ACA OVERVIEW

Provided by:
The SEBO Group

This ACA Overview is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. Readers should contact legal counsel for legal advice.

Comparison of the AHCA and the BCRA

HIGHLIGHTS

The U.S. Senate and the House of Representatives have both drafted proposed bills to repeal and replace the ACA.

- Both bills would repeal or modify some ACA rules, but retain key consumer protections.
- Both bills include new programs and requirements that are not related to the ACA.
- However, the House and Senate bills include some key differences that may impact employers.

On May 4, 2017, the U.S. House of Representatives passed its proposed bill to repeal and replace the Affordable Care Act (ACA), called the **American Health Care Act (AHCA)**. Then, on June 22, 2017, Republicans in the U.S. Senate released a discussion draft of their proposal, called the **Better Care Reconciliation Act (BCRA)**. Although the Senate bill closely mirrors the proposal passed in the House, there are some major differences that may affect employers.

On July 3, 2017, the Congressional Research Service (CRS) issued a **comparison report** of the House's AHCA and the Senate's BCRA. This ACA Overview includes the CRS report, which contains tables that, together, provide an overview of AHCA and BCRA provisions, as compared to current law under the ACA.

- Table 1 includes provisions that apply to the private health insurance market.
- Table 2 includes provisions related to public health, taxes and implementation funding.

Both proposed bills also include significant changes to the Medicaid program, which are not included in this document.

Neither the House nor the Senate proposed bills have been enacted at this time. **Until legislation to repeal and replace the ACA is passed by Congress and signed into law by President Donald Trump, the ACA will remain in place**.

LINKS AND RESOURCES

- The CRS Comparison Report
- The House of Representatives' American Health Care Act
- The Senate's Better Care Reconciliation Act
- Congressional Budget Office reports for the AHCA and the BCRA

OVERVIEW OF THE LEGISLATIVE PROCESS

On May 4, 2017, House Republicans passed the AHCA as their proposal to repeal and replace the ACA. As a result, the AHCA moved on to the Senate for consideration. In response, Senate Republicans drafted the BCRA as their own ACA repeal and replacement bill. The BCRA is written as an amendment to the AHCA, where all of the House-passed language would be stricken, and the BCRA's language would be inserted in its place. Because the Senate version differs from the House version, the proposal, if passed by the Senate, would need to be approved by the House before being signed into law by the president.

Both the House and Senate's proposed legislation are budget reconciliation bills, which mean that they can only address ACA provisions that directly relate to federal spending and taxation. As a result, these proposals cannot fully repeal the ACA. Budget reconciliation legislation can be passed by both houses with a simple majority vote. However, a full repeal of the ACA must be introduced as a separate bill that would require 60 votes in the Senate to pass.

Comparing the House and Senate Proposals

Both the AHCA and the BCRA would repeal or modify ACA provisions. For example, both of the proposals would:

- Substitute the ACA's premium tax credit for premium tax credits with different eligibility rules and calculation requirements;
- Effectively eliminate the ACA's individual and employer mandates; and
- Repeal many of the new taxes and fees established under the ACA.

In addition, both the AHCA and the BCRA include new programs and requirements that are not related to the ACA. For example, under each, a new fund would be created to provide funding to states for specified activities intended to improve access to health insurance and health care in the state.

Although the AHCA and the BCRA share many provisions, **the BCRA strikes some AHCA provisions and adds some new provisions**. For example, the BCRA would not allow states to apply for waivers from three ACA requirements (instead, the BCRA would modify the ACA's existing state innovation waivers).

Congressional Budget Office (CBO) Reports

The CBO issued a cost estimate for the AHCA on May 24, 2017, and a separate cost estimate for the BCRA on June 26, 2017. According to these estimates, the AHCA would **reduce federal deficits** by $119 billion between 2017 and 2026, while the BCRA would reduce federal deficits by $321 billion over that same time period ($202 billion more than the estimated savings for the AHCA). In addition, the CBO estimates that both the AHCA and the BCRA would **increase the number of uninsured individuals** as compared to current law—an estimated 14 million under the AHCA and an estimated 15 million under the BCRA in 2018, and an estimated 23 million under the AHCA and an estimated 22 million under the BCRA in 2026.

