Comparison of House & Senate Health Reform Bills

Senate passage of a badly flawed version of health reform legislation on Christmas Eve completed an historic year in Congress – where more progress was made towards comprehensive health reform than anytime in 60 years.

The House & Senate will have to resolve hugely important differences in their bills this month before they can send a final bill to President Obama – whether to tax health benefits to fund coverage for the uninsured, create a public insurance health plan option to hold down health costs and keep insurers honest, and require all employers to pay their fair share are the top three. The outcome of negotiations on those key issues will determine how well, or poorly, the legislation will work for working families.

Neither bill is the one that we would have written. But the House bill is, in most respects, very good. The Senate bill has many good provisions in it, but is badly flawed in key areas.

By way of background, below is a simplified list of common reform elements in both the House and Senate bills, followed by a more detailed comparison of differences on five key issues. For more detail see comparison prepared by House Tri-Committee Staff (Ways & Means, Energy & Commerce, Ed & Labor) at www.speaker.gov/pdf/HScomparison.pdf.

Common Elements

Overall Design in Both House & Senate Bills – keeps the structure of the current system – employment-based insurance with public programs for the elderly and poor – but makes major changes to address serious shortcomings in coverage, quality and cost of care. The changes will result in significant systemic change that, within ten years, will make health care in America very different.

But health care will not see a radical make over. For instance, even as the legislation outlaws the worst insurance abuses and puts in place strong consumer protections, it won't reduce the role of private insurance, and it won't immediately reduce the cost of health services that drive the ongoing outrageous growth in US health spending. The legislation aims at comprehensive reform of health care as it now exists, not elimination of the failed private insurance system or overhaul of the medical industry.

Consumer Protections in Insurance

- Prohibits denial of coverage or higher rates due to pre-existing conditions.
- No longer permits insurers to cancel coverage when someone files a claim.
- Bans annual or lifetime limits on claims payments by insurers.
- Sets up procedures for disclosure, review & justification of insurance rate increases

- Requires health plans to have appeals process that meet certain standards and states to have an external appeal process for people dissatisfied with the result of the internal one.
- Ends gender discrimination whereby insurers charge higher rates for women
- Reduces age-based variation in rates – instead of charging older people five or more times what younger people pay, insurers will not be able to charge any more than twice (House) or three times more (Senate).
- Either eliminates rate variation for tobacco use (House) or limits it at 1.5:1 (Senate)
- Sets minimum benefits standards for insurance.
- Covers out of school children – children up to age 27 will be covered under family plans

More Affordable Coverage for Active Workers

- Caps out-of-pocket costs – $10,000 (House) & $11,000 (Senate) maximum annual limits, largely eliminating the cause of medical bankruptcies that now total 700,000 a year, 2/3rds of which involve fully-insured people who still can't afford their medical bills.
- A range of cost-containment provisions that are estimated by independent experts to result in savings to families of between $2,000 and 3,000 per year in premiums by 2019.
- Prohibits co-pays for check-ups & preventative tests – insurers must provide, free of charge, mammograms, cancer screening, tests for diabetes and other chronic conditions, and regular check-ups.
- Requires that insurance companies rebate to policy-holders any spending in excess of 15% of total expenditures spent on things other than medical claims, e.g., administrative expenses, marketing, executive salaries, and profit.
- New insurance exchanges with standardized rules and simplified procedures that prevent insurers from choosing policy-holders based on lowest risk, reduce administrative cost, and provide a "level playing field" insurance market to promote competition and consumer choice.
- The exchanges will be open to small/ medium employers or plans in 2013 (House) and 2014 (Senate). In 2015 (House) and 2017 (Senate), exchanges open to large employers/plans.
- Lowers small & medium size group insurance rates – the new "insurance exchange" with standardized benefit packages and uniform application process is estimated to cut administrative costs to the level of the most efficient large groups now enjoy, 5% (compared to 15-40% now).

