Side by Side Comparison – The Affordable Care Act and the American Health Care Act[1]

Provision	ACA	AHCA	BCRA	Graham-Cassidy Bill
Insurance Subsidies	Individuals who purchase insurance through the health insurance exchanges and who make less than $48,000 a year are eligible for federal subsidies that buy down the cost of insurance. Subsidies are on a sliding scale based on a person's income and the relative cost of insurance in their area. Subsidies are automatically applied to insurance bills through direct payment from federal government to insurer.	Insurance subsidies in the form of tax credits will be tied to a person's age rather than income, but will phase out for individuals making over $75,000 a year. People under 30 are eligible for a credit of $2000, while people over 60 would be eligible for $4000. These subsidies will not be tied to the cost of insurance in an area, but will be directly paid to the insurer by the federal government. Additionally, a new fund is established to provide around $85 billion in tax assistance due to high premiums for individuals age 50 to 64.	Starting in 2020, tax credits will be tied to income, age and geography for individuals between 0-350% of the federal poverty level, unless they are eligible for Medicaid under their state's rules. Subsidies are advanceable, like the ACA's. Tax credit is benchmarked to a less generous plan than under the ACA. Starting in 2019, anyone can purchase catastrophic coverage and if eligible, receive tax credits. ACA cost-sharing subsidies funded through the end of 2019.	Eliminates tax credits for individuals and small businesses in 2020. Eliminates cost-sharing reductions (CSRs) for low-income individuals purchasing private insurance through Exchanges. Starting in 2019, anyone in Individual or Small Group Market can purchase catastrophic coverage and if eligible, receive tax credits (through 2019). Converts federal subsidy money into a larger block grant in 2020 through 2026.
Individual Mandate	Unless exempted, individuals are required to obtain ACA-compliant health insurance or face an annual tax penalty.	Tax penalty will be dropped. Instead, individuals who go for more than two months without health insurance will face a "continuous coverage" surcharge of 30% when they buy a new insurance plan	Tax penalty will be dropped—retroactive to tax year 2016. Six-month waiting period for failing to maintain continuous coverage.	Tax penalty will be dropped — retroactive to tax year 2016.
Employer Mandate	Large companies are required to provide health insurance to their employees or face financial penalties.	This provision is repealed.	This provision is repealed.	Tax penalty will be dropped — retroactive to tax year 2016.
Young Adults	Young people are able to stay on their parents health insurance plans until the age of 26	This provision will remain in place.	This provision will remain in place.	This provision will remain in place.

[1] Sources cited:
H.R. 3590, *The Patient Protection and Affordable Care Act*, 111th Congress (2009-2010)
H.R. 1628, *The American Health Care Act of 2017*, 115th Congress (2017-2018)
H.R. 1628, *Better Reconciliation Act of 2017,* 115th Congress (2017-2018), draft released on July 13, 2017.
H.R. 1628, *Amendment in the Nature of a Substitute*, to be proposed by Senators Cassidy, Graham, Heller, and Johnson, draft released on September 13, 2017.
"Compare Proposals to Replace The Affordable Care Act," *The Henry J. Kaiser Family Foundation*
Park, Haeyoun and Margot Sanger-Katz, "The Parts of Obamacare Republicans Will Keep, Change or Discard," *The New York Times*, 6 March 2017.
Levey, Noam N. and Kyle Kim, "A side-by-side comparison of Obamacare and the GOP's replacement plan," *The Los Angeles Times*, 15 March 2017.
Edwards, Jackie, "House Rules Committee Releases Text of Amendment to Health-Care Bill," *Bloomberg*, 23 March 2017

