The Better Care Reconciliation Act of 2017 – A First Look

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Thursday's Senate "Discussion Draft" of the Better Care Reconciliation Act of 2017 (BCRA) is the first public indication of the Senate Republican's plans for health care reform. Because this is only a discussion draft, any health care reform legislation introduced in the Senate could differ from this draft in potentially significant respects. From a political standpoint, one would expect to see concessions made before any legislation is introduced. Because Senate leaders have indicated their intent to introduce and vote on reform legislation in the next few weeks, we are presenting our preliminary assessment and overview of the BCRA discussion draft to provide context for the likely political battles that will rapidly unfold.

Although portions of the Affordable Care Act (ACA) would remain untouched by the BCRA, if enacted, would significantly alter the outlook for Medicaid programs and the commercial insurance markets, including the Exchanges. The BCRA discussion draft, like the House-passed AHCA, would repeal virtually all ACA taxes, including the ACA-related taxes on investment income, medical devices, and health insurers. Cuts in Medicaid and, to a lesser extent, ACA subsidies would largely offset these tax cuts.

NEXT STEPS IN THE SENATE

The BCRA is technically an amendment to the House bill, which deletes everything the House proposed and replaces it with the new Senate language. This approach was key to avoiding lengthy consideration by the committees on jurisdiction, and allows the Senate majority leader to proceed directly to the Senate floor, according to the reconciliation process.

One necessary step prior to Senate consideration will be the release of a Congressional Budget Office (CBO) score of the legislation, which is expected early next week. Behind the scenes deliberations between Senate leadership staff and CBO is ongoing in an effort to ensure that the bill meets the requisite targets required by the budget resolution and other rules. The impact on insurance coverage, and the details of what happens to coverage for selected groups such as those 55-64, under 100% of poverty, and the like will play significantly in the debate.

In the Senate, the reconciliation process facilitates consideration of legislation by limiting debate on the bill to 20 hours and allows passage of a measure by a simple majority. At the conclusion of the 20 hours, there is what is known as a "votearama" in which Senators can offer an unlimited number of amendments.

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The reconciliation process also has a number of limitations – most notable among these is the "Byrd rule" which allows Senators to raise objections to any provision that is not primarily budgetary in nature. The Senate parliamentarian figures largely in the determination of whether a provision is in violation of the Byrd rule. It appears likely that a number of the provisions of the Senate bill will be challenged, but predicting an outcome here is very difficult. If challenges are successful to provisions that are significant in garnering individual Senator's support or eventual House passage, given the narrow margins for passage the Byrd rule could significantly affect the bills prospects.

With the debt ceiling and FY 2018 appropriations looming, Congress has to bring the health care debate to at least a temporary close to allow consideration of other policy matters. Republicans can afford to lose only 2 caucus votes (in which case Vice President Pence would cast the deciding vote.) As of this writing several Senators have expressed concerns about the draft, including the conservatives – Senators Paul, Lee, Cruz, and Johnson – and others viewed as more moderate – notably Senator Collins. Many are taking their time to study the bill, and likely awaiting a CBO score and estimates on impacts, before deciding their position. To a large degree, the Senate Majority Leader's challenge is the same as in the House – how to get enough conservative votes without losing moderates.

THE BCRA'S MEDICAID CUTS

The BCRA draft includes many of the same changes to the structure of the Medicaid program that the AHCA proposed, including a change to a per-capita cap system; an option for states to receive block grants; and the elimination of Medicaid expansion. While there are many similarities between the House and Senate bills, there are differences in the treatment of Medicaid that would result in deeper cuts to the program. For example, the BCRA includes the same inflation increases (tied to the medical care component of CPI) for the per-capita cap as the AHCA included. But, the BCRA only uses the medical care component of the CPI until 2025, and then uses the general CPI for all urban consumers, which will result in a slower rate of increases in funding for Medicaid. And, although BCRA phases out enhanced funding for Medicaid expansion over three years beginning in 2021, it may still result in more immediate consequences given that seven states have "trigger laws" that would immediately void their Medicaid expansions with *any* change in federal support, and the BCRA does not appear to continue higher federal funding after 2020 for grandfathered expansion enrollees.

