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Senate Releases Draft Reform Legislation

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On June 22, 2017, the Senate released draft health care reform legislation, the Better Care Reconciliation Act of 2017 ("BCRA"). It is substantially similar to the America's Health Care Act ("AHCA"), legislation passed by the House last month.

The Senate bill is not without controversy, drawing criticism from Democrats, moderate and far-right Republicans. The Senate Majority Leader has indicated that the bill will be brought for a vote before the 4th of July recess. Because no Democrats will vote in favor of "repeal and replace" legislation, the Republicans will need 51 votes. This means no more than two Republican Senators can vote against the legislation. So far, at least five have announced their opposition to the bill. Further, the Congressional Budget Office is expected to score the bill early this week, which may affect the vote count. There will be a significant amount of negotiation and political maneuvering to determine whether the Republicans can secure the votes to pass one of their major policy initiatives, to repeal and replace the Affordable Care Act ("ACA").

The following chart highlights some of the key aspects of the ACA and how they would be changed by AHCA and BCRA. This chart is targeted at specific aspects of the law that affect employers sponsoring group health plans. Changes to Medicaid and other government programs are not addressed.

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	ACA	AHCA	BCRA
Status	Current law	House introduced 3/6; Withdrawn 3/24/2017; Reintroduced and passed with amendments 5/4/2017; Senate is on the clock	Senate draft bill released 6/22/2017
Individual mandate	Requires all U.S. citizens and legal residents to have qualifying health coverage (unless an exemption applies) Failure to have qualifying coverage may result in a penalty of the greater of $695 (as indexed) or 2.5% of household income (capped at the average national cost of Bronze level coverage)	Eliminates individual mandate penalty ($0) effective January 1, 2016 Uses a 30% surcharge (based on the cost of the insurance premium) on individuals who are without coverage for at least 63 days and then buy coverage • Surcharge would apply for a period of 12 months • States may use health status underwriting as opposed to the 30% surcharge in the individual market	Eliminates individual mandate penalty ($0) effective January 1, 2016 New 6/26/2017. Imposes a 6-month waiting period on individuals buying health insurance in the individual market who, during the prior 12 months, had a break in coverage of at least 63 consecutive days (effective January 1, 2019)
Employer Mandate	Applicable large employers may pay a penalty if full-time employees receive subsidized coverage in the Marketplace Penalties are assessed when there is no offer of minimum essential coverage to the full-time employee and children and when there is an offer of coverage, but the coverage is not affordable or does not meet minimum value Employers must report to the IRS on offers of coverage, affordability and minimum value using Forms 1094-C and 1095-C	Eliminate penalties as of January 1, 2016 ($0) 1094-C and 1095-C remain Efforts may be made to condense reporting to align on Form W-2, making the 1094-C and 1095-Cs obsolete	Eliminate penalties as of January 1, 2016 ($0) 1094-C and 1095-C remain
High Cost Plan Excise Tax	40% excise tax on health insurance coverage that exceeds $10,200 for self-only and $27,500 for coverage other than self-only Effective date is January 1, 2020	Same as ACA except the effective date is pushed out to January 1, 2026	Same as AHCA
Other Taxes and Fees	Introduced a host of new taxes and fees	Repeals most ACA imposed taxes and fees, including: • Additional Medicare tax on wages and investment income • Health insurance carrier tax • Medical device tax and pharmaceutical fee Keeps the PCORI fee Removes $ cap on health FSA contributions	Same as AHCA
Wellness	Increases available wellness incentives under the HIPAA rules to 30% (50% for tobacco use) Care must be taken to coordinate with other federal rules (ADA and GINA)	Same as ACA	Same as ACA

