This brief side-by-side summary includes the key HR provisions pending in the House and Senate-passed health reform bills. The House and Senate bills must now be reconciled into a final conference report to be passed by each chamber.

****As of January 5, 2010****

Provision	Senate "H.R. 3590, the Patient Protection and Affordable Care Act," passed 12/24/09 by a vote of 60-39	House "H.R. 3962, Affordable Health Care for America Act," passed 11/07/09 by a vote of 220-215	SHRM Position
Individual Mandate – requires individuals to have health coverage.	Yes, requires U.S. citizens to maintain minimum essential coverage beginning in 2014. Individuals who do not purchase coverage will pay the greater of $95 in 2014, $495 in 2015 and $750 in 2016, or up to two percent of income by 2016, up to a cap of the national average bronze plan premium. Families will pay half the amount for children up to a cap of $2,250 for the entire family. After 2016, dollar amounts will increase by the annual cost of living adjustment.	Yes, requires individuals to have coverage or pay a penalty of 2.5% of their adjusted gross income above the filing threshold or the average premium on the Exchange.	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.
Employer Mandate – requires employers to offer insurance and penalizes those who don't.	No requirement to offer coverage, but all employers with more than 50 full-time employees that do not offer coverage (and have at least one full-time employee receiving the premium assistance tax credit) would be required to make a payment of $750 per FTE to the government. If an employee opts out of an employer plan because the premium would exceed 9.8 percent of the employee's income and receives a tax credit, the employer	Yes. Small employers with an annual payroll that does not exceed $500k are exempt from this requirement. Requires employers to pay 72.5 percent of the premium for individuals and 65 percent of the premium for families. Employers offering coverage would be subject to an 8 percent payroll tax for employees who decline qualified employer coverage that would cost more than 12 percent of the employee's income.	"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.

	assessment would be the lesser of $3,000 for each employee receiving a premium credit or $750 for each full-time employee.		
Employer Penalty – penalty for those employers not offering coverage.	See above. In addition, an employer with more than 50 FTEs that requires a waiting period before an employee can enroll in health care coverage will pay $400 for any full-time employee in a 30-60 day waiting period and $600 for any full-time employee in a 60-90 day waiting period in 2014. Exempts employers with 50 or fewer employees from any of these penalties.	Employers not offering coverage would be subject to a penalty equal to 8% of average total wages paid annually.	See above.
Employer Requirement	Requires employers that offer coverage to provide a free choice voucher to employees with incomes less than 400% FPL whose share of the premium exceeds 8% but is less than 9.8% of their income and who choose to enroll in a plan in the exchange. The voucher amount is equal to what the employer would have paid to provide coverage to the employee under the employer's plan. Employers providing free choice vouchers will not be subject to penalties for employees that receive premium credits in the exchange. Requires employers with more than 200 employees to automatically enroll employees into health insurance plans offered by the employer, allowing for an employee opt-out.	Requires 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, beginning in 2013.	SHRM supports strengthening the employer-based system. Subjecting employers to additional requirements, including "free choice vouchers," undermines the employment-based system.
Employee Retirement Income Security Act (ERISA) Changes	Retains state regulation of insured health plans and federal regulation of self-insured plans. Allows states to obtain limited waivers of federal health-related laws and regulations to pursue state reform initiatives, but the waivers do not apply to ERISA covered plans.	Applies state law remedies to health insurance coverage purchased by employers in a state health insurance exchange; prohibits reductions in employer-sponsored retiree health benefits, unless the reduction is also made to benefits for active participants; requires all employer-	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

