

Congressional Health Reform Proposals

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	House: America's Affordable Health Choices Act of 2009 (HR 3962)	Senate: Patient Protection and Affordable Care Act (HR 3590)
Individual Mandate	Included	Included
Changes in Tax policy	Mandate enforced through 2.5% tax penalty on adjusted gross income (over \$9350 for an individual and \$18,700 for couples) up to cost of average national premium, with exemptions based on religion or hardship	Mandate enforced through phased in penalty starting at \$95 in 2014, \$350 in 2015 and \$750 in 2016, with exemptions for financial hardship or religious objections
Individual premium subsidies	Sliding scale refundable tax credits up to 400% FPL (\$88,000+ for a family of four) with contributions on both premiums and cost-sharing	Sliding scale tax credits for individuals and families up to 400% FPL (\$88,000+ for a family of four) who are not offered affordable employer-provided coverage
Employer Requirements	Pay or play: 72.5% of premium cost for single and 65% for family OR pay 8% of payroll into Health Insurance Exchange Trust fund (small business exemption: first \$500,000 in salary, incremental increases in payroll tax between \$50,000 and \$75,000)	Mandate for employers of 200+. Pay or play with fee requirement (capped at \$750 per employee) for employers with 50+ employees whose employees receive tax credits through the Exchange (small business exemption for employers of less than 50 employees)
Employer premium subsidies	Sliding scale tax credits to employers with fewer than 25 employees and average wages less than \$40,000 for up to 50% of their premium costs. Temporary reinsurance program for employers providing coverage to retirees 55 to 64 from 2013 to 2015	Sliding scale tax credits to employers with fewer than 25 employees and average wages less than \$40,000 for up to 50% of their premium costs. Temporary reinsurance program for employers providing coverage to retirees 55 to 64 until the end of 2013

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Purchasing Pools for Individuals, Small Employers and the Uninsured	National Health Insurance Exchange with risk adjustment and options for states to form their own; open to individuals and small employers (25 employees in year 1, 50 in year 2 and 100 in year 3), immediate funding for state high risk pools	Individual and small group State Health Insurance Exchanges, open to small employers (50 employees in year 1, 100 at state option), immediate funding for state high risk pools
New Public Plan Option	Yes, but only through the Exchange, requires that costs of plan be financed fully through premium revenues. Payment rates to providers are negotiated, Medicare providers are considered participating in plan unless they opt out. Start-up funding for non-profit co-ops, formed state by state	Yes, public plan at negotiated rates with option for states to opt out. Federal start-up funding for Consumer Operated and Oriented Plans (CO-OP, with minimum one co-op per state
Medicaid Expansion and Reform	To 150% FPL for all individuals (\$16,245 for an individual) with full federal funding of expansion eligibles for first two years and 91% of their costs after 2 years, CHIP (Child Health Insurance Program) children required to obtain coverage through Exchange	To all individuals up to 133% FPL with full federal funding of expansion eligibles for first three years and an average of 90% of their costs after 3 years, CHIP eligibility extends to 250% FPL and states’ FMAP (federal matching) increased from an average of 70% to 93% in 2014 for CHIP kids
Medicare Reform	Modify payment rates to include efficiency incentives, reduce payments to hospitals with excessive readmissions, bundle payments for post acute care, phase Medicare Advantage payments down to Medicare rates, eliminate doughnut hole for seniors, negotiate for lower drug prices in Medicare Part D	Immediate 50% manufacturer discount on negotiated prices in Part D to close doughnut hole, coverage for biannual personal prevention and wellness plan, removal of preventive service cost sharing, pilot programs for healthy living incentives, establish new Medicare Advantage benchmarks incentivizing care coordination