Coverage Expansion

- Between $436 billion (Senate) and $602 billion (House) budgeted to subsidize coverage (through public programs, mostly Medicaid, and private insurance) for people with incomes up to 400% of the federal poverty level, or approximately $89,000, to pay for health coverage.

- Tax credits of up to 50% of the cost of coverage for employers with 50 workers or less and annual wages up to $50,000, for up to five years (House) and six years (Senate) Amounts vary by tax year, workforce size and income level.
- Medicaid coverage extended to $150 of federal poverty level (FPL) (House) and 133% FPL (Senate).
- Federal gov't pays 100% of costs of Medicaid expansion for two years & 91% thereafter (House) or 100% for two years and then 32.3 percentage points above current federal payments in each state, i.e., 82.3% to 95% (Senate). [Exception: Nebraska will continue to be paid 100%.]

More Affordable Coverage for Retirees & Seniors

- Cost relief for early retiree coverage – a new re-insurance program will pick up 85% of the cost of treatments between $15,000 and 90,000 for retirees ages 55-64.
- $500 immediate increase in Medicare drug allowance.
- Phased closing of Medicare drug program "donut hole" where seniors have to pay 100% of drug costs.
- 50% cut in price of brand name drugs for seniors in donut hole until it is eliminated.

Cost Containment

- National strategy for controlling costs, starting in Medicare and extending to private health insurance, that reforms the payment method for doctors, hospitals, and other care providers by basing payment on the quality, effectiveness, and efficiency of services, instead of just the number of procedures performed.
    - Automate processes to lower costs of record keeping & processing reduce unnecessary duplication of tests and avoid costly errors in treatment, e.g., new drugs that cause adverse interactions with other drugs
    - Pay for services on value, not just volume -- rapid testing and expansion of programs with redesigned payment systems to encourage higher quality care while lowering costs
    - Increase primary care physician payments, while not raising overall physician spending in Medicare, as an incentive for more primary care docs
    - Federal innovation center charged with developing new models of organizing and paying for care, such as "Accountable Care Organizations", and expanding them through-out Medicare once tested and proven.
    - Reducing hospital-acquired infections by the widespread adoption of proven protection protocols.
    - Hold hospitals accountable for costs of preventable hospital re-admissions
    - Aggressive anti-fraud and abuse procedures.
    - Comparative effectiveness research to improve care and inform clinical and patient decisions
    - Prevention and wellness
    - Establish a regular priority-setting process for federal health policy with substantial multi-stakeholder input
    - Require reporting from all health providers on national, stanradized measures of quality.

    - Widespread reporting on the results of quality measurement that permit easy and accurate comparisons of performance by physicians and patients.
- This cost containment strategy is projected to save the federal government $450-500 billion by 2019 (Congressional Budget Office). Specifics include:
    - Reducing payments to "private plan" Medicare, i.e., Medicare Advantage by $135-170 billion over ten years.
    - Lowering the annual Medicare rate adjustments for hospitals is projected to save $150 billion/ten years.
    - A new Independent Payment Advisory Committee that will take over much of Congress' authority to set payment rates and, therefore, greatly reduce the ability of insurance and medical industry lobbyists to push rates higher and higher rates. Projected to save $28 billion over ten years.
- Many outside experts predict that actual savings will exceed CBO estimates, which historically have been very low. Actual savings from the 1983 and 1997 Medicare payment reform bills was double what CBO projected. Costs of Medicare prescription drug benefit enacted in 2003 were 40% less than CBO predicted.
- The private sector is expected to adopt much of the above cost containment measures developed for Medicare with a projected savings of $150-200 billion over the first ten years, and substantially more in the second decade (Commonwealth Fund/Center for American Progress)

Federal Spending and Deficit

- Fully paid for by new revenue and cost savings in Federal programs
- Both bills would reduce the federal deficit by approximately $130 billion/ten years and considerably more over twenty years