		sponsored coverage to meet detailed federal requirements.	that would undermine and erode this essential statute.
Benefits – requires plans to offer a specific benefits package.	Requires health plans to be sold in the insurance exchanges to cover an essential benefits package.	Requires essential benefits package covering broad range of medical, mental health, prescription drug, and rehabilitative services.	SHRM supports employer flexibility in plan design.
Public Plan – a government run health insurance plan designed to compete with private plans	No, does not include a public plan option or a Medicare buy-in provision for those 55-64.	Yes. Creates a new public health insurance option as part of the health insurance exchange and allows for negotiated rates.	SHRM is concerned with a public plan option because inadequate public plan reimbursement under current law has resulted in significant cost-shifting to private plans, increasing costs for both employers and employees.
Health Care Cooperative – owned and controlled by its members.	Yes. Establishes a federal program to assist establishment and operation of nonprofit, member-run health insurance issuers.	Yes. Requires the Health Choices Commissioner to establish a "Consumer Operated and Oriented Plan Program" to assist organizations that wish to start up a non-profit health insurance cooperative and provides start up loans for these organizations.	SHRM continues to analyze the health care cooperative approach to determine its impact on employer-sponsored health plans.
Cafeteria Plans	Caps FSA contributions at $2,500. Excludes over-the-counter medications without a doctor's prescription as reimbursable expenses under FSAs, HRAs, MSAs and HSAs. Increases penalties on non-medical HSA and MSA distributions to 20 percent.	Limits salary reduction contributions to health FSAs to $2,500. Prohibits FSA, HSA and HRA reimbursements for over-the-counter medications (unless doctor prescribed or insulin). Increases the 10 percent penalty on distributions from HSAs that are not used to pay for health related expenditures to 20 percent.	SHRM is concerned with efforts to limit health spending accounts.
Wellness Provisions	Allows employers to offer premium discounts and other awards for up to 30 percent of the total premium to individuals who satisfy a health standard and includes provisions to ensure that discriminatory practices do not occur. The Secretary of HHS would have the authority to issue regulations to allow financial incentives up to 50 percent. Provides grants for up to 5 years to small employers that establish	Creates a grant program to help small and mid-sized employers establish or strengthen workplace wellness programs. Participating employers must offer the programs to all employees and cannot mandate participation nor use participation as a condition to receive any financial incentive. Requires the Secretary to develop and periodically update a national strategy designed to improve the nation's health through evidence-based clinical and	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.

	wellness programs.	community-based prevention and wellness activities.	
Health Care Quality Improvements	Provides access to Medicare claims data for use in measuring provider performance. Establishes a value-based purchasing program for hospitals starting in 2013 and makes improvements to the physician quality reporting initiative.	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.
Health Information Technology (IT)	Provides for the establishment of protocols and standards for enrollment in federal and state health and human services programs.	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.
Subsidies – tax credits to help employers or individuals buy health coverage.	Provides a refundable credit for coverage under a qualified health plan. The premium assistance credit amount is calculated on a sliding scale starting at 2.8 percent of income for those at or above 100 percent of poverty and phasing out to 9.8 percent of income for those at 400 percent of poverty. Provides a sliding scale tax credit to small employers with fewer than 25 employees and average annual wages of less than $50,000 that purchase health insurance for their employees.	Tax credits available on a sliding scale for individuals and families between 133-400% of FPL. Small business tax credits are available for businesses with 10 or fewer employees and $20k or less in average wages.	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.
Financing – how health reform is generally paid for.	**High Cost Plan Excise Tax** – New 40% excise tax on insured and self-insured group health coverage that is above a threshold of $8,500 for single coverage and $23,000 for family plans. The tax would apply to the amount of the premium in excess of the threshold. The threshold would be indexed at CPI-U plus one percentage point, and a transition rule would increase the threshold for the 17 highest cost	Health care "surcharge" on taxpayers with adjusted gross income in excess of $1million (married filing a joint return) and $500k (single) at a rate of 5.4 percent; excise tax of 2.5 percent on medical devices; eliminates the tax deduction for employers who receive a government subsidy for providing retiree prescription drug coverage; health spending account limitations.	SHRM supports a "shared responsibility" approach to financing health reform and believes tax incentives should be used as vehicles to expand coverage.

	States for the first 3 years. An additional threshold amount of $1,350 for singles and $3,000 for families is available for retired individuals age 55 and older and for plans that cover employees engaged in high risk professions. **Medicare HI Tax** – Imposes an increase of .9 percent in the FICA tax paid on wages above $200,000 (single, $250k couples) beginning in 2013. Increase is only applicable to amounts paid by the employee. **Premium Taxes** – A new federal premium tax of $2 on each covered life in an insured or self-insured health plan would be assessed to finance a comparative effectiveness research program. **Indoor Tanning Tax** – Imposes a 10 percent tax on the amount paid for indoor tanning services. **Health Industry Fees** – New taxes on segments of the health care sector.		
Retiree Health Care	Eliminates the deduction for the subsidy for employers who maintain prescription drug plans for their Medicare Part D eligible retirees.	Prohibits employers from reducing retirees' health benefits after those retirees have retired, unless the reduction is also made to benefits for active participants. Eliminates the tax deduction for employers who receive a government subsidy for providing retiree prescription drug coverage.	SHRM supports employer flexibility in plan design and benefit offerings, including retiree health care benefits.