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Waste and fraud in Medicare/Medicaid	Refuse payment for health-care acquired conditions, provider screening in high risk areas, requiring evaluations and reports under integrity programs	New directive to coordinate care for dual-eligibles, Provider screening, one PI database to capture/share data, increase penalties for false claims, increase anti-fraud activities
Innovative public payment mechanisms	Medical home, value-based purchasing, bundling, pay-for-performance, partial capitation	Provide bonus payments for care management activities, bundle payments for acute+post-acute care, incentives for accountable care organizations
Insurance Market Reform	Guaranteed issue and renewability, minimum benefits package, rating variation only on age (2:1), family size and geography, 85% medical loss ratio, repeals insurers' federal anti-trust exemptions	Guaranteed issue and renewability, rating variation on age (3:1), tobacco use, wellness incentives, family structure and geography
Benefits	Grandfathers existing benefits, 4 benefits categories: basic, enhanced, premium and premium plus (ranging from 70 to 95% of cost of covered benefits); prohibits annual/lifetime limits and cost sharing for preventive services; allows children to stay on their parents' plan through age 25 at parents' option	Grandfathers existing benefits, 4 benefits categories ranging from 60 to 90% of the cost of the covered benefit packages; prohibits annual/lifetime limits and cost sharing for preventive services; allows children to stay on their parents' plan through age 26 at parents' option
Other Market Reform	Individual market coverage acceptable under mandate is purchased through the Exchange, risk adjustment, allow states to form 'health care choice compacts' for interstate sale of insurance	Require reporting and disclosure on medical loss ratios and service charges, risk sharing mechanisms including risk adjustment, reinsurance, and risk corridors, allow states to form 'health care choice compacts' for interstate sale of insurance
Individuals Without Legal Residency Documents	Excluded from public subsidies through the Exchange	Excluded from public subsidies and purchasing through the Exchange
Cost Sharing Limits	Annual cost sharing limits of \$5,000/individual and \$10,000/family	Annual cost sharing limits of \$5,950/individual and \$11,900/family, with reduced limits for those under 400% FPL

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Cost Containment	Require payment and provider incentive disclosures from drug and device manufacturers, standardized claim forms, quality reporting requirements, operating rules for processing and increasing electronic data exchange, justifying annual premium increases, allow generic versions of biologics after 12 years	Established long term care insurance program (CLASS Program), Require payment and provider incentive disclosures from drug and device manufacturers, improve transparency of information in hospital and skilled nursing facilities, 10% Medicare payment bonus for primary care practitioners and providers in shortage areas, increase imaging utilization rate from 50% to 90% to calculate payment
Prevention	Eliminate cost-sharing, cover only proven services, create task forces on Clinical Preventive Services and Community Preventive services for evidence-based recommendations, Wellness grants	Eliminate cost sharing, cover only proven preventive services, provide incentives through program to complete behavior modification programs, provide grants to states to promote integration of health care services and other services
Quality and System Performance	Establish Center for Comparative Effectiveness within AHRQ, increase Medicaid payments to primary care, develop national priorities for performance and quality, report and transparency on quality, create accountable care organization pilots	Establish bundling programs and value-based purchasing program to pay hospitals based on performance and quality in public programs, improve transparency public reporting on quality indicators, establish institute for comparative effectiveness research, create Innovation Center within CMS, grants for the co-location of behavioral and physical health services as well as a demonstration project to create medical homes for the treatment of chronic disease

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State Roles	Coordinate enrollment of individuals, determine eligibility for affordability credits, grant waivers to states seeking to establish single payer system	Allow states the option to create unique system meeting federal floor, merge into regional Exchange, create coops, enter into compacts to create interstate health coverage, incentives to promote access to preventive services
Cost and Financing	\$1 trillion over 10 years paid for through savings in Medicare and Medicaid and 5.4% surcharge on incomes over \$500,000/\$1,000,000 for individuals/families; annual fees on insurers, medical device manufacturers and pharmaceutical manufacturers, reduces overpayments to Medicare Advantage plans Reduces federal deficits by \$109 billion over 10 years and covers 36 million uninsured	\$849 billion over 10 years, funded by 40% excise tax on “Cadillac” group health plans costing over \$8,500/\$23,000 for individual/family, limits on HSA contributions and expenses, eliminating exclusion for employer Part D subsidy, annual fees on insurers, medical device manufacturers and pharmaceutical manufacturers, 5% tax on elective cosmetic surgery, increase in Medicare payroll tax by 0.5% on individual/families earning over \$200,000/\$250,000, Medicare and Medicaid savings Reduces federal deficits by \$127 billion over 10 years and covers 31 million uninsured
Other reform	Require report on future role, appropriate targeting, and distribution of DSH payments, reform GME to increase primary care training, voluntary long term care insurance program for seniors, no federal funding for elective abortions through Exchange or Medicaid, plans must segregate their public funds to assure that individuals choosing more extensive abortion coverage pay the full cost of the extended coverage, public plan does not provide abortion coverage	Reform GME to promote primary care and residency programs in rural and underserved area through slot-redistribution programs, allow physician assistants to order post-acute care services and serve hospice patients voluntary long term care insurance program for seniors, no federal funding for elective abortions through Exchange or Medicaid, all plans must segregate their public funds to assure that individuals choosing more extensive abortion coverage pay the full cost of the extended coverage

Senate: HR 3590: <http://democrats.senate.gov>

House: HR 3962: http://rules.house.gov/bills_details.aspx?NewsID=4483