THE COUNCIL

Steptoe
STEPTOE & JOHNSON LLP

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A Comparison of the Affordable Care Act (ACA), the House's American Health Care Act (AHCA), and the Senate's Better Care Reconciliation Act (BCRA)

	ACA	AHCA (House)	BCRA (Senate – July 13)
Employee Pre-Tax Treatment of Group Plan Premiums	Premiums for employer-sponsored coverage excluded from employees' taxable income; employers required to report cost of coverage on Form W-2.	Does not cap the employee tax benefit for employer-sponsored coverage; retains the obligation that the employer report coverage amounts on Form W-2, and an additional W-2 field is added: each month with respect to which an employee is eligible for a group health plan.	Does not cap the employee tax benefit for employer-sponsored coverage
Insurance Subsidies	Federal income-based subsidies (available to eligible individuals with incomes between 100%-400% of the federal poverty level) for individual coverage purchased on the exchanges.	Replaces federal subsidies with a refundable tax credit that is tiered by age: • $2,000 per year for anyone under 30; • $2,500 per year for 30-39; • $3,000 per year for 40-49; • $3,500 for 50-59; and • $4,000 for over 60. Reduces the credit amount for individuals with income over $75,000, or $150,000 for joint filers, by 10% of gross income over those threshold amounts; credits capped for family at $14,000 per year; no credit eligibility if coverage includes abortions. Limits the tax credit to individual market plans and unsubsidized COBRA coverage (on or off exchanges). Credits are not available to individuals who are eligible for a group health plan (including employer plans), Medicare, Medicaid or other government coverage. They also are not available for ACA grandfathered or grandmothered (i.e., grandfathered plans that received transition relief from CCIIO) plans.	Retains ACA premium subsidy structure, but adjusts eligibility and amounts. Available to individuals with incomes not above 350% of the federal poverty level. Adjusts benchmark plan for subsidy awards to a "skinnier", cheaper plan (58% AV) with the median premium cost of all QHPs in the rating area (rather than second lowest-cost silver plan). Subsidies are tiered by income and age. Credits are not available to individuals who are eligible for a group health plan. Subsidies are not available for plans that cover abortions. Beginning in 2020, subsidies may be used for catastrophic health plans.
Individual Mandate	Requires individuals (unless exempted) to obtain ACA-compliant health insurance or else pay a tax penalty.	Effectively eliminates the individual mandate by making penalty $0 as of 2016; incentivizes continuous coverage by imposing a 30% surcharge on otherwise-applicable premiums for individuals who go more than 2 months without coverage (subject to state waivers that permit health status underwriting in some	Effectively eliminates the individual mandate by making penalty $0 as of 2016. Incentivizes continuous coverage by mandating a 6-month waiting period for coverage for individuals who cannot demonstrate 12

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		circumstances).	months of continuous coverage (i.e., had a 63+ day gap in creditable coverage, as defined in the Code)
Employer Mandate	Requires employers with 50 or more full-time employees to offer ACA-complaint health insurance; absent such an offering, imposes penalties on covered employers.	Effectively eliminates the employer mandate by making penalty $0 as of 2016.	Effectively eliminates the employer mandate by making penalty $0 as of 2016.
Essential Health Benefits	Requires individual and small group plans to offer 10 essential health benefits; no dollar limits allowed on essential health benefits (including in large group market)	States may apply for waivers to establish their own essential health benefit requirements for individual and small group markets	Does not contain an EHB-specific waiver, but generally loosens/expands the ACA's Sec. 1332 waiver process and requirements to give states more flexibility with respect to broader ACA requirements (including QHP requirements, EHBs, etc.). Allows anyone to enroll in a catastrophic plan beginning in 2019 (no longer limited by age or exemption from MEC requirements); and includes catastrophic plan enrollees in the individual and small group market single risk pools.
Wellness	Permits employers to adopt wellness incentives, within certain nondiscrimination parameters, for group health plan participants to meet wellness targets.	Retains ACA wellness program structure.	Retains ACA wellness program structure.
HSAs	Leaves in place HSA rules authorized by the Medicare Modernization Act of 2003, including: • Allows individuals to put $3,400 and families to put $6,750 into a tax-free health savings account; • Non-qualified distributions are subject to a 20% tax penalty, though amounts withdrawn for qualified medical expenses are not subject to income tax; and • Only prescribed medicines (non OTC) are considered qualifying medical expenses that get preferred tax treatment.	Modifies certain HSA rules, including: • Increases annual tax free contribution limit to equal the limit on out-of-pocket cost sharing under qualified high deductible health plans ($6,550 for self only coverage, $13,100 for family coverage in 2017); • Allows spouses to make catch-up contributions to the same HSA; • Reduces tax penalty for HSA withdrawals used for non-qualified expenses from 20% to 10% (retains provision that amounts withdrawn for qualified medical expenses are not subject to income tax); and • Allows OTC drugs as qualified medical expenses.	Modifies certain HSA rules, including: • Increases annual tax free contribution limit to equal the limit on out-of-pocket cost sharing under qualified high deductible health plans ($6,550 for self only coverage, $13,100 for family coverage in 2017); • Allows spouses to make catch-up contributions to the same HSA; • Reduces tax penalty for HSA withdrawals used for non-qualified expenses from 20% to 15% (retains provision that amounts withdrawn for qualified medical expenses are not subject to income tax); • Allows OTC drugs as qualified medical expenses; • Allows payment of medical expenses for dependents through age 26; • Allows payment of HDHP premiums (only for amounts above any premium tax credit and only if the HDHP is not an employer-sponsored plan for which an income deduction is allowed under § 106); and • Prohibits HSA funds from being used to pay for HDHPs that cover abortions.
Taxes and Fees	Levies various fees and taxes on, *inter alia*, insurance companies, pharmaceutical manufacturers, and medical device manufacturers; and taxes net investment income and high-cost, employer-sponsored coverage ("Cadillac tax").	Eliminates the Cadillac tax for years 2020 through 2025 (leaving the possibility that the tax could be imposed beginning in 2026). Repeals several other ACA taxes and fees beginning in 2017:	Eliminates the Cadillac tax for years 2020 through 2025 (leaving the possibility that the tax could be imposed beginning in 2026). Repeals small business tax credit after tax year 2019 (and in the

