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Comparison of Health Reform Proposals

Georgia Health Policy Center

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On July 13, 2017, the Senate Budget Committee released an updated discussion draft of the Better Care Reconciliation Act of 2017 (BCRA), proposed legislation to repeal and replace the Affordable Care Act (ACA). The following information compares key components of the ACA; the American Health Care Act (AHCA) the House's bill to repeal and replace the ACA, and the BCRA.

	Affordable Care Act (ACA)	American Health Care Act (AHCA)	Better Care Reconciliation Act (BCRA)
Medicaid			
Medicaid funding	States retain Federal Medical Assistance Percentage (FMAP) for traditional populations. Enhanced FMAP for expansion population are reduced from 100% in 2014 to 90% in 2020 and subsequent years.	Changes Medicaid funding to per capita caps and optional block grants (nonelderly, nondisabled) 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 state spending in FY 2016 used as base. States exceeding per capita caps are required to repay overage. States using the block grants may retain unspent dollars.	Funds Medicaid using per capita caps starting in FY 2020. Prior to FY 2025, growth rates for children, expansion enrollees, and nondisabled adults under 65 years increase based on the medical care component of the CPI-U. Growth rates for the elderly and disabled are based on the medical care component of the CPI-U plus 1%. For FY 2025 and after, growth rates for all groups are based on CPI-U. States can choose block grants for expansion enrollees or nonexpansion adults under age 65 years. Beginning in FY 2020, certain states may receive adjustments to per capita target amounts between 0.5% and 2.0% if expenditures in the prior year are 25% above or below the national average. Actual amounts are determined by the Health and Human Services (HHS) secretary and must be budget neutral. Provides for a maximum of $5 billion for public health emergencies between Jan. 2020 and Dec. 2024.
Medicaid expansion	Expands Medicaid to 138% of the federal poverty level (FPD) at state option and require a single, streamlined application for tax credits, Medicaid, and CHIP. 100% FMAP for 2014-2016 is phased down to 90% FMAP by 2020 and beyond.	States that expanded as of March 1, 2017 retain enhanced FMAP so 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.	Phases out the enhanced FMAP for expansion states (those expanding prior to March 1, 2017), by calendar year (CY) 2023. Enhanced FMAP is reduced to 85% in CY 2021, 80% in CY 2022, and 75% in CY 2023. States that expanded after Feb. 28, 2017 receive the state's regular FMAP for expansion enrollees.
Work requirements	Not addressed.	States are 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	Reduces aggregate Medicaid Disproportionate Share Hospital (DSH) allotments. Requires HHS to develop a methodology to distribute the DSH reductions based on uninsured rates. Provides states with new options for offering home and community-based services (HCBS).	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.	Nonexpansion states can apply for a portion of $2 billion each year for FY 2018-2022. Allotments can be used to adjust payment amounts for Medicaid providers. Payments to states will be funded at 100% by the federal government in FYs 2018-2021 and at 95% in FY 2022. Exempts nonexpansion states from Medicaid DSH allotment reductions and ignores this exemption when determining Medicaid DSH allotment reductions for expansion states. Nonexpansion states receive an increase to their Medicaid DSH allotment in FY 2020 if their per capita FY 2016 DSH allotment is below the national average.
Home and community-based services	Not addressed.	Not addressed.	Establishes an $8 billion HCBS demonstration project. States may use the money to make payment adjustments that provide and improve the quality of HCBS under Section 1915 (c), (d), or (i). The demonstration project takes place from Jan. 2020 through Dec. 2023.

	Affordable Care Act (ACA)	American Health Care Act (AHCA)	Better Care Reconciliation Act (BCRA)
Individual Market			
Individual mandate	Introduces a coverage mandate requiring individuals to have health insurance or pay a fine.	Repeals the individual mandate, but penalizes individuals for letting coverage lapse by allowing insurers to charge a 30% one-year surcharge when purchasing insurance.	Repeals the individual mandate. Requires those who have had a coverage lapse of more than 63 days to wait six months before enrolling in insurance.
Tax credits for purchasing insurance	Available for 100-400% FPL. Tax credits vary by age, income, and where individuals live. 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 and can be used to purchase catastrophic policies.
Cost-sharing reduction subsidies	Provides subsidies to insurers in exchange for reduced out-of-pocket expenses for low-income individuals using their Marketplace health plans.	Eliminates cost-sharing reduction (CSR) subsidies 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 and under can be covered by their parents' health plan.	Retains ACA provision.	Retains ACA provision.
Essential health benefits	Requires insurers to cover a list of essential health benefits (EHB), including items like prescription 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. Insurers can sell policies that do not meet EHB requirements as long as they offer at least one plan that complies with state standards.
Community rating	Insurers cannot charge customers more or deny coverage based on preexisting conditions.	Insurers can charge customers more based on preexisting conditions, if they allow their coverage to lapse.	Insurers cannot charge customers more or deny coverage based on preexisting conditions.
Stability funding	Creates risk adjustment, temporary reinsurance program (2014–2016), and temporary Marketplace risk corridors (2014–2016). Creates Section 1332 waiver program, starting in 2017.	Creates patient and state stability fund to help states innovate ways to stabilize their individual markets, including high-risk pools or premium subsidies. States have leeway in how they spend the funds ($130 billion over a decade).	Establishes the State Stability and Innovation Program to fund reinsurance programs and promote market stabilization ($182 billion divided into short-term and long-term funding over a decade). The Centers for Medicare and Medicaid Services will administer $50 billion in short-term funding for reinsurance (until 2021). The remaining $132 billion is available to states from 2019-2026 for controlling insurance costs for high-risk purchasers, funding reinsurance programs, provider payments, and cost-sharing reductions.
Other			
Employer mandate	Requires employers with more than 50 employees to provide affordable and comprehensive coverage.	Repeals the mandate.	Repeals the mandate.
Taxes	Taxes on certain Medicare plans, health insurance, medical devices, and tanning beds; increases medical deduction threshold to 10%.	Repeals ACA taxes and restore medical deduction threshold to 7.5%.	Repeals most ACA taxes and restore medical deduction threshold to 7.5%. Retains the Medicare health insurance payroll tax.
Health savings accounts	Individuals can contribute up to $3,400 and families up to $6,750 per year.	Starting in 2018, individuals can contribute up to $6,550 and families could contribute up to $13,100 per year.	Starting in 2018, individuals can contribute up to $6,550 and families can contribute up to $13,100 per year. Funds can be applied to premiums for high-deductible plans.
Public health / community health centers	Creates Prevention and Public Health (PPH) Fund (budget of $931 million in 2017). Creates Community Health Center (CHC) Fund ($11 billion over five 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. Adds $24.86 billion in grants for substance use disorder (SUD) treatment for FYs 2018-2026 and $50.4 million in annual funding for SUD research for FYs 2018-2022.