

Congressional Health Reform Proposals

By Adam Dougherty
Insure the Uninsured Project
July, 2009

	House Tri-Committee Draft	Senate HELP Committee Affordable Health Choices Act	Senate Finance Committee Proposal
Individual Mandate	Included	Included	Included
Changes in Tax Policy	Mandate enforced through 2% tax on adjusted gross income up to cost of average national premium, with exemptions based on religion or hardship	Mandate enforced through tax penalty, with exemptions for states without American Health Benefit Gateway, Indian tribes, and those for whom coverage is not affordable	Mandate enforced through excise tax equal to a percentage of the premium for the lowest cost option in Exchange, exemptions for financial hardship, with additional considerations affecting tax preference for HSAs and flexible spending accounts
Individual Premium Subsidies	Sliding scale credits up to 400% FPL with contribution caps on premiums and cost-sharing	Sliding scale credits up to 500% FPL with contribution caps on premiums and cost-sharing	Tax credits for individuals and families between 100% and 400% FPL, level set as percentage of income or premium, additional limits on cost-sharing
Employer Requirements	Pay or play: 72.5% of premium cost for single and 65% for family OR pay 8% of payroll into HIE Trust fund (small business exemption)	\$750/employee fee for employers who do not offer coverage	Policy under dispute
Employer Premium Subsidies	Credits to employers with fewer than 25 employees	Credits to employers with fewer than 50 full-time employees, temporary reinsurance program for employers providing coverage to retirees 55 to 64	Provide some small employers with tax credit
Purchasing Pools	National Health Insurance Exchange with risk adjustment and four benefits categories: basic, enhanced, premium, premium plus	State-based American Health Benefit Gateways with optional regional Gateways within states, adjustments based on Secretary's recommendations	National or regional Health Insurance Exchanges, require all state-licensed insurers in small/non-group markets to participate
New Public Plan Option	Yes, requires that costs of plan be financed fully through premium revenues. Payment rates set at Medicare rates, plus bonus for participation in both	Yes, to be offered through state Gateways	Policy under dispute

	House Tri-Committee Draft	Senate HELP Committee Affordable Health Choices Act	Senate Finance Committee Proposal
Medicaid Expansion	To 133% FPL for all individuals with full federal funding of expansion, require CHIP enrollees to obtain coverage through HIE	To 150% FPL, with CHIP-eligible individuals able to choose between program or another qualified plan in Gateway	To 115% FPL, CHIP eligibility to 275% FPL in 2013, allow individuals 55-64 to buy into Medicare until Exchange is underway
Innovative Payment Mechanisms	Medical home, value-based purchasing, bundling, pay-for-performance, partial capitation	Incentives for better coordinate care, reducing readmissions	Provide bonus payments for care management activities, bundle payments for acute+post-acute care
Benefits	Creation of essential benefits package by Health Benefits Advisory Council covering 70% of actuarial value of benefits	3 benefit tiers with essential benefits package specified by Medical Advisory Council	4 benefit categories (lowest, low, medium, high) that plans must comply with
Insurance Market Reform	Guaranteed issue and renewability, minimum benefits package, rating variation only by age, 85% medical loss ratio	Guaranteed issue and renewability, rating variation on family structure, geography, actuarial value, and age	Guaranteed issues and renewability, rating variation on age, tobacco use, family structure, geography
Other Market Reform	Prohibit coverage purchased through individual market as acceptable under mandate outside HIE	Require cost reporting, medical loss ratio established by Secretary, preventive service coverage, dependent coverage up to age 26	Not specified
Cost Containment	Standardized claim forms, quality reporting requirements, operating rules for processing and increasing electronic data exchange	Provide grants to improve system efficiency (medical home model, community health teams, medication management services)	Require payment and provider incentive disclosures from drug and device manufacturers, improve transparency of information in skilled nursing facilities
Medicare Reform	Modify payment rates to include efficiency incentives, reduce payments to hospitals with excess readmission, bundle payments for post acute care, 85% medical loss ratio for Medicare Advantage plans	Not specified	Expand eligibility for Medicare HIT incentives through ARRA to additional providers, restructure Medicare Advantage payments for efficiency and quality, allow accountable care organizations to share in quality cost savings through Medicare
Waste and Fraud in Medicare / Medicaid	Refuse payment for health-care acquired conditions, provider screening, require evaluations and reports under integrity programs	Establish Health Care Program Integrity Coordinating Council to better address waste, fraud, and abuse	Intensive provider screening, develop One PI database to capture/share data, increase penalties for false claims, increase anti-fraud activities

	House Tri-Committee Draft	Senate HELP Committee Affordable Health Choices Act	Senate Finance Committee Proposal
Prevention	Cover only proven services, eliminate cost-sharing, create task forces on Clinical Preventive Services and Community Preventive services for evidence-based recommendations	Develop national strategy with specific goals, create a health investment fund to expand and sustain	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
Quality and System Performance	Establish Center for Comparative Effectiveness within AHRQ, increasing Medicaid payments to primary care, develop national priorities for performance and quality	Create Patient Safety Research Center, develop interoperable standards for HIT, require public reporting on quality measures	Establish value-based purchasing program to pay hospitals based on performance and quality, improve public reporting, establish framework for CCE research, create Chronic Care Management Innovation Center within CMS
Cost Sharing	Annual cost sharing limits of \$5,000/individual and \$10,000/family	Tiered benefits coverage range from 76% to 93% of cost, cost sharing limits unspecified	Policy under development
State Role	Coordinate enrollment of individuals, determine eligibility for affordability credits	Establish Gateways with federal standards, create temporary RightChoices programs for immediate access to preventive/chronic disease services for uninsured	Allow states the option of merging the non-group and small group markets, requires state insurance commissioners to provide oversight for consumer protections, premium taxes, and rating reviews
Other Reforms	Require report on future role, appropriate targeting, and distribution of DSH payments, reform GME to increase primary care training	Establish voluntary insurance program to purchase community living assistance services, reform GME (with focus on pediatric, primary, and geriatric care), establish Health Care Workforce Commission, provide funding to increase community health centers and school-based health centers	Change Medicaid FMAP formula to include state poverty level data and increase rates during economic downturns, increase access to home and community based services through Medicaid, reform GRE to promote primary care and residency programs in rural and underserved areas

Sources:

Finance Committee: <http://finance.senate.gov/sitepages/Policy%20option%20report.html>

HELP Committee: http://help.senate.gov/BAI09A84_xml.pdf

House Tri-Committee:

<http://edlabor.house.gov/documents/111/pdf/publications/DraftHealthCareReform-BillText.pdf>

<http://www.kff.org/healthreform/sidebyside.cfm>