



Comparison of the Three Major Health Care Reform Bills in Congress

Issue	Senate Finance	Senate HELP	House Tri-Comm Bill
<p>Employer requirements</p>	<p>Assess employers with more than 50 employees that do not offer coverage a fee for each employee who receives a tax credit for health insurance through an exchange. The penalty is the lesser of a flat dollar amount equal to the average national tax credit for each full-time employee receiving a tax credit or \$400 times the total number of fulltime employees in the firm. Exempt employers with 50 or fewer employees from the penalty. Require employers with 200 or more employees to automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of coverage if they have coverage from another source.</p>	<p>Require employers to offer health coverage to their employees and contribute at least 60% of the premium cost or pay \$750 for each uninsured full-time employee and \$375 for each uninsured part-time employee who is not offered coverage. For employers subject to the assessment, the first 25 workers are exempted. Exempt employers with 25 or fewer employees from the requirement to provide coverage.</p>	<p>Require employers to offer coverage to their employees and contribute at least 72.5% of the premium cost for single coverage and 65% of the premium cost for family coverage of the lowest cost plan that meets the essential benefits package requirements or pay 8% of payroll into the Health Insurance Exchange Trust Fund. [E&L Committee amendment: Provide hardship exemptions for employers that would be negatively affected by job losses as a result of requirement.] Eliminate or reduce the pay or play assessment for small employers with annual payroll of less than \$400,000: – Annual payroll less than \$250,000: exempt – Annual payroll between \$250,000 and \$300,000: 2% of payroll; – Annual payroll between \$300,000 and \$350,000: 4% of payroll; – Annual payroll between \$350,000 and \$400,000: 6% of payroll. [E&C Committee amendment: Extend the reduction in the pay or play assessment for small employers with annual payroll of less than \$750,000 and replace the above schedule with the following: – Annual payroll less than \$500,000: exempt – Annual payroll between \$500,000 and \$585,000: 2% of payroll;</p>

			<ul style="list-style-type: none"> – Annual payroll between \$585,000 and \$670,000: 4% of payroll; – Annual payroll between \$670,000 and \$750,000: 6% of payroll.] <p>Require employers that offer coverage to automatically enroll into the employer’s lowest cost premium plan any individual who does not elect coverage under the employer plan or does not opt out of such coverage.</p>
<p>Premium subsidies to employers</p>	<p>Provide small employers with fewer than 25 employees and average annual wages of less than \$40,000 that purchase health insurance for employees with a tax credit.</p> <p>Phase I: For tax years 2011 and 2012, provide a tax credit of up to 35% of the employer’s contribution toward the employee’s health insurance premium if the employer contributes at least 50% of the total premium cost or 50% of a benchmark premium. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than \$20,000. Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 25% of the employer’s contribution toward the employee’s health insurance premium.</p> <p>Phase II: For tax years 2013 and later, for eligible small businesses that purchase coverage through the state exchange, provide a tax credit of up to 50% of the employer’s contribution toward the employee’s health insurance premium if the employer contributes at least 50% of the total premium cost or 50% of a benchmark premium. The credit will be available for two years. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than \$20,000. Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 35% of the employer’s contribution toward the employee’s health insurance premium.</p> <p>Create a temporary reinsurance program for employers providing health insurance coverage to retirees ages 55 to 64. Program will reimburse employers or insurers for 80% of retiree claims between \$15,000 and \$90,000. Appropriate \$5 billion to finance the program.</p>	<p>Provide qualifying small employers with a health options program credit. To qualify for the credit, employers must have fewer than 50 full-time employees, pay an average wage of less than \$50,000, and must pay at least 60% of employee health expenses.</p> <p>The credit is equal to \$1,000 for each employee with single coverage and \$2,000 for each employee with family coverage, adjusted for firm size (phasing out as firm size increases) and number of months of coverage provided. Bonus payments are given for each additional 10% of employee health expenses above 60% paid by the employer. Employers may not receive the credit for more than three consecutive years. Self-employed individuals who do not receive premium credits for purchasing coverage through the Gateway are eligible for the credit.</p> <p>Create a temporary reinsurance program for employers providing health insurance coverage to retirees ages 55 to 64. Program will reimburse employers for 80% of retiree claims between \$15,000 and</p>	<p>Provide small employers with fewer than 25 employees and average wages of less than \$40,000 with a health coverage tax credit. The full credit of 50% of premium costs paid by employers is available to employers with 10 or fewer employees and average annual wages of \$20,000 or less. The credit phases-out as firm size and average wage increases and is not permitted for employees earning more than \$80,000 per year.</p> <p>Create a temporary reinsurance program for employers providing health insurance coverage to retirees ages 55 to 64. Program will reimburse employers for 80% of retiree claims between \$15,000 and \$90,000. Payments from the reinsurance program will be used to lower the costs for enrollees in the employer plan. Appropriate \$10 billion over ten years for the reinsurance program.</p>