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	ACA	AHCA	BCRA
Benefit Design Reforms	All group health plans must: • Not impose annual or lifetime dollar limits on essential health benefits • Cover children to age 26 • Not retroactively terminate coverage • Not impose waiting periods of more than 90 days • Not include pre-existing condition exclusions In addition, non-grandfathered group health plans must: • Cover preventive care at 100% in-network • No discriminate in favor of highly compensated in insured plans (not currently enforced) • Adopt enhanced claims, appeals and external review procedures • Limit individual out-of-pocket expenses to prescribed thresholds ($7,150 self-only/ $14,300 family for 2017) • Cover routine costs associated with clinical trials • Include certain patient protections and cover emergency services as in-network when provided out-of-network	AHCA retains all of the benefit design reforms of the ACA except in the individual market where a 30% surcharge is permitted on individuals who have a gap in coverage of at least 63 days; the surcharge lasts 12 months Additionally, the AHCA gives power to the states (with approval from HHS) to reduce the essential health benefits currently defined under federal law	Retains all of the ACA benefit design reforms Provides some additional flexibility in waiver process for states to design alternative standards (not clear how far reaching this is) New 6/26/2017. Imposes a 6-month waiting period on individuals buying health insurance in the individual market who, during the prior 12 months, had a break in coverage of at least 63 consecutive days (effective January 1, 2019)
Small Group and Individual Rules	Offer at least a bronze level of coverage (60% plan) with all of the essential health benefits Costs of insurance may only differ based on the following: • Plan and tier of coverage; • Age (3:1); • Geographic location; • Tobacco-status (5:1)	Allows 5:1 age-banded rates Offer coverage below a Bronze level (i.e., 58% plan) Permits states to waive certain federal requirements for state based initiatives: • Age rating above 5:1 • Identify a state's own set of essential health benefits beginning in 2020 • Beginning in 2019, use health status rating (assuming there is a high risk pool) as opposed to the 30% surcharge in the individual market when someone purchases coverage after a 63 day gap in coverage	Allows 5:1 age-banded rates Provides some additional flexibility in waiver process for states to design alternative standards (not clear how far reaching this is) New 6/26/2017. Imposes a 6-month waiting period on individuals buying health insurance in the individual market who, during the prior 12 months, had a break in coverage of at least 63 consecutive days (effective January 1, 2019)

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Health Savings Accounts (HSAs)	Eligible individuals may contribute up to the statutory maximum contributions (for 2017, $3,400 self-only and $6,750 for family) Withdrawals from HSAs for non-qualified medical expenses are subject to a 20% penalty No joint HSAs No reimbursement of qualified medical expenses incurred prior to establishment of the HSA	Effective January 1, 2018 increase the maximum HSA contribution for a calendar year to equal the out-of-pocket cost sharing under the QHDHP rules ($6,550 self-only; $13,100 family for 2017) Permit both spouses eligible for a $1,000 catch-up contribution to make the contribution to the same HSA Permit reimbursement of qualified medical expenses from the HSA when they were incurred up to 60 days before the HSA is established Reinstates the 10% penalty for withdrawals from the HSA for non-qualified expenses	Same as AHCA
OTC	Tax favored accounts cannot reimburse OTC medicines and drugs without a prescription	Reinstates pre-ACA rules that permit reimbursement of OTC medicines and drugs without a prescription	Same as AHCA
Certificates of Creditable Coverage	No longer applicable after December 31, 2013	No specific guidance	New 6/26/2017- will require issuance of certificates of creditable coverage to prove continuous coverage over the prior 12-month period
Association Health Plans	Generally limits the ability for unrelated small employers to pool together under a single employer plan and take advantage of large employer underwriting	Creates more flexibility for association medical plans to be established	Creates new small business health plans to allow unrelated employers to purchase large group coverage Incorporated into ERISA – must be insured and receive federal and state approval
Premium tax credits in Marketplace	Makes available premium tax credits for individuals between 100%-400% of FPL without access to affordable MEC Computed based on the second lowest cost silver plan (70% plan) available in the Marketplace Individuals with unaffordable employer based coverage may access premium tax credits	Phases out premium tax credits By 2020 introduce income based tax credits adjusted for age (and reduced for individuals with income over $75,000)	Funds cost-sharing subsidies through 2019 Will make future subsidies available to income between 100%-350% of FPL Amount of credit will be computed based on a 58% plan in the Marketplace Denies access to tax credits to individuals with access to employer coverage
MLR	Requires insurance carriers to meet certain thresholds for insured health plans • At least $0.85/$0.80 (small group) of every $1 must go pay claims or activities to improve health care quality • Rebates must be paid to policy holders when the carrier fails to maintain the appropriate ratio	N/A	Requires states to establish and administer the MLR at the state level for plan years beginning January 1, 2019

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