COMPARISON OF HEALTH CARE REFORM PROPOSALS

AMERICAN PSYCHIATRIC ASSOCIATION

Topic	ACA	AHCA (House)	BCRA (Senate) – June 2017	BCRA (Senate) – July 2017
Medicaid	Substantially retained the existing federal matching formula (FMAP), which is fundamentally calculated based on the affluence of each state, and roughly ranges from 50% for the most affluent states to 80% for the least affluent states.	Eliminates the existing federal matching formula (FMAP) in 2020. Beginning in 2021, states will have the option of receiving a lump-sum block grant payment or a per beneficiary amount (i.e. per capita cap) based on the number of enrollees and healthcare expenditures, with an annual inflation adjustment pegged to the medical component of the consumer price index. States are also allowed to implement working requirements for Medicaid beneficiaries. **This approach is expected to cut Medicaid spending by $880 billion over 10 years, and threaten the 14 million Medicaid beneficiaries diagnosed with a mental illness.**[1]	Beginning in FY 2020, state Medicaid programs will be funded on a fixed per beneficiary amount (i.e. per capita cap). The per capita cap is calculated based on past expenditures, and in the long run is expected to grow at a slower rate than the House bill. (Sec 133) The bill also requires more frequent Medicaid eligibility redeterminations and gives states the option of imposing work requirements as a condition for eligibility, with an increased federal match for administrative expenses. (Sec 130 and 131) States would also have the option of applying to fund their Medicaid programs under a block grant known as the Medicaid Flexibility Program. (Sec 134) States may also include inpatient psychiatric services as an optional benefit in their Medicaid plans, with a federal match of 50%. (Sec 138)	The July version of the BCRA retains the substance of the Medicaid provisions in the June version. Some slight modifications include: • Different calculation of past expenditures in states that expanded Medicaid between 2015 and 2016 • Creation of a new demonstration waiver for home and community-based services, subject to an overall funding limit • Defines categories of enrollees in states opting for a block grant Medicaid Flexibility Program • Grants HHS secretary authority to exempt Medicaid expenditures from per capita cap in the event of a public health emergency

[1] See: https://www.cbo.gov/publication/52486

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Essential Health Benefits / 1332 Waivers	Requires insurers to offer 10 essential health benefits (as defined by the HHS Secretary) in all ACA-governed coverage. These benefits include mental health and substance use disorder services, as well as prevention services.	Allows states to establish their own standards for essential health benefits beginning in 2020 by applying for a Limited Waiver with HHS. **Giving states flexibility in defining essential benefits could cause 7.5 million Americans to lose mental health and substance use coverage altogether.**[1]	The requirement of benchmark benefit packages will be sunset by December 31, 2019. (sec 126) Flexible block grants allow states to establish their own standards for health assistance --including mental health and substance use disorder coverage under the Medicaid Flexibility Program (sec 134) Section 1332 waivers are not expected to allow states to let insurers reject or charge more to people with pre-existing conditions. But the expanded 1332 waiver program, will let states allow insurers to offer less than comprehensive plans, potentially leaving patients with increasingly substantial medical bills. (sec 206) The bill will also change the percentage of costs, this means potentially more deductibles and out-of-pocket expenses for patients. States get a $2 billion incentive to apply for a waiver and would be able to forgo Obamacare's insurance requirements. (sec 206)	Subject to the optional Cruz Amendment (described below), the July version of the BCRA retains these provisions from the June version of the BCRA. Adds an optional amendment (the "Cruz amendment") which, if it becomes a part of the final bill, would allow insurers to offer plans that do not comply with the ACA's mandatory coverage provisions, including: • Essential health benefits • Coverage of pre-existing conditions • Ban on increasing premiums for individuals with pre-existing conditions • Limitations on out-of-pocket costs • Free annual preventative care visits Insurers seeking to offer these non-compliant plans would be required to offer at least two ACA-compliant plans (one Gold-rated and one Silver-rated) in the same area.

[1] Frank, Richard G., and Glied, Sherry A. "Flexibility on 'essential benefits' will increase cost of insurance for pregnancy, addiction, and mental illness. Web blog post. *First Take*. STAT, Mar. 20, 2017. Accessed May 10, 2017.