		<p>\$90,000. Program will end when the state Gateway is established. Payments from the reinsurance program will be used to lower costs for enrollees in the employer plan.</p>	
<p>Tax changes related to health insurance</p>	<p>Impose a tax on individuals without qualifying coverage of \$750 per adult per year to be phased-in beginning in 2014. Impose an excise tax in 2013 on insurers of employer-sponsored health plans with aggregate values that exceed \$8,000 for individual coverage and \$21,000 for family coverage (these threshold values will be indexed to the consumer price index for urban consumers (CPI-U) plus 1%). The threshold amounts will be increased for retired individuals age 55 and up and for employees engaged in high-risk professions by \$1,850 for individual coverage and \$5,000 for family coverage.</p> <p>In the 17 states with the highest health care costs, the threshold amount is increased by 20% initially; this premium increase is subsequently reduced by half each year until it is phased out in 2015.</p> <p>The tax is equal to 40% of the value of the plan that exceeds the threshold amounts and is imposed on the issuer of the health insurance policy, which in the case of a self-insured plan is the plan administrator or, in some cases, the employer. The aggregate value of the health insurance plan includes reimbursements under a flexible spending account for medical expenses (health FSA) or health reimbursement arrangement (HRA), employer contributions to a health savings account (HSA), and coverage for dental, vision, and other supplementary health insurance coverage.</p> <p>Conform the definition of medical expenses for purposes of employer provided health coverage (including HRAs and health FSAs), HSAs, and Archer medical savings accounts to the definition for purposes of the itemized deduction for medical expenses. This change will exclude the costs for over-the counter drugs not prescribed by a doctor from being reimbursed through an HRA or health FSA and from being reimbursed on a tax-free basis through an HSA or Archer MSA.</p> <p>Increase the tax on distributions from a health savings account that are not used for qualified medical</p>	<p>Impose a minimum tax on individuals without qualifying health care coverage of \$750 per individual per year (maximum family penalty of 4 times the individual penalty).</p>	<p>Impose a tax on individuals without acceptable health care coverage of 2.5% of modified adjusted gross income.</p>

	<p>expenses to 20% (from 10%) of the disbursed amount. Limit the amount of contributions to a flexible spending account for medical expenses to \$2,500 per year. Increase the threshold for the itemized deduction for unreimbursed medical expenses from 7.5% of adjusted gross income to 10% of adjusted gross income for regular tax purposes. Individuals age 65 and older are exempt from the increased threshold. Impose new fees on segments of the health care sector:</p> <ul style="list-style-type: none"> – \$2.3 billion annual fee on the pharmaceutical manufacturing sector; – \$4 billion annual fee on the medical device manufacturing sector; and – \$6.7 billion annual fee on the health insurance sector. 		
<p>Creation of insurance pooling mechanisms</p>	<p>Create state-based exchanges for the individual market and small business health options program (SHOP) exchanges for the small group market. Allow small businesses with up to 100 employees to purchase coverage through the SHOP exchanges beginning in 2015 and permit states to allow businesses with more than 100 employees to purchase coverage in the SHOP exchange beginning in 2017. Create the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of non-profit, member-run health insurance companies in all 50 states and District of Columbia. To be eligible to receive funds, organizations must not be an existing organization, substantially all of its activities must consist of the issuance of qualified health benefit plans in each state in which it is licensed, governance of the organization must be subject to a majority vote of its members, must operate with a strong consumer focus, and any profits must be used to lower premiums, improve benefits, or improve the quality of health care delivered to its members. Require CO-OPs to meet the same requirements as private insurance plans in the exchanges related to solvency, licensure, provider payments, network adequacy, and any applicable state premium assessments. Require all state-licensed insurers in the individual and small group markets to participate in the exchanges.</p>	<p>Create state-based American Health Benefit Gateways, administered by a governmental agency or non-profit organization, through which individuals and small employers can purchase qualified coverage. States may form regional Gateways or allow more than one Gateway to operate in a state as long as each Gateway serves a distinct geographic area.</p>	<p>Create a National Health Insurance Exchange, through which individuals and employers (phasing-in eligibility for employers starting with smallest employers) can purchase qualified insurance, including from private health plans and the public health insurance option. Create a new public health insurance option to be offered through the Health Insurance Exchange that must meet the same requirements as private plans regarding benefit levels, provider networks, consumer protections, and cost-sharing. Require the public plan to offer basic, enhanced, and premium plans, and permit it to offer premium plus plans. Finance the costs of the public plan through revenues from premiums. For the first three years, set provider payment rates in the public plan at Medicare rates and allow bonus payments of 5% for providers that participate in both Medicare and the public plan and for pediatricians and other providers that don't typically participate in Medicare. In subsequent years, permit the</p>

