



This brief side-by-side summary includes the key HR provisions pending in the various health reform bills at the conclusion of committee consideration of the proposals. Please note that as these bills continue through the legislative process, any or all of these provisions are subject to change. This chart will be updated to reflect additional health care reform developments.

**\*\*As of October 15, 2009\*\***

Provision	Senate HELP Committee “Affordable Health Choices Act”	Senate Finance Committee “America’s Healthy Future Act”	House Tri-Committee “H.R. 3200, America’s Affordable Health Choices Act”	SHRM Position
<b>Individual Mandate</b> – requires individuals to have health coverage.	Yes, requires individuals to have coverage to pay a \$750 annual penalty.	Yes, requires individuals to have coverage or pay a penalty. The penalty would be \$750 per adult household, and the penalty would be phased in as follows: For 2013, \$0; \$200 for 2014; \$400 for 2015; \$600 in 2016 and \$750 in 2017. Exemptions from the tax will be made for individuals where the full premium of the lowest cost option available to them (net of subsidies and employer contribution, if any) exceeds eight percent of their adjusted gross income.	Yes, requires individuals to have coverage or pay a penalty of 2.5% of modified adjusted gross income above a specified level.	SHRM supports a “shared responsibility” approach to health reform. Because the human and economic costs of the uninsured pose serious consequences to the United States, all stakeholders, including purchasers, consumers, payers, providers, and policy makers have a shared interest in improving access to health care.

<b>Employer Mandate</b> – requires employers to offer insurance and penalizes those who don't.	Yes; exempts employers with 25 or fewer employees.	No requirement to offer coverage, but all employers with more than 50 employees that do not offer coverage would be required to reimburse the government for those employees who receive tax credits for health insurance.	Yes; exempts employers with payroll under \$250k. The Energy and Commerce Committee version exempts employers with payroll under \$500k.	“Pay or play” proposals would limit employers’ flexibility and innovation. Under this approach, some employers may simply choose to “pay” rather than offer coverage, leaving employees without the coverage they have grown accustomed to.
<b>Employer Penalty</b> – penalty for those employers not offering coverage.	Failure to offer coverage would result in a penalty of \$750 per full-time employees per year and \$375 for part-time employees per year.	Reimbursement “fee” would require employer to pay the lesser of the flat dollar amount (established by the Secretary of HHS and equal to the national average tax credit) multiplied by the number of fulltime employees receiving a tax credit or a fee of \$400 per employee paid on its total number of fulltime employees.	Employers not offering coverage would be subject to a penalty equal to 8% of average total wages paid annually.	See above.
<b>Employee Retirement Income Security Act (ERISA) Changes</b>	Maintains state regulation of insurance health plans and federal regulation of self-insured plans; adds federal requirements under ERISA on employer-sponsored health coverage.	No ERISA changes.	Waives ERISA’s preemption rules to permit a state that has a “single payer system” to require employer participation in the state program; prohibits reductions in employer-sponsored retiree health benefits.	The flexibility and certainty of the ERISA framework has been essential to the success of the employer-based system. SHRM opposes changes to ERISA, including onerous or impractical requirements that would undermine and erode this essential statute.
<b>Benefits</b> – requires plans to offer a specific benefits package.	Requires essential benefits package covering broad range of medical, mental health, prescription drug, and rehabilitative services.	No minimum benefit requirements.	Requires essential benefits package covering broad range of medical, mental health, prescription drug, and rehabilitative services.	SHRM supports employer flexibility in plan design.
<b>Public Plan</b> – a government run health insurance plan designed to	Yes; the government would negotiate payment rates with providers.	Does not include a public plan option.	Yes. Public plan provider rates would be 5% higher than Medicare rates for the first 3 years. After that the Administration	SHRM is concerned with a public plan option because inadequate public plan reimbursement under current law has resulted in

