RegulatoryResources

BCRA, AHCA and ACA

On June 22, 2017, Senate Republicans released the **Better Care Reconciliation Act (BCRA)**, a bill that would repeal or modify parts of the **Affordable Care Act (ACA)** and other laws that affect employee benefits, and amended the bill on June 26 and July 13, 2017. The BCRA was released after the House of Representatives passed the **American Health Care Act (AHCA)** on May 4, 2017.

What are the next steps?

If the Senate passes the BCRA, the House and Senate would focus on reconciling the BCRA and AHCA into one final bill. Then, if both houses approve the final bill, it would be sent to President Trump for signature.

The following chart highlights certain important differences and similarities between the BCRA (as amended), AHCA and ACA.

Benefit Mandates	**The ACA mandated the following for group health benefit plans and the BCRA and AHCA did not propose changes to these provisions.** • **Coverage of children through age 26** Health plans that offer dependent child coverage must make the coverage available until a child reaches the age of 26. Both married and unmarried children qualify for coverage. • **Prohibition on imposing annual or lifetime dollar maximums** Health benefit plans cannot impose annual or lifetime dollar maximums on Essential Health Benefits (EHBs)[1]. • **Waiting period limit** Group health benefit plans cannot impose waiting periods longer than 90 days. • **Preventive Services** Non-grandfathered health plans must provide 100% coverage for certain preventive services and immunizations provided by a network doctor or hospital. Cost-sharing requirements, such as copayments, deductibles or coinsurance, are prohibited for certain preventive services provided by a network healthcare provider. • **Prohibition on pre-existing condition exclusions** Group health benefit plans cannot impose pre-existing condition exclusions. • **Cost sharing maximums for in-network EHBs** The maximum amount that a group health benefit plan member must pay out of pocket (OOP) for in-network EHBs[1] is set annually by federal regulators. For the 2018 plan year, OOP expenses cannot exceed $7,350 for a self-only coverage and $14,700 for family coverage.

Age Rating Ratio/ Minimum Medical Loss Ratios	**BCRA:** Like the AHCA, the BCRA would implement an age rating ratio of 5:1 for adults in the individual and small group insurance market for plan years beginning on or after Jan. 1, 2019. A fully insured health benefit insurer would not be able to charge an older individual more than five times the premium rate that the plan charges a 21-year-old. A state would be able to apply for a waiver of the AHCA's age-rating ratio. The waiver would allow a state to apply a ratio higher than 5:1 for age-based premium ratings in the individual and small group health insurance markets. Federal minimum medical loss ratios for individual, small group and large group fully insured plans would sunset for plan years beginning on or after Jan. 1, 2019. States would be required to set their own minimum medical loss ratios and rebates starting on Jan. 1, 2019. **AHCA:** The AHCA would implement an age rating ratio of 5:1 for adults in the individual and small group health insurance markets for plan years beginning on or after Jan. 1, 2018. A fully insured health benefit insurer would not be able to charge an older individual more than five times the premium rate that the plan charges a 21-year-old. A state would be able to apply for a waiver of the AHCA's age-rating ratio. The waiver would allow a state to apply a ratio higher than 5:1 for age-based premium ratings in the individual and small group health insurance markets. The bill would provide no changes to minimum medical loss ratios. **ACA:** The ACA imposed an age rating ratio of 3:1 in the individual and small group insurance market, meaning that a fully insured health benefit plan cannot charge an older individual more than three times the premium rate that the plan charges a 21-year-old individual. Minimum medical loss ratios are required in the individual, small and large group insured market.
Employer Mandate	**BCRA and AHCA:** The bills would retroactively eliminate the employer tax penalty, beginning in calendar year 2016. **ACA:** Employers with at least 50 full-time equivalent employees face potential tax penalties if they do not offer affordable health coverage that provides minimum value to at least 95 percent of their full-time employees and dependent children to age 26, and one or more of their full-time employees obtains a premium tax credit through a health insurance exchange.
Essential Health Benefits[1]	**BCRA:** The bill would make it easier for states to waive EHBs and actuarial value metal levels in the individual and small group insurance market.

