July **2017**

Comparing Key Provisions: Affordable Care Act, American Health Care Act, and Better Care Reconciliation Act

On June 22, 2017, Senate Republicans released a discussion draft of the Better Care Reconciliation Act, their proposal to repeal and replace the Affordable Care Act (ACA). The Senate draft retains a similar overall structure as the American Health Care Act, which passed the U.S. House of Representatives in May 2017, but includes some notable differences. The following table compares key provisions of the Affordable Care Act, American Health Care Act, and Better Care Reconciliation Act. This document reflects the revised Better Care Reconciliation Act as of July 13, 2017. CHRT will update this table if the Senate votes to approve the motion to proceed.

Category	***Affordable Care Act***	***American Health Care Act*** (Passed U.S. House of Representatives: May 4, 2017)	***Better Care Reconciliation Act*** (Revised U.S. Senate Discussion Draft: July 13, 2017)
Ensuring Continuous Coverage	Individuals who experience a lapse in coverage longer than 3 months pay individual mandate penalty ($695 or 2.5% of income above $10,000 in 2017).	Repeals the ACA's individual mandate penalty. Individuals who experience a lapse in coverage longer than 63 days would pay 30% higher premiums for one year upon re-enrolling in individual coverage.	Repeals the ACA's individual mandate penalty retroactive to 1/1/2016. Individuals who experience a lapse in coverage longer than 63 days would be subject to a six-month waiting period before re-enrolling in individual coverage.
Tax Credits for Individual Market Coverage	Provides income-adjusted, advanceable refundable tax credits for individual market coverage; income limit of 400% federal poverty level (FPL). Structure of tax credits accounts for the cost of insurance in a given geographic area. Tax credits determined based on cost of second-lowest cost silver plan, with an actuarial value of 70%. Tax credits cannot be used to purchase catastrophic plans offered on the Health Insurance Marketplace.	Starting in 2020, provides age-adjusted, advanceable refundable tax credits from $2,000 to $4,000 for individual market coverage; credits phase out at incomes of $75,000-$115,000. Tax credits are not linked to the cost of insurance.	Retains ACA tax credit structure until 2020. Effective immediately, tax credits cannot be used to purchase health insurance plans that cover abortion. Starting in 2020, provides income- adjusted, advanceable refundable tax credits for individual market coverage if individuals are not eligible for Medicaid coverage and up to income limit of 350% FPL. Tax credits determined based on cost of median benchmark plan, with an actuarial value of 58%. **The July revision would allow tax credits to be used to purchase catastrophic plans.**
Cost-Sharing Reductions	Provides cost-sharing reductions (CSRs) for individuals earning up to 250% of the federal poverty line.	Repeals CSRs in 2020; does not fund CSRs in the interim.	Appropriates funding for CSRs through 2019. Repeals CSRs in 2020.
Medicaid Expansion	Authorizes states to expand Medicaid for individuals up to 138% FPL with an enhanced federal match rate.	Allows Medicaid expansion to continue in states that have already expanded the program with enhanced federal matching rate until 2020 (90%). In 2020, the enhanced federal matching rate continues indefinitely for expansion enrollees covered as of Dec. 31, 2019, who do not have a lapse in coverage for longer than 1 month. All others would receive the traditional federal matching rate (65.15% for Michigan in 2016).	Allows Medicaid expansion to continue in states that expanded the program before Mar. 1, 2017 with enhanced federal matching rate through 2020 (90%). Gradually phases out enhanced federal match rate for Medicaid expansion from 2020-2023: • **2020**: 90% Federal Medical Assistance Percentage (FMAP) • **2021:** 85% FMAP • **2022:** 80% FMAP • **2023:** 75% FMAP • **Beyond 2023**: traditional FMAP
Medicaid Funding Structure	Does not change underlying structure of the "traditional" Medicaid program, where the federal government guarantees matching funds for states' Medicaid expenses.	Shifts the entire Medicaid program to a per-capita cap system in 2020. Under a per-capita cap system, states would receive a fixed per-enrollee payment for different enrollment groups based on fiscal year (FY) 2016 expenses and payments would grow with medical inflation (plus one percentage point for elderly, blind, and disabled). States can apply for a waiver to instead choose a block grant system for children and non-disabled, non-elderly adults. States can impose work requirements on non-disabled, non-elderly, non-pregnant adult Medicaid enrollees.	Shifts the entire Medicaid program to a per-capita cap system in 2020. Caps would be based on expenses for a state-chosen period of time consisting of eight consecutive quarters between Q1 of 2014 and Q2 of 2017. **The July revision allows states that expanded Medicaid in 2016 to choose a period of no less than four consecutive quarters.** Payments would grow with medical inflation (plus one percentage point for elderly, blind, and disabled) until 2025, when growth rate decreases to CPI-U for all enrollees. Children with disabilities are exempt from caps. States can apply for a waiver to instead choose a block grant system for non-disabled, non-elderly adults. States can impose work requirements on non-disabled, non-elderly, non-pregnant adult Medicaid enrollees. **In the July revision, state Medicaid expenditures related to a public health emergency are excluded from the per-capita caps. In addition, this revision would eliminate retroactive Medicaid eligibility for non-elderly, non-blind, non-disabled individuals.**
Health Savings Accounts (HSAs)	Individuals/families can contribute up to $3,400/$6,750 into health savings accounts.	Increases HSA contribution limits; spouses can make additional contributions.	Increases HSA contribution limits up to current limits for deductibles and out-of-pocket costs ($6,550 for individuals, $13,100 for families); spouses can make additional contributions. **The July revision would allow individuals to use HSA funds to pay for high-deductible health plan premiums. HSAs may not be used to purchase plans that cover abortion.**