Major Differences

1. Financing Coverage Expansion

Provision	House	Senate
Tax on Health Benefits	No provision	A 40% excise tax on health insurance administrators for plans valued in excess of $8,500 (individual) or $23,000 (family) (raises $149 billion over ten years)
Progressive Financing	Income surcharge of 5.4% on individual income over $500,000 & families over $1 m (raises $460 billion)	Increase Medicare tax on earnings over $200,000 (individual) and $250,000 (married couples) by .9%, from 1.45% to 2.35% (raises %54 billion)

The AFL-CIO will continue to fight against an excise tax on health benefits, for the House surcharge on income for families with income over $1 million, for the Senate increase in the Medicare tax for families earning over $250,000, and for other progressive revenue sources, such as limiting itemized deductions for wealthy Americans ($318 billion) or applying the Medicare tax to unearned income for families making $250,000 + per year ($110 billion).

2. Public Health Insurance Plan Option

Provision	House	Senate
Public and publicly accountable	Public and publicly accountable, administered by qualified non-profit plans, public plan bears financial risk.	No public option. Two national plans, at least one being non-profit, that would track requirements of FEHBP plans
National, not state-based	National	National
Able to establish payment rates	Secretary will negotiate provider rates not lower, than Medicare and not higher, in the aggregate, than the average rates paid in the exchange.	Office of Personnel Management will negotiate rates with national plans

The AFL-CIO will continue to fight for a strong public option as the only credible proposal before Congress for *near term* cost containment and to create real competition among insurers.

3. Employer Responsibility to Provide Coverage

Provision	House	Senate
A meaningful contribution toward good coverage	Employers are required to contribute 72.5%/65% (single/family) of employees' premium costs for coverage purchased inside or outside of the exchange. 5-year grace period on some requirements for existing employer/union plans.	Employers are not required to provide coverage. But employers pay penalty if either no coverage or insufficient coverage is provided. (see below) Permanently grandfathers existing plans with any level of coverage.
Or a monetary contribution toward exchange subsidies	Employers that choose not to offer insurance coverage will pay a surcharge of 2% ($500,000+ payroll) to 8% ($750,000+ payroll). No payment is required for employers with payroll of less than 50 workers or $500,000. Proportionate contributions for part-time employees.	Employers with 50+ workers and $500,000 payroll **– in construction, 5 or more workers and $250,00 0 payroll** – that do not offer coverage pay penalty of $750 x total # or workers if any full-time employee gets a tax credit. If employer offers coverage that doesn't pay 60% of expected costs & costs less than 9.8% of a worker's income, the employer is required to pay a) $3,000 for each FT employee receiving credit with a cap of $750 times total # of FT employees.
Employer/Union fund assistance with early retiree costs	Ten billion dollar fund to reimburse employment-based plans for 80% of cost of procedures costing between $15,000-90,000 for retirees 55+ and families.	Provisions similar to House bill, except funding would not exceed $5 billion.

The AFL-CIO will continue to fight for genuine employer mandate (House), which covers 11 million more workers and raises $135 billion to pay for subsidies – compared to $28billion from Senate penalty -- but also the lower threshold for construction in the Senate bill and House early retiree reinsurance funding .