Essential Health Benefits[1] Cont.	**AHCA:** Beginning on or after Jan. 1, 2020, individual and small group health insurance policies would no longer need to meet certain actuarial value metal levels, and states would be allowed to apply for a waiver of the ACA's EHB requirements for the individual and small group health insurance markets. With the waiver, states would be able to establish their own EHB requirements. **ACA:** While policies in the individual and small group health insurance markets are required to provide 10 categories of benefits known as EHBs, self-funded health benefit plans do not have to include EHBs. However, if self-funded health benefit plans do include EHBs, they are prohibited from imposing lifetime or annual dollar limits on these benefits.
FSAs, HSAs and HRAs	
Contributions to Flexible Spending Accounts (FSAs)	**BCRA and AHCA:** The contribution limit would be eliminated effective Jan. 1, 2018. **ACA:** An employee is allowed to contribute a maximum of $2,600 to a medical FSA for plan years beginning on or after Jan. 1, 2017. A cost-of-living adjustment is made each year.
Health Savings Accounts (HSAs)	**AHCA and BCRA:** **HSA contributions:** Beginning with tax year 2018, the bills would increase members' annual HSA tax-free contributions limit to the out-of-pocket maximum limit for HSA-qualified high-deductible health plans. In 2018, a group health plan's annual in-network out-of-pocket maximum for EHBs cannot exceed $7,350 for a self-only plan and $14,700 for other than single coverage. **Contributions for married couples:** Married couples would not have to take into account whether their spouse is also covered by an HSA-qualified high-deductible health plan. Their aggregate contributions to their respective HSAs could be more than the annual contribution limit for family coverage. Their annual contribution limit would be reduced by any amount paid to Archer Medical Savings Accounts of either spouse for the taxable year, and then the remaining contribution amount would be divided equally between the spouses unless they agree on a different division. If both spouses were eligible to make catch-up contributions before the close of the tax year, each spouse's catch-up contribution would be included when dividing up the contribution amounts between the spouses. This would effectively allow both spouses to make catch-up contributions to one HSA. These provisions regarding married couples would apply to taxable years beginning in 2018. **Timing of qualified medical expenses:** HSA withdrawals could be used to pay qualified medical expenses incurred before the HSA was established, if the HSA was established within 60 days of when an individual's coverage under an HSA-qualified plan begins, effective for coverage beginning after Dec. 31, 2017.

Health Savings Accounts (HSAs) Cont.	**Current law:** **HSA contributions:** Qualifying high-deductible health plan members may establish an HSA. HSA contributions made by individuals can be subtracted from their gross income for tax purposes. Contributions made by employers, including through salary-reduction agreements, are excluded from income, Social Security and Medicare taxes. For 2017, the contribution limit is $3,400 for those enrolled in self-only coverage and $6,750 for those enrolled in family coverage, with a $1,000 catch-up contribution limit for HSA participants age 55 or older. **Contributions for married couples:** If either spouse has HSA-qualified family coverage and both spouses have their own HSAs, their aggregate contributions to their respective HSAs cannot be more than the annual contribution limit for family coverage.
Over-the-Counter (OTC) Drugs and FSAs, HSAs and HRAs	**BCRA and AHCA** Beginning with the 2017 tax year, participants would no longer need a prescription for OTC drugs or insulin to be considered a qualified expense under an HSA, FSA or HRA. **ACA:** Participants are required to have a prescription for OTC drugs to qualify for tax-free reimbursement from FSAs, HSAs and HRAs.
Health Insurance Industry Fee *(Also known as the Health Insurance Tax)*	**BCRA and AHCA:** The fee would retroactively be eliminated beginning with calendar year 2017. **ACA:** The annual fee is imposed on certain health insurers, but a one-year moratorium was placed on the fee for calendar year 2017. The fee is scheduled to begin again in calendar year 2018.
Individual Mandate	**BCRA and AHCA:** Both would retroactively repeal the individual mandate penalty effective Jan. 1, 2016. **ACA:** Americans are required to maintain health insurance, qualify for an exemption or pay a penalty.
Premiums in the Individual Health Insurance Market/ Subsidies	**BCRA:** Insured plans offered in the individual market on or after Jan. 1, 2019, would be required to impose a 6-month waiting period on individuals who have a gap in creditable coverage in the 12 months prior to enrolling in coverage. States would be able to set their own loss ratios in the individual, small and large group market and determine the amount of rebates effective Jan. 1, 2019. The bill would add an age-adjusted component to existing premium tax credits in the individual market. The bill would appropriate to the Health and Human Services Secretary such sums as necessary for cost-sharing subsidies through Dec. 31, 2019. Cost-sharing subsidies would terminate for plan years in 2020.

