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Comparison of Health Reform Proposals

Georgia Health Policy Center

COMPARISON OF HEALTH REFORM PROPOSALS

On June 21, 2017, the Senate Budget Committee released a discussion draft of its proposed legislation to repeal and replace the Affordable Care Act (ACA), the Better Care Reconciliation Act of 2017 (BCRA). The following information supplements the Georgia Health Policy Center's previous brief on the American Health Care Act (AHCA), the House's bill to repeal and replace the ACA, and compares key components of the ACA, AHCA, and BCRA.

	ACA	AHCA	BCRA
Medicaid			
Medicaid funding	States retained Federal Medical Assistance Percentage (FMAP) for traditional populations. Reduced enhanced FMAP for expansion population from 100% in 2014 to 90% in 2020 and subsequent years.	Changes Medicaid funding to per capita caps and optional block grants starting in fiscal year (FY) 2020. Growth rates based on variations of the medical care component of the Consumer Price Index for All Urban Consumers (CPI-U), with FY 2016 state spending used as the base. States exceeding per capita caps required to repay overage. States using the block grants may retain unspent dollars.	Changes Medicaid funding to per capita caps and optional block grants starting in FY 2020. Per capita growth rates based on variations of the medical care component of the CPI-U. Block grants are based on CPI-U. State spending for eight consecutive quarters (chosen by state) from FYs 2014–2017 used as base. States that exceed their per capita caps are required to repay the overage. States using the block grants may retain unspent dollars. Puts additional restrictions on states' ability to use provider fees to draw down matching federal funds.
Medicaid expansion	Expanded Medicaid to 138% of the federal poverty level (FPL) at state option and required a single, streamlined application for tax credits, Medicaid, and CHIP. 100% FMAP for 2014-2016, phased down to 90% FMAP by 2020 and beyond.	States that expanded as of March 1, 2017, will retain enhanced FMAP as long as enrollees have no more than a one-month break in coverage. Other states have until Dec. 31, 2017, to expand Medicaid, although they will only receive their state's regular FMAP.	Three-year phase out of enhanced FMAP for expansion states (those expanding prior to March 1, 2017), starting in 2021.
Work requirements	Not addressed.	States will be able to institute work requirements for certain populations and receive a 5% increase in their administrative FMAP.	States will be able to institute work requirements for certain populations and receive a 5% increase in their administrative FMAP.
Safety net funding	Reduced aggregate Medicaid Disproportionate Share Hospital (DSH) allotments. Required the Health and Human Services secretary to develop a methodology to distribute the DSH reductions based on uninsured rates. Provided states with new options for offering home and community-based services.	Nonexpansion states can apply for a portion of $2 billion each year for FYs 2018-2022. These allotments can be applied to the costs of providing health care services for Medicaid members, the uninsured, and the underinsured. Payments to states funded at 100% by the federal government in FYs 2018-2021 and at 95% in FY 2022.	Non-expansion states can apply for a portion of $2 billion each year for FYs 2018-2022. These allotments can be applied to the costs of providing health care services for Medicaid members, the uninsured, and the underinsured. Payments to states funded at 100% by the federal government in FYs 2018-2021 and at 95% in FY 2022.
Children's Health Insurance Plan (CHIP)	Created a minimum eligibility level for all children of 138% FPL. Extended CHIP funding to 2015 and increased the FMAP up to 100%.	Reverts the mandatory Medicaid income eligibility level for poverty-related children back to 100% of FPL. States could cover this population in their CHIP.	Reverts the mandatory Medicaid income eligibility level for poverty-related children back to 100% of FPL. States could cover this population in their CHIP.
Individual Market			
Individual mandate	Introduced a coverage mandate requiring individuals to have health insurance or pay a fine.	Repeals the individual mandate and penalizes individuals for letting coverage lapse by allowing insurers to charge a 30% one year surcharge for insurance.	Repeals the individual mandate and penalizes individuals for letting coverage lapse by requiring insurers to impose a six month waiting period for insurance.
Tax credits for purchasing insurance	Credits available for 100-400% FPL. Tax credits vary by age, income, and location; Based on cost of benchmark plan with 70% actuarial value (AV).	Flat tax credits based on age. For single incomes over $75,000 or couple incomes over $150,000, credit is reduced.	For 0-350% FPL. Tax credits vary by age, income, and where individuals live, but are less generous than ACA credits. Credits are based on cost of benchmark plan with 58% AV.