Category	*Affordable Care Act*	*American Health Care Act* (Passed U.S. House of Representatives: May 4, 2017)	*Better Care Reconciliation Act* (Revised U.S. Senate Discussion Draft: July 13, 2017)
Private Insurance Market Regulations	Requires private insurance plans to comply with the following requirements: • **Age Bands:** Plans can vary rates between the oldest and youngest enrollees by no more than 3:1. • **Guaranteed Issue and Community Rating:** Plans cannot deny individuals coverage or charge more for coverage based on health status. • **Essential Health Benefits:** Private insurance plans must provide coverage for 10 categories of services. Applies to Medicaid, individual, and non-grandfathered small group plans. • **Medical Loss Ratio:** Private insurance plans must spend 80% of premium revenue on health care and quality improvement for individual and small group plans, and 85% for large employer groups.	Widens age bands to 5:1. Allows states to apply for three types of waivers: • Starting in 2018, widen age bands for the individual and small group market beyond the 5:1 ratio proposed in AHCA. • Starting in 2019, opt out of community rating requirements, allowing insurers to underwrite policies for certain individuals based on health status if the state is operating a program under AHCA's Patient and State Stability Fund. This would only apply to individuals with a lapse in coverage greater than 63 days. Individuals who maintain continuous coverage cannot be underwritten based on health status. • Starting in 2020, determine essential health benefits for the individual and small group market.	Starting in 2019, widens age bands to 5:1, and allows states to choose their own more or less restrictive standards. Starting in 2019, allows states to determine Medical Loss Ratio. Repeals essential health benefits for Medicaid plans. Expands flexibility for states to seek waivers under section 1332 of the ACA. **The July 13 revision includes a provision referred to as the Cruz Amendment: Starting in 2020, insurers that offer an ACA-compliant gold, silver, and benchmark plan on the Health Insurance Marketplace would be eligible to receive funds from the State Stability and Innovation Program for high-cost enrollees. These insurers would also be allowed to offer non-compliant plans exempt from nine major ACA requirements, including community rating, guaranteed issue, essential health benefits, and the Medical Loss Ratio. Individuals cannot use tax credits to purchase non-compliant plans, but may use HSA funds for these plans.**
Market Stability and Risk Pool	Starting in 2014, prohibited plans from denying coverage based on pre-existing conditions or engaging in medical underwriting. Created temporary federal high-risk pool from 2010-2013 until individuals with pre-existing conditions could purchase coverage on Health Insurance Marketplaces.	AHCA initially provided $100 billion over nine years to establish the Patient and State Stability Fund (PSSF). States could use these funds for a variety of purposes to stabilize insurance markets, including establishing high-risk pools. After subsequent amendments, total PSSF funding increased to $138 billion: $15 billion earmarked for maternity coverage, newborn care, and behavioral health; $15 billion to create a federal "invisible risk sharing program" covering claims over $10,000 for individuals with certain health conditions (to be determined by the CMS Administrator); and $8 billion over the 2018-2023 period to lower premiums and out-of-pocket costs for individuals with pre-existing conditions living in community rating waiver states who have had a lapse in coverage longer than 63 days and purchase individual market coverage.	Creates the State Stability and Innovation Program, with funding divided between short-term and long-term activities: • **Short-Term State Stability and Innovation Program:** Total of $50 billion for the 2018-2021 period. Funds would be available to the CMS Administrator to incentivize insurers to participate in the Health Insurance Marketplaces. • **Long-Term State Stability and Innovation Program:** Total of $62 billion for the 2019-2026 period. States could apply for funds for the following purposes: providing financial assistance for high-risk individuals on the individual market, promoting insurer participation and premium stabilization in the individual market, or providing financial assistance to reduce out-of-pocket costs for individual market enrollees. States must provide matching funds beginning in 2022. **The July revision increased funding for the Long-Term State Stability and Innovation Program by $70 billion. One percent of funds from both the short- and long-term programs would be reserved for states with premiums that are 75% higher than the national average. Currently, only Alaska would be eligible for the reserved funds. Through a separate fund, states would also receive $45 billion from 2018-2026 for substance use treatment and recovery services and for addiction research.**
Taxes and Fees	Enacts a number of taxes and fees: • "Cadillac" tax: 40% tax on high-cost employer-sponsored plans • 2.3% excise tax on sales of medical devices • 0.9% Medicare payroll tax increase for households earning more than $200,000 • 3.8% tax on unearned income for high-income households • 10% tax on indoor tanning services • Annual fee for producers and importers of brand-name pharmaceuticals • Annual fee for health insurance providers	Repeals ACA taxes and fees in 2017. Cadillac tax would be delayed until 2026.	Repeals ACA taxes and fees on a different schedule than AHCA. Most taxes and fees would be repealed in 2018. Tanning tax would be repealed in 2017. Cadillac tax would be delayed until 2026. **The initial version of BCRA would have repealed the Medicare payroll tax and unearned income tax, but the July revision keeps the taxes in place.**