Medicaid Expansion: The ACA expanded the Medicaid program, in states that chose to participate, to cover most individuals (including children and childless adults) below 138 percent of the poverty line. Along with this expanded coverage, the federal government provided participating states increased funding to cover the expansion population. Currently, the federal government pays about 95% of an expansion states' Medicaid expenditures for the expansion population, with that percentage dropping to 90% in 2020 and remaining at that same level going forward. This enhanced payment is in contrast to the federal matching assistance percentage otherwise available under Medicaid, which ranges from 50% to 83%, and has provided a significant incentive for states to expand their Medicaid programs.

The BCRA phases out the enhanced federal payments for the expansion population, in contrast with the AHCA which would have eliminated the enhanced federal payments beginning in 2020 with respect to beneficiaries enrolled after December 31, 2019. The BCRA will allow states that expanded Medicaid before March 1, 2017 to continue to receive the enhanced levels of federal funding set forth in the ACA through 2020. At that point, the enhanced federal matching assistance percentage for the expansion population will be reduced to 85% in 2021, 80%, in 2022, and 75% for 2023, so that by 2024, states that expanded Medicaid will receive the same match rate as for their other covered populations.

While the AHCA would continue indefinitely the enhanced FMAP for the expansion population with respect to individuals enrolled in Medicaid on December 31, 2019 who did not have a break in coverage thereafter, the BCRA appears not to contain this concept. Instead, BCRA but would completely eliminate the enhanced FMAP effective January 1, 2024. Thus, while the BCRA has been promoted as being more generous to states that have expanded their Medicaid programs by phasing out the enhanced FMAP over years after 2020, it is in this respect less generous to the expansion states.

The elimination of the enhanced FMAP will likely cause expansion states to eliminate the expansion population from their Medicaid programs, as we anticipate that states will not be in a positon to absorb the additional costs of covering these

individuals.

Per Capita Caps. Like the AHCA, the BCRA would limit federal expenditures by imposing a "per-capita cap" on the amount of state Medicaid expenditures that the federal government will match beginning federal fiscal year 2020. Separate caps will be computed for different groups of beneficiaries. For example, there will likely be higher cap amounts for enrollees who are disabled or older than for enrollees who are younger.

Under the new system, the per capita cap will be calculated using a base period of per enrollee spending. Unlike the AHCA, which used a 2016 base year, the base periods for the caps would be chosen by the states, based on eight consecutive quarters from the first quarter of 2014 through the second quarter of 2017. And, after the base year amounts are established, annual increases will be pegged to the medical care component of the Consumer Price Index (CPI) for all urban consumers (U.S. city average) with one percentage point being added for beneficiaries who are elderly or adults who are blind or disabled until 2025, and then will be the general CPI for all urban consumers (U.S. city average). The switch to the general CPI in 2025 is a change from the AHCA, and is likely to result in a significant reduction in the annual increases to the per capita caps beginning in 2025.

The per capita caps do not apply to breast and cervical cancer patients, children covered under Children's Health Insurance Programs, partial-benefit enrollees, and the Indian Health Service.

Finally, a new provision in the BCRA provides reduced federal funding for states with high Medicaid per capita expenditures and increases federal funding for states with low per capita Medicaid expenditures. Section 133 provides that if a state spends 25% more than average per enrollee, its Medicaid contribution will be cut by between 0.5% to 2% the following year. On the other hand, if a state spends 25% less than average per enrollee, its Medicaid contribution will be increased by between 0.5 to 2%. However, these increases or decreases for a particular year reduce payments only for that year, and do not flow through to later years. Also, there is an exclusion for low-population density states.