	Require guarantee issue and renewability and allow rating variation based only on age (limited to 4 to 1 ratio), tobacco use (limited to 1.5. to 1 ratio), family composition, and geography in the non-group and the small group market (new rules for small group market will be phased in over five years). Require risk adjustment in the individual and small group markets and prohibit insurers from rescinding coverage.		Secretary to establish a process for setting rates. [E&C Committee amendment: Require the public health insurance option to negotiate rates with providers so that the rates are not lower than Medicare rates and not higher than the average rates paid by other qualified health benefit plan offering entities.] Health care providers participating in Medicare are considered participating providers in the public plan unless they opt out.
Levels of Coverage	<p>Create four benefit categories of plans plus a separate “young invincible plan” to be offered through the exchange, and in the individual and small group markets:</p> <ul style="list-style-type: none"> – Bronze plan represents minimum creditable coverage and would cover 65% of the benefit costs of the plan, with an out-of-pocket limit equal to the Health Savings Account (HSA) current law limit (\$5,950 for individuals and \$11,900 for families in 2010); – Silver plan includes minimum benefits, covers 70% of the benefit costs of the plan, with the HSA out-of-pocket limits; – Gold plan includes the minimum benefits, covers 80% of the benefit costs of the plan, with the HSA out-of-pocket limits; – Platinum plan includes the minimum benefits, covers 90% of the benefit costs of the plan, with the HSA out-of-pocket limits; – Young Invincible plan available to those 25 years old and younger and provides catastrophic coverage only with the coverage level set at the HSA current law levels except that prevention benefits would be exempt from the deductible. 	<p>Create three benefit tiers of plans to be offered through the Gateways based on the percentage of allowed benefit costs covered by the plan:</p> <ul style="list-style-type: none"> – Tier 1: includes the essential health benefits, covers 76% of the benefit costs of the plan, and limits out-of-pocket costs to the Health Savings Account (HSA) current law limit (\$5,950 for individuals and \$11,900 for families in 2010); – Tier 2: includes the essential health benefits, covers 84% of the benefit costs of the plan, and limits out-of-pocket costs to 50% of the HSA limit (\$2,975 for individuals and \$5,950 for families); and – Tier 3: includes the essential health benefits, covers 93% of the benefit costs of the plan, and limits out-of-pocket costs to 20% of the HSA limit (\$1,190 for individuals and \$2,380 for families). 	<p>Create four benefit categories of plans to be offered through the Exchange:</p> <ul style="list-style-type: none"> – Basic plan includes essential benefits package and covers 70% of the benefit costs of the plan; – Enhanced plan includes essential benefits package, reduced cost sharing compared to the basic plan, and covers 85% of benefit costs of the plan; – Premium plan includes essential benefits package with reduced cost sharing compared to the enhanced plan and covers 95% of the benefit costs of the plan; – Premium plus plan is a premium plan that provides additional benefits, such as oral health and vision care.
Select Financing Provisions (tentative expectations)	The Congressional Budget Office estimated the cost of the revised Finance Committee bill at \$829 billion over ten years, projecting the bill will reduce the federal deficit by \$81 billion over ten years. These costs are financed through a combination of savings from Medicare and Medicaid and new taxes and fees. The primary sources of Medicare and Medicaid savings include incorporating productivity	The Congressional Budget Office estimates this proposal will cost \$645 billion over 10 years. Because the Senate HELP Committee does not have jurisdiction over the Medicare and Medicaid programs or revenue raising authority,	The Congressional Budget Office estimates the net cost of the proposal (less payments from employers and uninsured individuals) to be \$1.042 trillion over ten years. Approximately half of the cost of the plan is financed through savings from Medicare and Medicaid, including

	<p>improvements into Medicare market basket updates, reducing payments to Medicare Advantage plans, creating the Medicare Commission charged with finding savings in the program, changing the Medicaid drug rebate provisions, and cutting Medicaid and Medicare DSH payments. The largest source of new revenue will come from an excise tax on high cost insurance—insurance plans that exceed \$8,000 for single coverage and \$21,000 for family coverage—which CBO estimates will raise \$215 billion over ten years. The threshold values for high cost plans are indexed to the CPI-U, which typically increases at a lower rate than health insurance premiums, so it is expected that this tax will raise more money over time. CBO estimates the proposal will reduce the deficit by \$49 billion over ten years. The modified Chairman’s Mark of the America’s Healthy Future Act of 2009, released on September 22, 2009, will use \$28 billion of the existing \$49 billion surplus to offset the costs of the changes.</p>	<p>mechanisms for financing the proposal will be developed in conjunction with the Senate Finance Committee.</p>	<p>incorporating productivity improvements into Medicare market basket updates, reducing payments to Medicare Advantage plans, changing drug rebate provisions, reducing potentially preventable hospital readmissions, and cutting Medicaid DSH payments. The remaining costs are financed through a surcharge imposed on families with incomes above \$350,000 and individuals with incomes above \$280,000. The surcharge is equal to 1% for families with modified adjusted gross income between \$350,000 and \$500,000; 1.5% for families with modified adjusted gross income between \$500,000 and \$1,000,000; and 5.4% for families with modified adjusted gross income greater than \$1,000,000. These surcharge percentages may be adjusted if federal health reform achieves greater than expected savings.</p>
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Sources: Kaiser Foundation; House Education and Labor (E&L), Ways and Means (W&M), Energy and Commerce (E&C)Committees; Senate Finance and Health, Education, Labor, and Pensions (HELP) Committees

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