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		• Annual provider fee; • Net investment income tax; • Prescription drug tax; and • Medical device tax. Medicare payroll tax increase repealed as of 2023.	meantime, will not allow credit for plans that cover abortion). Repeals several other ACA taxes and fees, including: • Annual provider fee (will not go into effect after current 2017 moratorium); • Prescription drug tax (2021); and • Medical device tax (2018). Retains the following from the ACA: • 3.8% net investment income tax; • 0.9% additional Medicare payroll tax for high earners; and • Cap on deduction insurers can take for salaries and other remuneration paid to top executives.
Popular ACA Market Reforms	Preexisting Condition Coverage: Prohibits insurers from denying coverage to people who have preexisting medical conditions. Dependent Coverage (Under 26): Allows individuals to stay on their parents' health insurance plans until the age of 26. Annual/Lifetime Limits: Prohibits insurers from setting certain dollar limits on how much they will pay.	Retains ACA market reforms. Regarding preexisting conditions - states may apply for waivers that allow health status underwriting, in certain circumstances, for individuals who do not maintain continuous coverage (in lieu of 30% surcharge).	Generally retains ACA market reforms, but allows states to opt out of many of them through section 1332 waivers. Requires states, starting in 2019, to set their own MLR and rebating rules. Adds a new ERISA structure that allows for the establishment of association health plans as large group plans for small businesses/individuals. These plans would be exempt from the community rating and essential benefit requirements currently imposed on small group and individual plans. Would preempt state barriers to establishment of such plans.
Age Rating	Permits insurers to charge elderly customers no more than 3 times what they charge young adults.	Increases the ACA ratio, allowing insurers to charge elderly customers up to 5 times what they charge young adults. State waivers also available to further increase the age rating ratio.	Increases the ACA ratio, allowing insurers to charge elderly customers up to 5 times what they charge young adults. Allows states to set a different ratio for adults.
Medicaid Expansion	Allows states to expand Medicaid coverage for low-income individuals, and provides federal support for such expansion.	Discontinues the ACA's Medicaid expansion in 2020 (but allows states to continue expansion with less federal support); allows states to impose a work requirement on nondisabled, nonelderly, non-pregnant adults as a condition of Medicaid coverage; and otherwise restructures the federal financing system for Medicaid into a per capita model (with per-enrollee caps on federal payments).	Provides that the ACA Medicaid expansion ends at the end of 2019, but states have option to continue expansion (with phased out federal assistance for expansion enrollees between 2020 and 2023); sunsets Medicaid EHB requirements at end of 2019; allows states to impose a work requirement on nondisabled, nonelderly, non-pregnant adults as a condition of Medicaid coverage; restructures the federal financing system for Medicaid into a per capita cap model (with an optional block grant approach); and provides for "bonus payments" to states that achieve lower than expected expenditures.