Block Grants. Under the BCRA, states will have the option to elect to receive a block grant, instead of a per enrollee lump sum by conducting a Medicaid Flexibility Program. To receive block grants, states will have to submit applications to the Secretary of HHS describing the state's proposed program and demonstrating compliance with federal requirements.

The block grants will be limited to Medicaid enrollees who are not (1) 65 or older, (2) blind and disabled and 19 years of age or older, (3) under 19 years of age, or (4) expansion enrollees. In other words, the block grants will be limited to non-disabled adults under age 65 who are not expansion enrollees. This is a significant limitation as compared to the AHCA.

These block grants will be fixed sums of money for a ten-year period, with annual increases based on the CPI for all urban consumers (U.S. city average), not the medical component of the CPI. The amount of funding for the initial period under the block grant will be based on the maximum amount the state would have received under the per capita cap. States electing to receive block grants will not be able to receive any allowances for increased populations or other changed circumstances. However, the block grant option does provide states flexibility on how to spend and structure their Medicaid programs. States choosing a block grant will have greater flexibility to establish enrolment conditions, covered benefits (although there would remain 14 mandatory benefit categories), and cost sharing obligations.

The federal funds available each year to a state from a block grant will be equal to the state's FMAP multiplied by the state's Medicaid expenditures, so that a nonfederal share will still be required to draw down federal funds. Any block grant funds not used by a state in one year may roll over to subsequent years so long as the state continues to choose the block grant option. Any Medicaid costs above the block grant amount are the state's responsibility.

The draft includes a maintenance of effort ("MOE") requirement, although we find this provision unclear. The state is required to make expenditures equal to the product of the block grant and the state's enhanced FMAP. A state that does not meet the MOE requirement will have its block grant in the succeeding year reduced.

***Hospital Presumptive Eligibility*.** Like the AHCA, the BCRA draft eliminates the ability of hospital's ability to enroll beneficiaries through presumptive eligibility.

Optional Work Requirement. The BCRA, similar to the AHCA, contains optional work requirements that states can impose beginning in 2017. Under the BCRA, States may require that non-disabled, non-elderly, and non-pregnant individuals enrolled in Medicaid engage in some amount of "work activities," as defined by law.

Bonus Payments. Under the draft, states that underspend within their caps for federal fiscal years 2023 through 2026 will receive an increased federal matching percentage. The BCRA would also require states to meet certain quality measures (to be determined through later regulations) to receive such increases. A total amount of $8 billion is specified for these payments.

Disproportionate Share Hospital Payments. In a section entitled, "Restoring Fairness in DSH Allotments," the BCRA proposes to maintain Medicaid Disproportionate Share Hospital (DSH) payment reductions instituted under the Affordable Care Act for Medicaid expansion states. For non-expansion states, however, the bill would (1) eliminate the DSH payment reductions and (2) in fiscal year 2020 would provide a funding increase to such states to bring them up the per-person DSH allotment national average, as calculated for all states.

Provider Taxes: Currently, provider taxes that will be matched by federal funds under Medicaid may not exceed 6% of net patient service revenue for the class of provider subject to the tax. This percentage is reduced under the BCHA by 0.2% percentage points for fiscal years 2021 through 2025, so that the percentage would be 5.0% in fiscal year 2025 and subsequent fiscal years.

Elimination of retroactive enrollment. Consistent with the AHCA, the BCHA would eliminate the retroactive enrollment of Medicaid beneficiaries. Enrollment would begin in the month of application effective October 1, 2017.

OIG Audits: Each state's spending under the per-capita based Medicaid program shall be audited not less than once every three years by HHS's Office of Inspector General, and those audits shall be conducted using random sampling.