Projected Impacts of AHCA and BCRA

On May 24, 2017, the Congressional Budget Office (CBO) released an estimate of the American Health Care Act's projected impacts on health insurance coverage and the federal budget.[1] On July 20, 2017, CBO released its score of the July 13 revised draft of the Better Care Reconciliation Act,[2] but did not include an estimate of the impacts of the Cruz Amendment in this score. The following table compares major elements of the CBO score for each bill.

Category	***American Health Care Act*** (Passed U.S. House of Representatives: May 4, 2017)	***Better Care Reconciliation Act*** (Revised U.S. Senate Discussion Draft: July 13, 2017)
Impacts on Coverage and Premiums	Compared to under current law, increases uninsured by 14 million in 2018.23 million more individuals would be uninsured by 2026 relative to current law. Changes would largely result from lower Medicaid enrollment. Compared to under current law, increases individual market premiums by 15% to 20% in 2018 and 2019. However, by 2026 premiums would be 10% lower than under current law.	Compared to under current law, increases uninsured by 15 million in 2018. 22 million more individuals would be uninsured by 2026 relative to current law. Changes would largely result from lower Medicaid spending and from decreased financial assistance for individual market coverage. Compared to under current law, increases individual market benchmark plan premiums by 20% in 2018 and 10% in 2019. However, by 2020 individual benchmark premiums would be 30% lower than under current law, largely due to the bill's lowering of actuarial value requirements for these plans. Benchmark plans would have high deductibles (estimated at roughly $13,000 for a single policyholder in 2026) and cover a smaller scope of services than benchmark plans under current law. CBO estimated that a single policy holder of a 58% actuarial value (AV) benchmark plan in 2026 would face an average deductible of $13,000, rendering the plan out of compliance with the federal limit on out-of-pocket costs for consumers (approximately $10,900 in 2026).
Impacts on Federal Budget	Compared to under current law, reduces the federal deficit by $119 billion over 10 years ($1.1 trillion decrease in spending, $992 billion decrease in revenues). Federal Medicaid spending would be reduced by $834 billion over 10 years.	Compared to under current law, reduces the federal deficit by $420 billion over 10 years ($903 billion decrease in spending, $483 billion decrease in revenues). Federal Medicaid spending would be reduced by $756 billion over 10 years.

ENDNOTES

[1] "Cost estimate for H.R. 1628, American Health Care Act of 2017," Congressional Budget Office, May 24, 2017: https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/americanhealthcareact.pdf
[2] "Cost estimate for H.R. 1628, Better Care Reconciliation Act of 2017," Congressional Budget Office, July 20, 2017: https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52941-hr1628bcra.pdf

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