TABLE 1. PROVISIONS RELATED TO PRIVATE HEALTH INSURANCE

PROVISION	CURRENT LAW	AHCA	BCRA
		Health Insurance Tax Credits and Cost-sharing Subsidies	
Premium Tax Credit	The ACA created a premium tax credit to help eligible individuals pay for qualified health plans (QHPs) offered through individual Exchanges only. Eligibility criteria include: • Status as a U.S. citizen, national or lawfully present individual; • Income between 100-400% of federal poverty level (FPL); and • Other criteria. The ACA also specified the tax credit calculation formula, which includes income as a factor and is based on a standard Exchange plan: the silver QHP—70% actuarial value (AV)—that has the second-lowest premium of all silver QHPs in a given local area. Eligible individuals may receive the credit in advance (that is, during the year), and payments are later reconciled when individuals file income tax returns. Individuals who receive excess credits must pay back those amounts; repayment amounts are capped for those with incomes under 400% of FPL.	**Beginning in 2018**, the AHCA would: • Allow the ACA tax credit to apply to certain off-Exchange and other plans; • Restrict how the credit could apply to coverage for abortion; and • Disregard the income-related caps for excess repayments of the ACA credit (requiring individuals to repay the entire amount of the tax credit overpayment, regardless of income level). **Beginning in 2019**, the AHCA would amend the tax credit calculation formula by specifying income and age as factors. **Beginning in 2020**, AHCA would replace the ACA tax credit with a different refundable, advanceable tax credit. The AHCA credit would be allowed for citizens, nationals and qualified aliens enrolled in QHPs who are not eligible for other sources of coverage. Credit amounts would be based on age, adjusted based on income, and capped according to a maximum dollar amount and family size.	The BCRA would make somewhat different changes to the ACA tax credit, beginning in 2020. Similar to the AHCA, the BCRA would: • Allow the tax credits for citizens, nationals and qualified aliens; and • Restrict how the credit could apply to coverage for abortion and disregard the income-related caps for excess credit repayments, beginning in 2018. The BCRA would also amend the ACA tax credit calculation formula by specifying income and age as factors, similar to the AHCA, but effective beginning in 2020. However, the BCRA would also change ACA eligibility criteria regarding access to employer-provided coverage and would change income eligibility from 100–400% of FPL to up to 350% of FPL. In addition, the standard plan used to determine the amount of the credit would have an AV of 58% and would have the median premium of all QHPs with 58% AV in the local area.

PROVISION	CURRENT LAW	AHCA	BCRA
Cost-sharing Subsidy	The ACA created subsidies to reduce cost-sharing expenses for eligible lower-income individuals enrolled in silver-level QHPs through Exchanges. The ACA directed HHS and the IRS to reimburse insurers for the reduced cost sharing. When Congress did not provide appropriations for the cost-sharing payments, the Obama administration financed the payments through a non-appropriated source. The House sued, claiming that the payments violated the Appropriations Clause of the U.S. Constitution.	The AHCA would repeal the cost-sharing subsidies effective for plan years beginning in 2020.	The BCRA would appropriate necessary funds for cost-sharing subsidies (including adjustments to prior obligations for the payments) from the date of enactment through Dec. 31, 2019. Payments incurred for 2018 and 2019 plan years could be available through Dec. 31, 2020. Then, similar to the AHCA, the BCRA would repeal the cost-sharing subsidies effective for plan years beginning in 2020.
Small Business Tax Credit	The ACA established a small business health insurance tax credit.	The AHCA would restrict how the small business tax credit could apply to coverage for abortion beginning in 2018, and would sunset the credit beginning tax year 2020.	Similar to the AHCA provision
Health Insurance Mandates			
Individual Mandate	The ACA created an individual mandate—a requirement for most individuals to maintain health insurance coverage or pay a penalty.	The AHCA would effectively eliminate the annual individual mandate penalty retroactively beginning in 2016.	Identical to the AHCA provision
Employer Mandate	The ACA requires employers that have at least 50 full-time equivalent employees to provide health coverage or face potential employer tax penalties, if one or more full-time employees obtain an Exchange premium tax credit.	The AHCA would effectively eliminate the employer tax penalties retroactively beginning in 2016.	Identical to the AHCA provision