	ACA	AHCA	BCRA
Individual Market			
Cost-sharing reduction (CSR) subsidies	Provided subsidies to insurers in exchange for reduced out-of-pocket expenses for low-income individuals using their Marketplace health plans.	Eliminates CSRs in 2020.	Eliminates CSRs in 2020.
Age rating bands	Older insurance customers can be charged a maximum of three times what younger customers pay for insurance.	Older insurance customers can be charged a maximum of five times what younger customers pay for insurance.	Older insurance customers can be charged a maximum of five times what younger customers pay for insurance.
Dependent care	Individuals age 26 years and under can be covered by their parents' health plan.	Retains ACA provision.	Retains ACA provision.
Essential Health Benefits (EHBs)	Required insurers to cover a list of EHBs including Rx drugs, mental health services, and hospitalizations.	Allows states to designate what EHBs insurers are required to cover.	Allows states to designate what EHBs insurers are required to cover.
Community rating	Insurers cannot charge customers more or deny coverage based on pre-existing conditions.	Insurers can charge customers more based on pre-existing conditions, if individuals allow their coverage to lapse.	Insurers cannot charge customers more or deny coverage based on pre-existing conditions.
Stability funding	Created risk adjustment, temporary reinsurance program (2014–2016), and temporary Marketplace risk corridors (2014–2016).	Creates fund to help states innovate ways to stabilize their individual markets including high-risk pools or premium subsidies. States may choose how to spend the funds ($130 billion over a decade). Establishes temporary federal invisible high-risk pool; funding for community rating waivers.	Establishes stability and innovation program to reimburse insurers bearing financial losses in the Marketplace ($112 billion over a decade). Operated in short-term (until 2021) by Centers for Medicare and Medicaid Services, then by states.
Medical loss ratio (MLR) standards	Required insurance companies to spend 80% of premium income on health care claims and quality improvement.	Not addressed.	Sunsets ACA's MLR standards starting in 2019, and allows states to set them going forward.
ACA § 1332 waivers	Created 1332 waiver program, starting in 2017, which allowed states to waive certain ACA provisions so long as coverage is at least as comprehensive, affordable, accessible, and budget neutral.	Not addressed.	Loosens 1332 waiver approval standards around cost-sharing and comprehensive coverage.
Other			
Employer mandate	Required employers with more than 50 employees to provide coverage that is affordable and comprehensive.	Repealed.	Repealed.
Taxes	Taxes on certain Medicare plans, health insurance, medical devices, and tanning beds. Increased medical deduction threshold to 10%.	Would repeal ACA taxes and restore medical deduction threshold to 7.5%.	Would repeal ACA taxes and restore medical deduction threshold to 7.5%.
Health savings accounts (HSAs)	Individuals can contribute up to $3,400 and families up to $6,750 per year.	Starting in 2018, individuals could contribute up to $6,550 and families could contribute up to $13,100 per year.	Starting in 2018, individuals could contribute up to $6,550 and families could contribute up to $13,100 per year.
Association health plans	Not addressed.	Not addressed.	Allows small businesses to purchase large group coverage together through associations (covered under Employee Retirement Income Security Act instead of state law).
Public health/ community health centers	Created Prevention and Public Health (PPH) Fund (FY 2017 budget, $931 million). Created Community Health Center (CHC) Fund ($11 billion over 5 years).	Repeals funding for PPH Fund; Continues CHC Fund with $422 million for FY 2017.	Repeals funding for PPH Fund; Continues CHC Fund with $422 million for FY 2017.

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