Essential Health Benefits	Insurers are required to offer 10 essential health benefits in all ACA-compliant coverage.	States establish their own standards for essential health benefits beginning in 2020 by applying for a Limited Waiver with HHS.	The ACA standard remains in place, though state may use a waiver to change the ACA standard. In 2020, with state approval, insurers may also offer plans that do not meet this standard as long as they provide least one gold, one silver, and one premium benchmark level plan that do cover essential health benefits.	The ACA standard remains in place, though a state may use a waiver to change the ACA standard starting in 2020 for a permitted purpose, such as lowering premiums.
Prohibition on Annual and Lifetime Limits	Insurers are barred from setting a limit on how much they have to pay to cover someone	This provision will remain in place.	This provision will remain in place.	This provision will remain in place.
Age-rated Limit	Insurers can charge elderly customers no more than 3 times what they charge young adults.	Insurers are able to charge elderly customers up to 5 times what they charge young adults. States can allow insurers to exceed this 5:1 ratio beginning in 2018 by applying for a Limited Waiver with HHS.	Insurers are able to charge elderly customers up to 5 times what they charge young adults. State can select a higher or lower standard (without applying for a waiver).	The ACA standard remains in place, though a state may use a waiver to change the ACA standard starting in 2020 subject to non-discrimination rules.
Health Status Premium Underwriting	Insurers are barred from considering health status as a factor in setting a household's premium.	By applying for a Limited Waiver with HHS, states can allow insurers to consider health status in setting premiums for an individual who fails to maintain continuous coverage starting in 2019, provided the state sets up a risk mitigation program or participates in the Federal Invisible Risk Sharing Program.	The ACA standard will remain in place. In 2020, with state approval, insurers may offer plans that consider health status prior to issuing the policy or setting the premium as long as they provide least one gold, one silver, and one premium benchmark level plan that do comply with the ACA standard.	The ACA standard remains in place, though a state may use a waiver starting in 2020 to allow issuers to vary premiums based on health status.
Preexisting Condition Coverage	Insurers are unable to deny coverage to people who have preexisting medical conditions	This provision will remain in effect for individuals that retain continuous coverage.	The ACA standard will remain in place. In 2020, with state approval, insurers may refuse to issue some plans based on an applicant's preexisting conditions as long as they provide at least one gold, one silver, and one premium benchmark level plan that are guaranteed issue.	The ACA standard will remain in place.
Relief for High Risk Individuals	Establishes two transitional programs, Reinsurance and Risk Corridors that run from 2014-2016 to provide funding to mitigate insurer losses that come from serving a high number of high risk individuals. Establishes a permanent Risk Adjustment program that transfers money between insurers based on the risk levels of their enrollees.	Establishes $100B state innovation funds 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 mental health and substance abuse. In addition, $8 billion is available for states that obtain Limited Waivers to permit health status underwriting.	Establishes a "short-term" fund for states to establish programs like reinsurance or high risk pools for high risk individuals: $15 billion in 2018 and 2019; $10 billion in 2020 and 2021. Establishes "long-term" funding for states in 2019 through the end of 2026 (ranging from $8 to $19.2 billion annually). For both funding streams, a state must contribute a portion of funds received to each state with premiums that are 75% higher than the national average (i.e., Alaska). $2B additional through 2019 to support state waivers.	Establishes a "short-term" fund for CMS to enter into arrangements with issuers to address coverage and access disruption within states: $10 billion in 2019 and $15 billion for 2020.

Medicaid Expansion	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 federal government has taken on almost all of the cost of this expansion, which is gradually phased down to 90%. Currently, 31 states have chosen to expand Medicaid coverage.	Medicaid expansion is discontinued 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.	Medicaid expansion will be phased down over three years beginning in 2020 and discontinued in 2023. Coverage of Medicaid expansion populations would not be subject to meeting "essential health benefits" requirements. Medicaid enrollment at ACA payment rates will be frozen at the end of 2019.	Eliminates enhanced federal match for expansion population starting in 2020, at which time no states can expand, even at a reduced match. Converts expansion funding, along with APTCs/CSRs, into a state block grant. $136-190 billion in annual federal funding is available to all states through 2026. A complex funding formula takes into account a state's population between 50-138% FPL.
Traditional Medicaid	Per prior legislation, Medicaid funding is based on federal matching formula (FMAP) based on the affluence of state. Federal match funding ranges from roughly 50% for affluent states to nearly 80% for the poorest states. ACA makes some changes to the Medicaid program, but does not substantially change this matching formula.	The FMAP model of open-ended federal match funding for Medicaid will be discontinued in 2020. Instead, states will have the option of receiving a lump sum block grant payment or a per-beneficiary amount based on enrollees and costs, with an annual inflation adjustment. States will also have the option of establishing a work requirement for recipients, and are eligible for 5% upward funding adjustment to cover administrative costs of doing so.	The FMAP model of open-ended federal match funding for Medicaid will be phased down over three years beginning in 2020. In 2023, states will have the option of receiving a lump sum block grant payment or a per-beneficiary amount based on enrollees and costs, with an annual inflation adjustment that is lower than the AHCA starting in 2026. Children with special needs will not be affected by caps, and children, the elderly and disabled will not be included under a block grant option. Caps can be lifted in declared public health emergencies. States that underspend within their caps will receive a bonus. Ends retroactive eligibility for non-elderly, nondisabled enrollees.	Like BCRA, converts FMAP model to per capita caps starting in 2020. Annual inflation adjustment would be less generous for children and non-elderly, non-disabled adults than for elderly and disabled beneficiaries. Offers states the option of receiving a block grant that can be used to cover populations that are not eligible for Medicaid, or drop groups that are mandatory under current law. Ends retroactive eligibility for non-elderly, nondisabled enrollees.
Health Savings Accounts	Currently, individuals and families can put $3400 and $6750, respectively, into a Health Savings Account tax-free. HSAs are only available to some consumers in the health insurance exchanges.	These levels will be raised to $6550 and $13,100 beginning in 2018. All individual market consumers can purchase HSAs.	HSA levels are raised similar to the AHCA. HSA funds can be used to pay premiums. The tax penalty for using HSA funds for ineligible products will be lowered from 20 to 10 percent.	The BCRA provisions are largely mirrored.
Tax Provisions	Insurance companies, pharmaceutical manufacturers, and medical device manufacturers all pay industry fees. Income tax on high earners. Employers with rich employer health benefits are subject to "Cadillac Tax".	Industry fees and taxes are repealed. Cadillac Tax delayed until 2026. The repeal of the Additional Medicare Tax Increase for high earners is delayed until the end of 2022.	Industry fees and taxes are generally repealed. Cadillac Tax delayed until 2026. Retains Medicare Tax Increase for high earners, the net investment income tax, and limits on deductibility of health insurance executive compensation.	Keeps industry fees and taxes except for medical device tax, which is repealed effective in 2018 (when current two-year moratorium expires).