states to require the application of state benefit mandates to all Exchange participating plans, but only if the state agrees to reimburse the Commissioner for any additional costs of affordability credits in that state due to the state benefit requirements.</p> <p>Defines who is eligible for participation in the Exchange. In Year 1, individuals not enrolled in other acceptable coverage and small employers with 10 or fewer employees are allowed into the Exchange. In Year 2, employers with 20 and fewer employees are allowed into the Exchange. In subsequent years, the Health Choices Commissioner is granted authority to expand employer participation as appropriate, with the goal of allowing all employers access to the Exchange.</p> <p>During the first four years of the Exchange, Medicaid-eligible individuals would generally be enrolled in Medicaid, not the Exchange. An exception is made for childless adults with incomes under 133% FPL who had other</p>
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	<p>States will receive federal support to contract with private and public entities to act as health coverage “navigators” to assist employers, workers, and self-employed individuals seeking to obtain coverage through Gateways.</p> <p>The Secretary will establish a public health insurance option (the Community Health Insurance Plan) that must comply with the same health plan requirements as private health insurance plans. The Secretary shall contract with qualified nonprofit entities to administer the Community Health Insurance Plan in the same manner as Medicare program contracting. After receiving an initial loan for start-up expenses, the Community Health Insurance Plan will be subject to a federal solvency standard. Plan premiums must be sufficient to cover the plan’s cost. There are no requirements that health care providers participate in the public plan or that individuals join the plan. The Secretary shall negotiate rates for provider reimbursement and rates shall not be higher than the average of all Gateway reimbursement rates.</p>	<p>qualifying coverage within the previous six months. Beginning with Year 5, any Medicaid eligible individual will be able to choose between Medicaid or the Exchange, with their state Medicaid program ensuring the provision of wrap-around benefits.</p> <p>Requires each participating health plan to provide one <i>basic</i> plan in each service area in which they operate. It is then optional for the plan to offer one <i>enhanced</i> and one <i>premium</i> plan, which may vary the level of cost sharing (not to exceed plus or minus 10 percent with regard to each benefit category). Allows a fourth tier, <i>premium-plus</i> plan, which allows plans to offer extra benefits. Requires plans be licensed in the state in which they plan to do business, abide by data reporting requirements, provide for the implementation of affordability credits, and additional requirements.</p> <p>Requires the Secretary of HHS to develop a public health insurance option to be offered as a plan choice with the Exchange, starting</p>
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<p>Refundable Tax Credits</p>	<p>Establishes premium credits to support the purchase of private health insurance through the Gateway. Credits will be provided on a sliding scale to individuals with incomes up to 400% FPL. Individuals may allow the Gateway to use IRS information to determine eligibility. New tax credits will be available to cover a portion of employee insurance costs. If a state has not yet established a Gateway, individuals within that state are not eligible for tax credits.</p> <p>To account for regional premium variations, credits will be based on a reference premium. The reference premium will be calculated based on the average premiums of the three lowest cost qualified plans offered in each area. Premiums will be risk adjusted (for variations in patient characteristics or risk factors). States are permitted to make payments for individuals that exceed required amounts or to defray costs of services in addition to the essential benefits package.</p>	<p>Tax credits for individuals and families up to 300% FPL to help offset the cost of private insurance premiums. Tax credit for premiums tied to the “silver” benefit plan and cost sharing subsidy also provided to reduce out-of-pocket expenses on services.</p>	<p>Creates sliding scale affordability credits for individuals with incomes up to 400% FPL. These credits apply only to Exchange-participating plans. In general, before Year 5, employees who are offered employer coverage are ineligible for affordability credits within the Exchange. Beginning in Year 2, employees who meet an affordability test showing that coverage under their employer-provided plan would cost more than 10% of income, are eligible to obtain income-based affordability credits in the Exchange. Starting in Year 5, employees of any income can choose to decline their employer-sponsored coverage and enter the Exchange and, if eligible, obtain affordability credits. The affordable premium amount is calculated on a sliding scale starting at 1% of income for those at or below 133% FPL and phasing out at 10% of income for those at 400% FPL. The reference premium is the average premium for the three lowest cost basic plans in the area in which the individual resides. The affordability cost sharing credit reduces cost sharing for</p>
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Medicaid Expansion	The Act assumes that Medicaid eligibility will be expanded (up to 150 percent of FPL) but this provision is within the jurisdiction of the Finance Committee.	Medicaid eligibility will be expanded to cover children and pregnant women at or below 133% of FPL and parents and childless adults at or below 100% FPL. Coverage will be phased in for parents and childless adults based on the following – 50% of FPL in 2010; 75% FPL in 2011; and 100% FPL in 2012. There will be a temporary increase in federal funding for expansion populations for five years and then funding will phase down to the regular state match.	Requires State Medicaid programs to cover non-disabled, childless adults under age 65 with income at or below 133% FPL, parents and individuals with disabilities under age 65 with income at or below 133% FPL, and newborns during the first year of life who do not otherwise have acceptable coverage upon birth. The federal government would pay 100% of the costs of Medicaid coverage for individuals in these categories. Each of these requirements would become effective in 2013. Allows State Medicaid programs to cover individuals with HIV with incomes and resources below state eligibility levels for individuals with disabilities. The costs of coverage of such individuals would be matched at an enhanced rate.
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