Medicaid Institutions for Mental Diseases: The BCRA provides states with the option to partially eliminate the Medicaid Institutions for Mental Diseases (IMD) exclusion, which prohibits federal matching funds to states for inpatient mental health treatment rendered in mental health facilities, such as psychiatric hospitals, with more than 16 beds to beneficiaries age 21 and older and under age 65. The BCHA would allow states the option to provide for 30 days of treatment in a month in an IMD, not to exceed 90 days in a calendar year. States choosing this option would have to comply with certain maintenance of effort requirements with respect to psychiatric services.

Women's Health Services: The BCRA prohibits states from providing funding to Planned Parenthood for one year.

Safety Net Funding for Non-Expansion States. The BCRA makes available an aggregate $2 billion annually for federal fiscal years 2018 to 2022 to states that did not (and do not) expand Medicaid. These funds are available to support payment adjustments to providers not to exceed the provider's cost of providing services to Medicaid enrollees and uninsured individuals. The FMAP for these additional expenditures is 100% for fiscal years 2018 through 2021, and 95% for fiscal year 2022.

THE BCRA AND THE COMMERCIAL MARKETPLACE

The BCRA proposal, if enacted, would have a significant impact on the individual insurance marketplace. First, it would decrease the incentive for healthier individuals to take up coverage by eliminating the individual mandate. Second, it would reduce subsidies for large portions of the population and eliminate cost-sharing reduction payments that subsidize deductibles, copayments, and out-of-pocket limits on certain plans. Third, it would provide significantly greater latitude for states to opt out of the Exchanges and essential benefit requirements. Fourth, like the AHCA, the BCRA would expand the ACA's premium age band from a 1-to-3 ratio to a 1-to-5 ratio, simultaneously reducing premiums for the young and

increasing premiums for older individuals. Fifth, it would eliminate the federal medical loss ratio (MLR), instead allowing states to set any MLR thresholds and rebate requirements in the individual and group markets. On the other hand, the BCRA would appropriate $112 billion to the State Stability and Innovation Program and $2 billion for substance use disorder treatment and recovery support services, and it would provide for interstate association health plans through the Small Business Health Plans program.

Elimination of the Individual and Employer Mandate Penalties. The BCRA, like the AHCA, eliminates the penalty for failing to maintain minimum essential coverage and the excise tax on large employers that fail to offer affordable, minimum value coverage to their full-time employees. The BCRA would technically leave the mandates in place, but reduce the penalties to $0, thereby withstanding a challenge under the Senate's rules for reconciliation legislation. The BCRA, however, leaves in place the ACA's guaranteed issue and modified community rating requirements, meaning that an individual would be able to forego taking up coverage until he or she becomes ill. Unlike the AHCA, the BCRA discussion draft contains no penalty for breaks in coverage, which would potentially lead to unsustainable premium increases as premiums rise and healthier individuals decline coverage. The AHCA's solution of a 30 percent premium surcharge following a break in coverage, however, was also problematic. the CBO concluded it would ultimately depress enrollment as individuals with breaks in coverage would be disincentivized from taking up coverage. In addition, such a premium surcharge would likely be subject to a challenge under the Byrd Rule, described earlier.

Subsidies: Cost-Sharing Reduction Payments. Like the AHCA, the BCRA discussion draft would eliminate cost-sharing reduction payments after December 31, 2019. These payments help reduce deductibles, copayments, and out-of-pocket maximums for Exchange enrollees earning between 100 and 250 percent of the federal poverty level so that covered services are more affordable. Over half of all Exchange enrollees currently enjoy reduced cost-sharing through these subsidies, and their elimination could dissuade individuals from purchasing or using coverage. On the other hand, the BCRA would provide an express appropriation for cost-sharing reduction payments through December 31, 2019, offering some near-term stability for insurers concerned that the Trump Administration might suspend these payments.