PROVISION	CURRENT LAW	AHCA	BCRA
	Federal Requirements Applicable to Private Health Plans		
Age Rating Restriction	Under the ACA, premiums for certain plans offered in the individual and small group markets may vary only by **family size** (self-only or family), **geographic rating area**, **tobacco use** (up to 1.5:1), and **age** (up to 3:1 for adults).	Under the AHCA, HHS could implement an age rating ratio of 5:1 for adults in the individual and small group markets for plan years beginning on or after Jan. 1, 2018. States would have the option to implement a different ratio for adults.	The BCRA would establish (in contrast to the AHCA, where HHS could establish) an age rating ratio of 5:1 for adults for plan years beginning on or after Jan. 1, 2019. Similar to the AHCA, states would have the option to implement a different ratio for adults.
Actuarial Value Requirement	The ACA required certain plans offered in the individual and small group markets to: • Cover 10 essential health benefits (EHBs); • Comply with certain cost-sharing limits; and • Meet a certain generosity level based on AV—bronze (60% AV), silver (70% AV), gold (80% AV) or platinum (90% AV).	Under the AHCA, plans offered after Dec. 31, 2019, would no longer need to comply with the actuarial value requirement.	No provision
Medical Loss Ratio (MLR)	MLR measures the share of enrollee premiums that health insurers spend on medical claims, as opposed to non-claims expenses. The ACA imposes the following minimum MLRs: • 80% in the individual and small group markets; and • 85% in the large group market. Insurers must issue rebates to policyholders each year they do not meet MLR standards.	No provision	Effective for plan years beginning on or after Jan. 1, 2019, the BCRA would eliminate the MLR ratios, the calculation of rebates and the penalties for noncompliance. Instead, states would be required to set their own MLR requirements.

PROVISION	CURRENT LAW	AHCA	BCRA
Continuous Health Insurance Coverage Incentive	The ACA includes the following provisions related to continuous coverage incentives: • The individual mandate; • Premium rating restrictions for plans in the individual and small group markets; • Expanded guaranteed-issue requirements for plans in the individual, small group and large group markets; and • The prohibition on excluding coverage of pre-existing conditions.	The AHCA would effectively eliminate the individual mandate penalty retroactively beginning in 2016. Instead, the AHCA would allow issuers of individual market plans to impose a 30% increase in monthly premiums on policyholders who: • Had a gap in coverage that exceeded 63 days in the prior 12 months; or • Aged out of their dependent coverage and did not enroll in coverage during the next open enrollment period. The premium increase would apply during the enforcement period, which is either a 12-month period or the remainder of the plan year (if a person enrolls in coverage outside the open enrollment period). The provision would be effective for coverage obtained during special enrollment periods for the 2018 plan year, and for all coverage beginning with the 2019 plan year.	The BCRA would effectively eliminate the individual mandate penalty, like the AHCA. However, the BCRA would require issuers offering plans in the individual market to impose a six-month waiting period on most individuals who had a gap in coverage that exceeded 63 days in the prior 12 months. Gaps of 63 days or less and gaps related to waiting periods would not be included when assessing 12 months of continuous coverage. For an individual who qualifies to enroll during an open or special enrollment period, if coverage is subject to a waiting period, the coverage would begin six months after the date on which the individual submits an application for coverage. For an individual who enrolls outside the open enrollment period and does not qualify for a special enrollment period, if coverage is subject to a waiting period, the coverage would begin the later of either: • Six months after the day on which the individual submits an application for coverage; or • The first day of the following plan year. This provision would be effective for coverage beginning on or after Jan. 1, 2019.