Premiums in the Individual Health Insurance Market/ Subsidies *Cont.*	**AHCA:** The bill: • would allow health insurers in the individual market to charge up to 30% more on policyholders with gaps in coverage[2], effective for: enrollment beginning plan year 2019 for a 12-month period and for special enrollment periods in 2018; • would eliminate the ACA's subsidies for qualified individual health policies offered through the health insurance exchanges, which are based on income, for plan years beginning in 2020; and • would provide a refundable tax credit for individual coverage based on age, adjusted by a formula that takes income into account beginning tax year 2019.[3] The bill would allow states to apply for a waiver of the continuous coverage penalty in the individual market and allow insurers to use health status as a factor when developing premiums for individuals, subject to an enforcement period. This waiver could apply to coverage obtained during special enrollment periods for plan year 2018 and for all coverage beginning with plan year 2019. **ACA:** Health insurers cannot charge individual insureds higher premiums than healthy people of the same age on the basis of a health status-related factor of the individual or dependents. A taxpayer is eligible for a premium tax credit for a qualified health plan whose household income for the taxable year is 100% but not more than 400% of the federal poverty level.
Reporting	
Section 6055/6056	**The ACA mandated the following and the BCRA and AHCA did not propose changes for employers:** Sections 6055 and 6056 were added to the Internal Revenue Code to collect data to help facilitate administration of the individual mandate, the employer mandate and cost sharing subsidies.
W-2	**BCRA:** The bill did not address W-2 reporting for employers. **ACHA proposal:** The bill would add an additional Form W-2 field to reflect each month that an employee was eligible for a health benefit plan. **ACA mandate:** Employers required to file 250 or more W-2 forms must report the total cost of their group health benefit plan on the W-2s.
Small Business Tax Credit	**BCRA and AHCA:** To qualify for the small business health insurance tax credit, a qualified health plan purchased by an employer cannot include coverage for abortions, except for abortions necessary to save the lives of women or abortions for pregnancies that are a result of rape or incest. The small business tax credit would not be available beginning with tax year 2020.

Small Business Tax Credit Cont.	**ACA:** A small business health insurance tax credit is available for employers with fewer than 25 full-time employees and equivalents with average annual wages that meet certain criteria. To qualify for the credit, employers must cover at least 50% of the cost of each of their employees' self-only health insurance coverage and purchase insurance through a Small Business Health Options Program (SHOP). The credit is available for only two years.
Small Business Health Plans	**BCRA:** Effective one year after the date of enactment, a small business health plan would be defined as a fully insured group health plan, offered by a health insurer in the large group market, whose sponsor, such as an association, franchisor or other entity, would receive certification by the Secretary of Labor, would have a constitution and bylaws stating its purpose and would provide for periodic meetings no less than annually, would be established as a permanent entity, for purpose other than providing health benefits to its members, such as an organization established as a bona fide trade association and would not condition membership on the basis of a minimum group size. Certification granted to a small business health plan would not be effective unless written notice of such certification was on file with the applicable state authority of each state in which the small business health plan operates. Voluntary termination of the small business health plan would be subject to not less than 60 days' notice to participants. **AHCA:** No similar provision. **ACA:** No similar provision.
Summary of Benefits and Coverage (SBC) and Glossary of Health Coverage and Medical Terms	**ACA mandated the following and the BCRA and AHCA did not propose changes:** Employers are required to provide an SBC for each benefit package offered by a plan for which a participant is eligible. The SBC and Glossary of Health Coverage and Medical Terms must be provided to all members by the first day of open enrollment (or eligible enrollment) and at other various times.
Taxes	
Cadillac Tax	**BCRA and AHCA:** The bill delays the 40% excise tax until Jan. 1, 2026. **ACA:** A 40% excise tax will be imposed on the aggregate cost of coverage of employer-sponsored health coverage that exceeds a specified dollar limit. If a tax is owed, it is levied on the entity providing the coverage (the health insurer or the employer).[4] Originally scheduled to take effect in 2018, the tax has been delayed until 2020.