Subsidies: Premium Tax Credits. The BCRA would also modify the ACA's premium assistance tax credits. The premium assistance tax credits would continue to be refundable, advanceable tax credits, but in 2020, eligibility for and the amount of tax credits would change as follows:

- Tax credits would be available to individuals earning less than 100 percent of the federal poverty level (FPL") if they are ineligible for Medicaid. The ACA does not generally provide subsidies for these individuals because it was expected that each state would expand Medicaid for this population. In non-expansion states like Texas and Florida, the BCRA's tax credit amendments would fill this gap for individuals earning between zero and 100 percent FPL.
- Tax credits would be eliminated for individuals earning between 350 and 400 percent FPL. Currently, the upper income limit for premium tax credits is at 400 percent FPL, but the BRCA proposes to lower that limit to 350 percent FPL ($42,210 for a single individual, $86,100 for a family of four). In contrast, the AHCA would provide smaller tax credits to all individuals, regardless of income.
- Tax credits would decrease with age. Under the ACA, the tax credit amount is calculated based on household income and size and the cost of benchmark coverage in the region. The BCRA would add age bands to the formula, decreasing the subsidy amounts for older individuals. For example, under current law, an individual earning $24,120 (200% FPL) would pay 6.3 percent of their monthly income ($126.63) for benchmark silver coverage, regardless of age. Under the BCRA, a 25-year-old individual at this income level would pay 4.3 percent of their monthly income ($86.43) for benchmark bronze coverage, while a 60-year-old individual would pay 10 percent of their monthly income ($201.00) for the same coverage. The AHCA as passed by the house would have gone one step further, basing tax credits exclusively on age rather than income or the cost of coverage.
- Tax credits would be benchmarked to bronze plans. The ACA bases subsidy amounts on the cost of the second-lowest-cost silver plan. The BCRA, on the other hand, would benchmark the subsidy amounts based on the median cost of a plan with an actuarial value of 58 percent (a low-end bronze plan). In marketplaces with a wide range of

bronze plans, including some broader network options, the median 58 percent actuarial value plan could have a higher premium than the second-lowest cost silver plan, but in many or most markets, the use of this lower actuarial value plan for benchmarking would reduce the amount of premium tax credits.

- Tax credits would be unavailable to anyone who could obtain coverage through their employer even if the employer-sponsored plan is unaffordable and/or does not provide minimum value coverage. Under current law, if the cost of employer-sponsored coverage exceeds 9.5 percent of an individual's household income or the value of employer-sponsored coverage is less than that of a bronze plan (*e.*, catastrophic coverage or a mini-med plan), that individual can decline employer-sponsored coverage and instead obtain Exchange coverage with premium assistance tax credits.

State Flexibility and Section 1332 Waivers. The BCRA discussion draft would amend the requirements for states seeking a waiver under section 1332 of the ACA. As it stands, Section 1332 of the Affordable Care Act authorizes state governments to obtain waivers to certain coverage requirements under the ACA, including the essential health benefit requirements. The BCRA amendments would allow states greater flexibility to pursue these waivers, would limit CMS' authority to decline a waiver application, and would provide $2 billion in additional funding to support state waivers. Key proposed changes to section 1332 include the following:

- *Elimination of the legislation requirement*. Under the BCRA, a state could pursue a waiver based on a certification signed by the governor and state insurance commissioner in lieu of authorizing legislation at the state level.
- *Limited guardrails.* The ACA provides that a waiver may only be granted if the state plan provides coverage that is at least as comprehensive as ACA Exchange coverage (including essential health benefits), limits out-of-pocket spending to the same extent as the Exchanges, provides coverage to a comparable number of its residents as the ACA, and will not increase the Federal deficit. The BCRA eliminates all but the last of these requirements and would require the Secretary of HHS to grant a request for a waiver unless the Secretary determines the state plan will increase the Federal deficit.
- *Additional Funding.* The BCRA provides grant funding for states that wish to apply and authorizes the use of long term state innovation and stability allotment funding to carry out these plans.
- *Expedited Approval Process and Waiver Terms.* The BCRA would also require the Secretary to establish an expedited process for urgent or emergency situations. The term for section 1332 waivers would be increased from a maximum of 5 years to 8 years, with unlimited opportunities for renewal of the waiver.