PROVISION	CURRENT LAW	AHCA	BCRA
		State Flexibility	
Waivers	ACA Section 1332 allows states to apply for State Innovation Waivers of certain ACA provisions, beginning in 2017. States may receive a Section 1332 waiver if the state's plan that would be put in place of the waived provisions meets the following criteria: • It provides coverage to as many residents as would be covered absent the waiver; • Coverage is as comprehensive & affordable as it would be absent a waiver; and • It does not increase the federal deficit. A Section 1332 waiver could result in residents not receiving certain financial assistance for which they otherwise would be eligible. If this occurs, the state is to receive *pass-through funding* (the aggregate amount of subsidies that would have been available to the state's residents had the state not received a waiver) to be used to implement the plan established under the waiver. Section 1332 specifies the information a state must include in its application for a waiver. A Section 1332 waiver cannot extend longer than five years unless a state requests, and is granted, continuation.	The AHCA would not modify ACA Section 1332. Instead, the AHCA would establish new waivers for states for one or more of the following purposes: • A state could apply for a waiver to implement a higher age rating ratio for adults than the ratio specified in the ACA, as amended by the AHCA, for plan years beginning on or after Jan. 1, 2018. • A state could apply for a waiver from the EHB requirement, and instead specify its own EHB, for plan years beginning on or after Jan. 1, 2020. • A state could apply to waive the AHCA's continuous coverage penalty, and instead allow issuers to use health status as a factor when setting premiums for individuals subject to an enforcement period. The waiver could apply to coverage obtained during special enrollment periods for the 2018 plan year, and for all coverage beginning with the 2019 plan year.	The BCRA would modify some provisions of ACA Section 1332, but it would not modify the list of ACA provisions that can be waived under ACA Section 1332. The BCRA would amend the eligibility criteria for receiving a waiver by requiring a waiver request to be granted unless the state's plan would increase the federal deficit. The BCRA would also modify the ACA provisions related to the pass-through funding by: • Allowing a state to request that all, or a portion of, the aggregate pass-through funding amounts determined by HHS be paid to the state; • Appropriating $2 billion to HHS for 2017 through 2019 to provide grants to states to submit an application for a Section 1332 waiver and implement a state plan under a Section 1332 waiver; and • Allowing a state to use funds received under the BCRA's Long-term State Stability and Innovation Program to carry out the state plan under a waiver. The BCRA would also modify the information a state is required to include in its Section

PROVISION	CURRENT LAW	AHCA	BCRA
	Under the ACA, the following requirements also apply to health plans: • Premium rating restrictions for plans in the individual and small group markets; • The prohibition on excluding coverage for pre-existing conditions; and • The EHB requirement for individual and small group market plans.		1332 waiver application, and would provide that a Section 1332 waiver is in effect for a period of eight years unless a state requests a shorter duration. A state could apply to renew the waiver for unlimited additional eight-year periods, and the waiver could not be canceled before the end of the eight-year period (including a renewal period).
Stability Fund	N/A	The AHCA would establish a Patient and State Stability Fund for states to undertake one or more of nine different types of activities related to stabilizing the state's private health insurance market. The AHCA would appropriate to the fund $15 billion in each 2018 and 2019, and $10 billion in each subsequent year through 2026. The AHCA would also provide an additional: • $15 billion in 2020 that states could use for: (1) maternity coverage and newborn care; and (2) prevention, treatment or recovery support services for mental or substance use disorders; and • $8 billion for 2018 through 2023 to states with a waiver under the AHCA related to allowing issuers to use health status as a factor when setting premiums.	The BCRA would add the following two new subsections related to CHIP that would provide funding for specified activities: • Subsection (h) would appropriate $15 billion for each 2018 and 2019, and $10 billion for each 2020 and 2021, to be used to fund arrangements with insurers to stabilize premiums and promote market participation and plan choice in the individual market. The total amount appropriated would be $50 billion to be used over 2018–2021. • Subsection (i) would establish a Long-term State Stability and Innovation Program to provide funding to states to undertake four types of allowed activities, from 2019 through 2026, related to stabilizing the state's private