HSA Distributions	**BCRA:** Distributions from HSAs would continue to be exempt from federal income taxes if used for qualified medical expenses. Like the AHCA, distributions from HSAs made after Dec. 31, 2016, for non-medical purposes would be taxed at a lower rate, beginning in 2017. Like the AHCA, distributions for qualified medical expenses incurred before the establishment of an HSA would be allowed as specified below without an additional tax penalty, beginning in 2018. Beginning in 2018, the BCRA would prohibit HSA funds from being used to pay the costs for a high-deductible health plan that covers abortion (except for an abortion necessary to save a woman's life or if the pregnancy is the result of rape or incest). **AHCA:** • Distributions from HSAs would be exempt from federal income taxes if used for qualified medical expenses. • Distributions from HSAs made after Dec. 31, 2016, and used for purposes other than paying for qualified medical expenses would be taxed at the reduced rate of 10%. • HSA withdrawals could be used to pay qualified medical expenses incurred before the HSA was established, if the HSA was established within 60 days of when an individual's coverage under an HSA-qualified plan begins, effective for coverage beginning after Dec. 31, 2017. **ACA:** • Withdrawals from HSAs are exempt from federal income taxes if used for qualified medical expenses. • HSA distributions used for purposes other than paying for qualified medical expenses are taxed at 20%. • Withdrawals from HSAs used to pay for qualified medical expenses incurred before the HSA was established are not exempt from federal income taxes.
Rx Drug Plans for Part D Eligible Retirees	**BCRA and AHCA:** Effective for taxable years beginning on or after Dec. 31, 2016, the BCRA and AHCA would reinstate business-expense deductions for retiree prescription drug costs without reduction of the amount by any federal subsidy. **Current law:** Employers that provide Medicare-eligible retirees with prescription drug coverage that meets or exceeds certain levels are eligible for federal subsidy payments. Under the ACA, beginning in 2013, the amount allowed as a deduction was reduced by the amount of the federal subsidy payment.

Sources: H.R. 1628: The American Health Care Act, May 4, 2017, Congressional Research Service; Section by Section Summary, Better Care Reconciliation Act (LYN17343) by Senate staff, June 26, 2017; Section by Section Summary, Better Care Reconciliation Act (ERN17490) by Senate staff, July 13, 2017

[1]The 10 EHB categories are: ambulatory patient services; emergency services; hospitalization; maternity and newborn services; mental health and substance abuse, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory service; preventive and wellness services and chronic disease management; and pediatric services (including oral and vision care).

[2]Those that had gaps in creditable 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.

[3]Under the AHCA, the following annual tax credits would be available: $2,000 for eligible individuals under 30; $2,500 for ages 30-39; $3,000 for ages 40-49; $3,500 for ages 50-59; and $4,000 for ages 60 and older. The tax credits would be phased out for individuals with an income of more than $75,000 ($150,000 for joint filers).

[4]The Cadillac tax would be imposed on employer-sponsored health benefit plans with costs exceeding $10,200 for single coverage and $27,500 for family coverage.

PLEASE NOTE: This material represents a high-level summary of provisions contained in the Better Care Reconciliation Act, the American Health Care Act and the Affordable Care Act and may not be construed as tax, legal or compliance advice. Please consult your professional benefits adviser or legal counsel regarding how these provisions may impact your specific health benefit plan.

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