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Medicaid Expansion	Allowed states may expand Medicaid coverage for low-income individuals by expanding the eligibility cutoff to 138% of the poverty level (about $16,640 for an individual). The original federal share of the cost was 100%, and has slowly been reduced to 90%. Currently, 31 states have chosen to expand Medicaid coverage.	Eliminates the ACA Medicaid expansion in 2020. Coverage of Medicaid expansion populations would not be subject to meeting "essential health benefits" requirements. Additional states are immediately prohibited from expanding Medicaid, and Medicaid enrollment at ACA payment rates will be frozen at the end of 2019. **This approach jeopardizes Medicaid coverage for the 1.3 million Americans with a serious mental illness, and the 2.8 million Americans with a substance use disorder who gained it under expansion.**[1]	States can no longer apply to expand their Medicaid programs in 2020. For states that elected to expand their Medicaid programs before that date, the federal match available to these states will decline beginning in 2020 and will end by 2023. (Sec 126)	The July version of the BCRA retains these provisions from the June version of the BCRA.
Private Insurance Subsidies	Allows individuals who purchase insurance through the ACA-established health insurance exchanges, and who earn less than $48,000 a year, to be eligible for federal subsidies that can be used towards the cost of the insurance. Subsidies are determined on a sliding scale based on a person's income and the relative cost of insurance in their area.	Establishes new tax credits to subsidize insurance, and ties them to a person's age rather than income and cost of insurance. People under 30 are eligible for a credit of $2000, while people over 60 would be eligible for $4000. Also establishes a new fund ($85 billion) in high-premium tax assistance for individuals age 50 to 64. **These credits are, on average, far less generous than current ACA subsidies.**	Preserves ACA tax credits, but subsidies are calculated based on the individual's age, income, and cost of plans available in the individual's location. However, because the cost of plans is based on a less-generous benchmark plan than under the ACA, subsidies will be lower. (Sec 102)	The July version of the BCRA retains these provisions from the June version of the BCRA Allows the use of funds in a Health Savings Account (HSA) for the purchase of insurance (Sec 118) Allows individuals above the age of 30 to purchase so-called "catastrophic plans" that impose very high deductibles, and makes these plans eligible for subsidies

[1] Frank, Richard G., and Glied, Sherry A. "Keep Obamacare to keep progress on treating opioid disorders and mental illnesses." Web blog post. *The Hill*, Jan. 11, 2017. Accessed May 10, 2017.

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Individual Mandate	Requires all non-exempted and non-dependent adult individuals to obtain health insurance (compliant with the ACA) or face an annual tax penalty.	Eliminates the ACA tax penalty. Imposes a surcharge of 30% on individuals who go for more than two months without health insurance before buying a new plan. States can, through a Limited Waiver with HHS, substitute the surcharge with a health status rating in 2019, provided that the state is operating its own risk mitigation program or participating in the Federal Invisible Risk Sharing Program.	Eliminates individual mandate by eliminating penalties for noncompliance. (Sec 104)	The July version of the BCRA retains these provisions from the June version of the BCRA.
Employer Mandate	Requires large companies (i.e. with 50 FTEs or more) to provide health insurance to their employees or face financial penalties.	Eliminates the ACA employer mandate.	Eliminates the ACA employer mandate by eliminating penalties for noncompliance. (Sec 105)	The July version of the BCRA retains these provisions from the June version of the BCRA.
Pre-Existing Condition Coverage	Prohibits insurers from denying coverage who have pre-existing medical conditions	Retains this ACA provision – *provided that individuals retain continuous insurance coverage.*	The Senate bill would require insurers to cover those with pre-existing conditions and charge everyone the same regardless of health history.	The July version of the BCRA retains these provisions from the June version of the BCRA.
Age-Rated Limit	Allows insurers to charge elderly individuals no more than 3 times what they charge young adults.	Allows insurers to charge elderly individuals no more than 5 times what they charge young adults. Also allows states, through a Limited Waiver with HHS, to exceed this ratio beginning in 2018.	Allows insurers to charge elderly individuals no more than 5 times what they charge young adults.	The July version of the BCRA retains these provisions from the June version of the BCRA.
Young Dependents	Allows young people to stay on their parents or legal guardians' health insurance plans until the age of 26.	Retains this ACA provision.	Retains this ACA provision.	Retains this ACA provision.
Prohibition on Annual and Lifetime Limits	Prohibits insurers from setting a limit on how much they have to pay to cover someone.	Retains this ACA provision.	Retains this ACA provision.	Retains this ACA provision.

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High-Risk Individuals	Establishes a permanent Risk Adjustment program that transfers money between insurers based on the risk levels of their enrollees.	Establishes a state innovation fund ($100 billion) for states to establish programs, such as reinsurance or high risk pools, that will provide or subsidize healthcare for high risk individuals. **An additional $15 billion is appropriated to states for risk mitigation programs focused on maternal health, mental health and substance use disorders**. In addition, $8 billion is available for states that obtain Limited Waivers to permit health status underwriting.	For long-term stability and innovation, states are required to describe spending mechanisms, including an option to establish or maintain a program to provide financial assistance to high-risk individuals. Long-term stability and innovation to be funded ($62b) from CY2019 through CY2026. (sec 206)	The July version of the BCRA largely retains these provisions from the June version of the BCRA, with slight modifications as to the amount and method of allocating these funds. The Cruz amendment also creates a fund to assist insurers offering non-ACA compliant plans with coverage of high-risk individuals enrolled in ACA-compliant plans.