PROVISION	CURRENT LAW	AHCA	BCRA
		The AHCA would also establish a Federal Invisible Risk-sharing Program to provide payments to insurers of individual market plans to help certain individuals with high-cost medical claims. The AHCA would appropriate $15 billion for the program to be used over 2018 through 2026. The total amount appropriated would be $138 billion to be used over 2018–2026.	health insurance market. The specific appropriation amounts would vary each year, with a total amount appropriated of $62 billion to be used over 2019–2026. The BCRA would apply some limitations to payments made under the new subsections (h) and (i), related to prohibiting federal funds for coverage and payment for abortion, prohibiting federal funds for required state contributions and citizenship documentation requirements. The total amount appropriated under both new subsections—(h) and (i)—would be $102 billion to be used over 2018–2026.
Employment-based Insurance Pools			
Small Business Health Plans (SBHPs)	Individuals and/or employers may pool together (such as through a trade or professional association) to purchase health insurance. Some states may regulate insurance sold to associations at the association level; associations made up of many members may be regulated as large groups in those states. However, federal regulation of association coverage generally applies at the member level. Thus, a large association of individuals or small businesses would be federally regulated as individual or small group insurance.	No provision	The BCRA would amend ERISA to establish SBHPs, defined as a fully insured group health plan offered by a large group insurer. The BCRA would: • Identify who is eligible for coverage under an SBHP; • List criteria that an entity must meet to sponsor an SBHP; and • Direct the Department of Labor (DOL) to create regulations about certification of SBHPs and qualified sponsors, as well as

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			other issues the DOL deems appropriate. The BCRA would preempt state laws that prohibit an insurer from offering coverage in connection with an SBHP. The BCRA provision would go into effect one year after enactment, and the DOL would be required to create regulations implementing the provision within six months of enactment.

TABLE 2. PROVISIONS RELATED TO PUBLIC HEALTH, TAXES AND IMPLEMENTATION FUNDING

PROVISION	CURRENT LAW	AHCA	BCRA
		Public Health	
Prevention and Public Health Fund	The ACA established the Prevention and Public Health Fund and provided a permanent annual appropriation for prevention and public health programs. Annual appropriation amounts were subsequently reduced.	The AHCA would repeal all Prevention and Public Health Fund appropriations starting in 2019, and would rescind any unobligated balance remaining at the end of 2018.	The BCRA would repeal the Prevention and Public Health Fund appropriations starting in 2018, but does not mention rescission.
Community Health Center Program	The ACA created the Community Health Center Fund, which provided mandatory appropriations to support the health center program for 2011–2015. The appropriations were subsequently extended for 2016–2017, for which $3.6 billion was appropriated to the fund in each year.	The AHCA would provide an additional $422 million to the Community Health Center Fund in 2017.	Identical to the AHCA provision

PROVISION	CURRENT LAW	AHCA	BCRA
Federal Payments to States	Planned Parenthood-affiliated health centers receive reimbursements, including from Medicaid and other federal programs, for family planning and other services provided to beneficiaries. Planned Parenthood and its affiliates may receive federal grants. Although some facilities provide abortions, federal funds are available for abortions only in cases of rape, incest or endangerment of a mother's life.	The AHCA would restrict a prohibited entity, for one year effective at enactment, from receiving direct spending (such as Medicaid reimbursements). A prohibited entity is: • A nonprofit organization; • An essential community provider that provides family planning, reproductive health and any other related services; • An organization that provides abortions in instances when the pregnancy is not the result of rape, incest or likely to endanger the mother's life; and • An organization that received federal and state Medicaid reimbursements in 2014 that exceeded $350 million. The CBO predicts only Planned Parenthood and its affiliates would be affected.	Identical to the AHCA provision
State Grants for Substance Abuse and Mental Health	The Substance Abuse and Mental Health Services Administration (SAMHSA) administers grants and other activities to support prevention/treatment of substance use disorder and mental illness. In 2016, Congress authorized $500 million to be appropriated for 2017 and 2018 for state grants to address the opioid abuse crisis.	Prevention, treatment and recovery services for mental or substance use disorders would be among the allowed uses of funds in the Patient and State Stability Fund, as would be established under the AHCA (described in Table 1).	The BCRA would appropriate $2 billion for 2018 to award grants to states "to support substance use disorder treatment and recovery support services for individuals with mental or substance use disorders." Funds would be available until expended. The BCRA would not amend (and does not refer to) any existing authorization.