Age Bands and Premiums. The BCRA, like the AHCA, would permit insurers to generally charge five times more for older enrollees than for younger ones, an increase from the 3-to-1 age band limit under current law. In scoring the AHCA's age banding provision, the CBO estimated that by 2026, premiums would increase by 20 to 25 percent for a 64-year-old enrollee, but reduce by a similar amount for a 21-year-old enrollee.

Medical Loss Ratio (MLR). Since 2011, the ACA has limited the amount of premium revenue that an insurer may expend on non-claims costs at 15 percent (large group plans) and 20 percent (small group plans). If non-claims expenditures, including profits, exceed these limits, plans are required to pay a rebate to the plan sponsor or enrollees. The BCRA would retain the MLR data reporting requirements, but it would eliminate the MLR itself and the rebate provisions. Instead, states would be required to set their MLR thresholds and determine the amount of any annual rebate to be paid.

State Stability and Innovation Program. The BCRA would create a state stability and innovation program, providing both short term and long term assistance to states to address coverage gaps caused by the repeal of cost-sharing reduction payments and other changes to the ACA. In total this program would provide $112 billion ($26 billion less than the House's AHCA) in assistance to states as follows:

- *Short Term Assistance to Insurance Issuers*. The short-term assistance dollars ($15 billion in 2018 and 2019 and $10 billion in 2020 and 2021) will be available to participating health insurance issuers to help stabilize premiums, to promote participation in the health insurance market and choice in plans in the individual market.

- *Long-Term Assistance to States.* The BCRA would appropriate an additional $62 billion for the long-term state stability and innovation program between 2019 and 2026. States may seek funding to (a) assist high-risk/high-utilization individuals without employer coverage by reducing premiums, (b) establish or maintain a program with health insurance issuers to help stabilize premiums and promote state health insurance market participation and choice in plans offered in the individual market, (c) provide payments to providers for the provision of health care services, as specified by CMS, and/or (d) help to reduce out-of-pocket costs (copayments, coinsurance, and deductibles) for individuals enrolled in plans offered in the individual market. Allotted funds that remain unused by a state after three years will be redistributed to other states. In addition, states would be required to match the federal long-term assistance funds based on a statutory formula that increases from 0 percent in 2019 to 35 percent in 2026. If CMS determines that a state is misusing the assistance funds, it may withhold, reduce, or recover payments made to the state. Additionally, CMS would be required to ensure that at least $5 billion of the assistance funds in each calendar year 2019 through 2021 are used to help stabilize premiums and promote state health insurance market participation and choice in plans offered in the individual market.

***Opioid Crisis*.** The BCRA would appropriate $2 billion in fiscal year 2018 for state grants to support substance use disorder treatment and recovery support services.

Small Business Health Plans. Finally, the BCRA would amend the Employee Retirement Income Security Act of 1974 (ERISA) to permit small employers to join interstate health coverage purchasing groups, better known as association health plans. In doing so, the BCRA would extend ERISA preemption of state insurance regulation to these small business health plans and confer regulatory authority over these plans on the Department of Labor in consultation with a single domiciliary state identified for each plan. On March 22, 2017, the House passed the Small Business Health Fairness Act of 2017 (H.R. 1101), which likewise would amend ERISA to provide for the establishment and governance of association health plans. The small business health plan provision of the BCRA may be vulnerable to a Byrd challenge under the Senate's reconciliation rules because it does not appear to affect federal revenues and spending.

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As we noted at the outset, the situation is highly fluid. There are ongoing negotiations within the Republican caucus in an effort to secure 50 votes, and will likely be changes to the BCRA before it is brought to the Senate floor. A CBO score is also expected by the middle of next week which may influence the debate and the content of the final bill. The Majority Leader has indicated that he may bring the bill to the floor by the end of next week

We will continue to monitor this process, and provide updates and analysis as appropriate.

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