4. Purchasing Exchange & Standards for Insurance Plans

Provisions	House	Senate
Insurance Exchanges	National exchange set-up and overseen by federal gov't. to negotiate and enforcing agreements with insurers. State laws continue unless they conflict with Federal standards.	State exchanges, with federal back-up in case states fail to do so by 2013.
Minimum benefit standards	Plans must coverage, on average, 70% of expected costs, i.e., "actuarial value" Max of15% of premiums for non-care	Plans must cover, on average, 60% of expected costs Max of 15% of premiums for non-care
Application of insurance standards	Imposes on all markets standards set in exchange for guarantee issue, premium rating, benefits, out-of-pocket protections, and prohibitions on pre-existing condition exclusions to all markets. Federal enforcement for plans inside and outside the exchange. State Attorneys General also authorized to act On violations.	Imposes on individual and group markets the exchange standards for guarantee issue, and prohibitions on pre-existing condition exclusions, but benefit and rating standards only in the individual and small group markets. (Also large groups or self-insured plans that enter exchanges.) Regulations are largely enforced by states.
Federal standards for plan transparency, data disclosure, consumer assistance, and rate review	Comprehensive provisions for plan transparency, data availability, and consumer assistance. $1 billion toward anti-price gouging enforcement in years 2010-2014. The exchange may deny excessive premium increases.	Transparency provisions and consumer assistance provisions. Prior to the Exchange, federal/state premium review ; continued monitoring after 2014 and power too reject plans for exchange for large rate hikes after 2009.
Eligible businesses	Open to individual and small groups only 2013 and phases in eligibility for small businesses over three years. In 2015, individuals and firms with up to 100 workers, with authority to allow all employers access to exchange.	By 2014, separate markets for individual and firms up to 100 workers (with option to merge the two), with state option to limit eligibility to employers with only 50 workers. In 2017, states may open exchange to large employers.

The AFL-CIO will fight for efficiency, competition, and choice in exchanges:

- **Retain the House provisions for Federal exchange.**
- **Adopt Senate provision making employers with 100 or fewer workers eligible for the exchange as soon as it is operational and eliminate state option to limit to firms with 50 workers. Retain House provision authorizing expansion of exchange to all employers as early as 2015**
- **Retain the House provisions extending insurance market reforms to all markets, including benefit standards and rating rules**
- **Retain the House provisions requiring federal standards for plan transparency and data disclosure, and combine the best of House and Senate provisions on consumer assistance, medical loss ratios, quality reporting and rate reform.**

5. Subsidies to Purchase Coverage and Affordability

Provision	House	Senate
Safeguard the middle class (at least to 400% FPL)	Includes premium protections up to 400% FPL	Includes premium protections up to 400% FPL
Offer premium protection in the exchange	Premium credits will be based on income tiers, starting at 1.5% of income for those at 133% FPL to 12% of income at 400% FPL.	Premium credits will be based on a sliding scale from 2.8% at 100% FPL to 9.8% at 300% FPL. Premiums are capped at 9.8% between 300-400% FPL. Families with income between 100-133% FPL will have their premium contributions capped at 2% of income.
Limit out-of-pocket cost exposure in the exchange	Cost-sharing exposure in the exchange is based on income tiers. Families in the lowest income bracket, 133-150% FPL, are subsidized for a plan covering 97% of anticipated costs, with a $500/$1,000 out-of-pocket limit. Families in the highest income bracket, 350-400% FPL are subsidized for a plan covering 70% of anticipated costs, with an out-of-pocket limit of $5,000/$10,000.	Cost-sharing exposure in the exchange is based on income tiers. Families in the lowest income bracket, 100-150% FPL, are subsidized for a plan covering 90% of anticipated costs, with a $1,980/$3,960 out-of-pocket limit (one-third of HSA limit). Families in the highest income bracket, 300-400% FPL have premiums capped at 9.8% of income and have an out-of-pocket limit of $3,960/$7,920 (two-thirds of HSA limit).
Ensure that employment-based insurance has similar protections	People with an offer of coverage from an employer are eligible for the exchange, including income-related premiums credits, if premiums exceed 12% of income.	People with an offer of coverage from an employer are eligible for the exchanges, including income-related premiums credits, if premiums exceed 9.8% of income. Or actuarial value is less than 60%. In qualified health plans, out-of-pocket spending cannot exceed HSA limits ($6,150/$12,300). In the small group market, plans cannot have deductibles higher than $2,000/$4,000.

The AFL-CIO will fight for affordability protections:

- **For persons at or below 250% Poverty Line in the exchange, from the House bill, retain premium protections and actuarial value standards**
- **For persons above 250% of the Poverty Line in the exchange, from the Senate bill, retain premium protections**