PROVISION	CURRENT LAW	AHCA	BCRA
		Tax Advantaged Accounts	
Tax on Over-the-counter Medications	Taxpayers may use several different types of tax-advantaged health accounts to pay or be reimbursed for qualified medical expenses. However, the ACA imposed the requirement that amounts paid for medicine or drugs are qualified expenses only in the case of prescribed drugs and insulin and not in the case of over-the-counter medications.	The AHCA would repeal the requirement, effective beginning tax year 2017.	Identical to the AHCA provision
Tax on Health Savings Accounts (HSAs) and Archer Medical Savings Accounts (MSAs)	Distributions from Archer MSAs and HSAs that are used for purposes other than paying for qualified medical expenses are taxed at 20%. Prior to the ACA, the tax rate on these distributions was 15% and 10% for Archer MSAs and HSAs, respectively.	The AHCA would reduce the applicable tax rate to 15% for Archer MSAs and 10% for HSAs, for distributions made after Dec. 31, 2016.	Identical to the AHCA provision
Contribution Limit on Health Flexible Spending Accounts (FSAs)	Under the ACA, an employee may contribute a maximum of $2,500 (as adjusted annually) to a health FSA established under a cafeteria plan.	The AHCA would repeal this limit, effective beginning tax year 2017.	The BCRA also would repeal this limit, but the repeal would be effective for plan years beginning in 2018.
Maximum Contribution Limit to HSAs	HSA contributions are subject to an annual limit, which is adjusted for inflation. In 2017, the limit is $3,400 for self-only coverage and $6,750 for family coverage.	The AHCA would increase the HSA annual contribution limits to match the out-of-pocket limits for HSA-qualified high deductible health plans, beginning in 2018.	Identical to the AHCA provision

PROVISION	CURRENT LAW	AHCA	BCRA
HSA Catch-up Contributions for Spouses	For a married couple, if either spouse has HSA-qualified family coverage and both spouses have their own HSAs, then both are treated as if they have only one family plan for purposes of the HSA contribution limit. Their annual limit is first reduced by any amount paid to Archer MSAs of either spouse for the year, and then the remaining amount is divided equally between the spouses (unless they agree differently). Each spouse is allowed to make catch-up contributions to his or her respective HSA, provided each spouse is eligible to do so.	Under the AHCA, with respect to the contribution limit to an HSA, married individuals would not have to take into account whether their spouse also is covered by an HSA-qualified high deductible health plan, beginning in 2018. The AHCA also would effectively allow both spouses to make catch-up contributions to one HSA.	Identical to the AHCA provision
Special Rule for Certain Medical Expenses Incurred Before Establishment of an HSA	In general, HSA withdrawals are exempt from federal income taxes if used for qualified medical expenses. However, HSA withdrawals are not tax-exempt if used to pay qualified medical expenses incurred before the HSA was established.	The AHCA would provide a circumstance under which HSA withdrawals may be used to pay qualified medical expenses incurred before the HSA was established, for coverage beginning after Dec. 31, 2017.	Almost identical to the AHCA provision
Tax Provisions			
Compensation from Certain Insurers	Generally, employers may deduct the compensation paid to employees as a business expense. However, under the ACA, certain health insurers cannot deduct the compensation paid to an officer, director or employee in excess of $500,000.	The AHCA would repeal this limit, effective beginning tax year 2017.	Identical to the AHCA provision