compete with private plans			would set rates.	significant cost-shifting to private plans, increasing costs for both employers and employees.
<b>Health Care Cooperative</b> – owned and controlled by its members.	Does not include health care cooperatives.	Authorizes the formation of the Consumer Owned and Oriented Plan (CO-OP), to be operated at the state, regional or national level to serve as a non-profit, member-run health plans to compete in the non-group and small group market.	Does not include health care cooperatives.	SHRM continues to analyze the health care cooperative approach to determine its impact on employer-sponsored health plans.
<b>Cafeteria Plans</b>	No specific provisions.	Caps FSA contribution at \$2,500 and excludes over-the-counter medications without a doctor’s prescription. Increases penalties on non-medical HSA distributions; creates a safe harbor from nondiscrimination rules for cafeteria plans sponsored by eligible small employers.	The Ways and Means Committee version included language prohibiting over-the-counter medical purchases as eligible expenses under FSAs/HSAs/HRAs.	SHRM is concerned with efforts to limit health spending accounts.
<b>Wellness Provisions</b>	Permits employers to establish premium discounts or rebates or modify co-pays or deductibles up to 30 % to encourage participation in wellness programs.	Codifies and enhances provisions of the HIPAA non-discrimination regulations, which allow rewards to be provided to employees for participation in or for meeting certain health standards related to a wellness program; provides that wellness programs that provide rewards based on an individual satisfying a standards that is related to a health factor do not violate the HIPAA non-discrimination rules if the program satisfies certain requirements. For these	No similar wellness provisions. Wellness and prevention initiatives for Medicare beneficiaries; calls for national prevention and wellness strategy.	SHRM strongly supports health promotion, prevention and wellness programs and believes that health reform must include provisions that will enable greater availability of these critical programs among employers and employees.

		programs, the bill would cap the reward at 30% of the employee-only coverage under the plan while providing protections for plan participants.		
<b>Health Care Quality Improvements</b>	Calls for a national strategy to improve the quality of the U.S. health care system; establishes health quality initiatives to reduce medical errors, reduce hospital admissions, improve patient safety, promote evidence-based medicine and disseminate best care practices.	Moves Medicare to pay for quality and value, including hospital, physician, home health and skilled nursing facility value-based purchasing; quality reporting for other providers.	Includes reforms in Medicare that will reward the quality of care delivered; establishes Center for Comparative Effectiveness Research; includes provisions on quality measurements.	SHRM strongly supports efforts to improve the quality of health care, including access to provider outcomes data.
<b>Health Information Technology (IT)</b>	Calls for the development of health IT standards and to promote the interoperability of systems for enrollment of individuals in federal and state health programs.	Includes several measures to promote the use of health IT.	No specific provisions on health IT.	SHRM supports policies that promote both public and private investment in the resources, standards, and technology needed to create an effective information network, including the creation of Electronic Health Records.
<b>Subsidies – tax credits to help employers or individuals buy health coverage.</b>	Tax credits available for individuals who purchase plans through the Gateways on a sliding scale up to 400% of FPL; employers with 50 or fewer full-time employees who pay 60% or more of their employees' health insurance premiums receive tax credit up to \$2,000 per employee to subsidize coverage.	Tax credits available on a sliding scale for individuals and families between 134-300% of the federal poverty level (FPL) to help offset cost of private health insurance; tax credit to small employers who offer health insurance to their employees.	Tax credits available on a sliding scale for individuals and families between 133-400% of FPL; provides a tax credit of up to 50 percent of the employer's coverage for certain small businesses that choose to provide health coverage for their employees.	SHRM believes that tax incentives should be used as vehicles to expand coverage and should be provided on an equitable basis regardless of the individual or form of business.

<p><b>Financing</b> – how health reform is generally paid for.</p>	<p>The HELP Committee does not have jurisdiction over tax policy. However, financing of health reform would encompass delivery system and insurance market reforms as well as an employer and individual mandate.</p>	<p>New 40% excise tax on insurers and self-insured employers if the aggregate value of the plan (including major medical, tax-free accounts, vision, dental, and other supplementary health coverage) exceeds \$8,000 for an individual or \$21,000 for a family in 2013 – the tax is equal to 40% of the aggregate value that exceeds these thresholds; the threshold amount is increased by \$1,850 for individual coverage and \$5,000 for family coverage for retired individuals over the age of 55 and for plans that cover employees engaged in high risk professions (firefighters, law enforcement, construction, etc.); new taxes on medical devices, insurance companies, and pharmaceuticals; limits FSA contributions.</p>	<p>Health care “surcharge” on the top 1.2% of earners –households with adjusted gross income in excess of \$350,000 (married filing a joint return) and \$280,000 single; cost cuts in public programs.</p>	<p>SHRM supports a “shared responsibility” approach to financing health reform and believes tax incentives should be used as vehicles to expand coverage.</p>
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