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PROVISION	CURRENT LAW	AHCA	BCRA
Tanning Tax	The ACA imposes a 10% excise tax on indoor tanning services.	The AHCA would repeal the tax, effective after June 30, 2017.	The BCRA also would repeal the tax, but effective after Sept. 30, 2017.
Tax on Prescription Medications	The ACA imposes an annual tax on certain manufacturers or importers of branded prescription drugs.	The AHCA would repeal the tax, effective in 2017.	The BCRA also would repeal the tax, but effective in 2018.
Health Insurance Providers Fee	The ACA imposes an annual fee on certain health insurers.	The AHCA would repeal the fee, effective in 2017.	Almost identical to the AHCA provision
Net Investment Income Tax	The ACA applies a 3.8% tax to certain net investment income of individuals, estates and trusts above specified amounts.	The AHCA would repeal the net investment tax, effective beginning tax year 2017.	Identical to the AHCA provision
Cadillac Tax on High-cost Group Health Coverage	The ACA established a 40% excise tax on high-cost employer-sponsored coverage (called the Cadillac tax). Implementation of the tax has been delayed until 2020.	The AHCA would further delay implementation of the tax until 2026.	Effectively the same as the AHCA provision
Medical Devices Excise Tax	The ACA established a 2.3% excise tax on the sale of certain medical devices.	The AHCA would repeal the tax, effective for sales after Dec. 31, 2016.	The BCRA also would repeal the tax, but effective for sales after Dec. 31, 2017.
Deduction for Medicare Part D Subsidy	Employers that provide Medicare-eligible retirees with qualified prescription drug coverage are eligible for federal subsidy payments. Prior to the ACA, employers were allowed to claim a business deduction for their qualified retiree prescription drug expenses, even though they also received	The AHCA would repeal the ACA change and reinstate business-expense deductions for retiree prescription drug costs without reduction by the amount of any federal subsidy. The change would be effective for taxable years beginning after Dec. 31, 2016.	Identical to the AHCA provision

PROVISION	CURRENT LAW	AHCA	BCRA
	the federal subsidy to cover a portion of those expenses. Under the ACA, beginning in 2013, the amount allowable as a deduction is reduced by the amount of the federal subsidy received.		
Income Threshold for Determining Medical Care Deduction	Under the ACA, taxpayers who itemize their deductions may deduct qualifying medical expenses exceeding 10% of their adjusted gross income (AGI). Prior to the ACA, the AGI threshold was 7.5% for all taxpayers.	The AHCA would reduce the AGI threshold to 5.8% for all taxpayers, beginning in 2017.	The BCRA would reduce the AGI threshold to 7.5% for all taxpayers, beginning in 2017.
Medicare Tax Increase	The ACA imposes an additional Medicare tax of 0.9% of an employee's wages or self-employment income. The additional tax applies only to taxpayers with taxable income over $250,000 if married filing jointly, $125,000 if married filing separately and $200,000 for all other taxpayers.	The AHCA would repeal the additional 0.9% Medicare tax for compensation received after, and taxable years beginning after, Dec. 31, 2022.	Identical to the AHCA provision
		Implementation Funding	
Implementation Funding	N/A	The AHCA would establish a $1 billion American Health Care Implementation Fund within HHS to implement the following AHCA provisions: per capita allotment for medical assistance, Patient and State Stability Fund, additional modifications to the premium tax credit and refundable tax credit for health insurance coverage.	The BCRA would establish a $0.5 billion fund within HHS—the Better Care Reconciliation Implementation Fund—that could be used for federal administrative expenses for carrying out the draft bill.

MEDICAID PROVISIONS

Both the AHCA and the BCRA also would make a number of changes to the Medicaid program. They would:

- Repeal some parts of the ACA related to Medicaid, such as the changes the ACA made to presumptive eligibility and the state option to provide Medicaid coverage to non-elderly individuals with income above 133% of the FPL; and
- Amend the enhanced matching rates for the ACA Medicaid expansion and the ACA Medicaid disproportionate share hospital (DSH) allotment reductions.

The most significant Medicaid-related new provisions in the AHCA and the BCRA would **convert Medicaid financing to a per capita cap model** (that is, per enrollee limits on federal payments to states) starting in 2020, with a block grant option for states. Both also include a provision that would allow states to require nondisabled, non-elderly, non-pregnant adults to satisfy a work requirement to receive Medicaid coverage.

However, the BCRA also strikes some AHCA provisions and adds some new provisions related to Medicaid. For example, the BCRA:

- Strikes a Medicaid provision in the AHCA that would let states disenroll high-dollar lottery winners; and
- Adds a few new Medicaid provisions, including provisions providing states the option to cover certain inpatient psychiatric services for non-elderly adults and to establish Medicaid and State Children's Health Insurance Program (CHIP) quality performance bonus payments.

A comparison of the AHCA and BCRA Medicaid provisions, as compared to current law under the ACA, can be found in the CRS Comparison Report.

MORE INFORMATION

Please contact The SEBO Group for more information on the ACA, the AHCA or the BCRA.

Source: Congressional Research Service