



The Better Care Reconciliation Act Legislative Summary

On June 22nd, Majority Leader Mitch McConnell (R-KY) released the first version of a comprehensive Senate Republican plan for repealing and replacing the Patient Protection and Affordable Care Act (PPACA), specifically the Better Care Reconciliation Act (BCRA). Although quite similar to the American Health Care Act (AHCA), which passed the House of Representatives in early May 2017, BCRA is a unique legislative proposal. Senate Republicans and outside stakeholders provided substantial feedback on the initial proposal prompting Senate Majority Leader McConnell to release a revised BCRA “discussion draft” on July 13th. The discussion drafts will precede introduction of formal legislation presumably under the same bill title. It is unclear at this time whether Senate Republicans can corral the 51 votes needed to pass their Obamacare replacement proposal under reconciliation, an arcane parliamentary procedure that prohibits a Senate filibuster and allows select bills to be passed with a simple majority. Majority Leader McConnell aimed to pass the initial discussion draft before the week long Independence Day District Work Period, however, the vote was delayed indefinitely due to insufficient support for the bill. A vote on the updated version of BCRA might occur sometime during the week of July 17th.

Like the AHCA, both BCRA discussion drafts consists of five major policy components, specifically the elimination of many existing PPACA taxes, the creation of new health care tax credits to assist individuals purchase health insurance, expanded access to health savings accounts (HSAs), federal funding to assist insurers and states stabilize the individual market, and Medicaid reforms.

Repealed PPACA Taxes

Similar to the AHCA, both versions of BCRA repeal many taxes enacted via PPACA. In fact, both Senate Republican bills immediately zero out any financial penalties for noncompliance with the individual or employer mandates. No individual or business will be subjected to *government* imposed fines for failing to obtain or provide insurance coverage. As an alternative means to encourage insurance coverage and stabilize the individual market, effective in 2019, BCRA requires individuals who fail to retain continuous health care coverage, defined as a break in coverage of more than 63 days in the prior 12 months, to wait six months prior to being able to purchase a new policy. Consumers, however, will not have to pay premiums during the waiting period. In comparison, the AHCA allowed insurers to assess a 30 percent premium surcharge on individuals who fail to retain continuous health care coverage.

The initial version of BCRA slated a whole host of unpopular levies for termination either by 2017 or 2018 including: the over-the-counter medication tax (2017); the 3.8 percent tax assessed to certain net investment income for couples making more than \$250,000; (2017); the 2.3 percent medical device tax (2018); increased taxes assess to non-qualified medical expenses paid via an HSA (2017); existing limitations on financial contributions to flexible savings accounts (FSAs) (2018); existing limitations on

tax deduction for employers who offer sufficient prescription drug coverage to their employees via the Retiree Drug Subsidy (2017); the higher adjusted gross income percentage threshold for medical expense itemized deductions (aka “Chronic Care Tax;” 2017); existing limitations on maximum contributions to HSAs (2018); prohibitions on both spouses making “catch-up” HSA contributions (2018); the health insurance tax or annual fee assessed to health insurance issuers (2017); the tax on brand manufacturer prescription medications (2018); and existing limitations on tax deductions associated with remuneration for insurance executives (2017). Almost all of these taxes are eliminated in 2017 in the AHCA.

The 10 percent tanning tax is eliminated in October 2017 under the initial Senate proposal, while the AHCA repeals this assessment in July 2017. Both the House bill and initial Senate discussion draft eliminate the small business tax credit effective in 2020 and the 0.9 percent Medicare payroll tax assessed to “higher earners” effective in 2023. The AHCA and first BCRA draft delay the Cadillac tax, or a 40 percent excise tax on high-cost employer sponsored health coverage, until 2026. The House bill and initial Senate proposal also prohibit Medicaid funding to Planned Parenthood for one year and disallows tax credits for purchasing insurance plans that also cover abortions.

The latest revised BCRA discussion draft, however, ultimately decided NOT to repeal the 3.8 percent tax assessed to certain net investment income for couples making more than \$250,000 (2017), the 0.9 percent Medicare payroll tax assessed to “higher earners” (effective in 2023), and the existing limitations on tax deductions associated with remuneration for insurance executives (2017).

Health Care Tax Credits

Similar to the House legislation, both BCRA versions replace the Obamacare subsidies and implement a new system of refundable tax credits to assist individuals and families purchase individual market insurance.

Under PPACA, only individuals or families that meet certain income thresholds, defined as persons with income between 100 to 400 percent of the federal poverty level (FPL), receive subsidies to offset the cost of purchasing prescriptive health insurance in the individual market. Individuals with incomes below these levels typically received health coverage through Medicaid. Obamacare subsidies are given directly to the insurance companies and beneficiaries who fail to buy policies that meet all statutory requirements via the exchanges are ineligible for the financial assistance.

In general, Republicans traditionally viewed Obamacare’s subsidies as expensive, inefficient, and highly rigid. As a result, effective in 2020, both Senate proposals create a system of advanceable (i.e. capable of being received on a monthly basis *before* taxes are filed) and/or refundable tax credits for individuals with income between 0 and 350% of the FPL. This change to the eligibility thresholds is designed to eliminate the Medicaid ‘coverage gap’ whereby some individuals are not eligible for Medicaid or PPACA subsidies. The Senate proposals bar anyone with government or employer-sponsored coverage from obtaining the tax credits. Yet, able-bodied individuals who may not be permitted to be covered under Medicaid based on the state in which they reside *would* be eligible for this tax credit. The tax credits vary based on age, family size, income, as well as geography and the amount of the tax credit will now

be pegged to the benchmark bronze plan which, under the Senate discussion drafts, will now have an actuarial value of 58 percent. Created by PPACA, actuarial value defines the average financial responsibility of an insurance plan for the health care expenses of a standard population (i.e. the plan pays 58% of medical costs and the beneficiary is responsible for the remainder).

Under both versions of BCRA, for individuals earning between 0-100 percent of the FPL, premiums could not exceed 2 percent of income. Premiums, however, are permitted to gradually increase based on age and income with up to a maximum of 16.2 percent for someone over the age of 59 at 350 percent of the FPL. For example, an individual who makes \$12,000 per year would have to contribute \$240 out-of-pocket for their premium, while an individual at age 60 who makes \$42,000 per year would be responsible for covering \$6,800 out-of-pocket for insurance premiums.

The system of tax credits under the House bill is solely based on age (not income) and is only available to individuals with income between 100 and 400 percent of the FPL. The AHCA also permits the tax payments to be used to purchase any eligible plan approved by a state and sold in their individual insurance market, including those off the exchange. The House bill also includes catastrophic coverage as a qualified plan, which is currently barred under Obamacare. *The revised Senate proposal, however, now allows all individuals (not just those under 30 years of age) to use the tax credits to purchase catastrophic plans (three primary care visits per year & federal protections that limit an individual's out-of-pocket costs).*

Another major difference between the House and both Senate proposals is the fact that BCRA funds the PPACA's controversial cost-sharing reductions (CSRs), or payments from the federal government to insurers to help low-income beneficiaries offset out-of-pocket costs (copayments, coinsurance, etc.) for two years prior to fully eliminating the program in 2020. The House bill is silent on CSRs.

Expanded Access to HSAs

Similar to the AHCA, both BCRA discussion drafts authorize expanded access to HSAs to ensure equal access to more affordable health insurance. HSAs allow individuals and employers to contribute to a tax-preferred account up to specific financial thresholds as long as they use a high-deductible health plan as their primary form of insurance coverage. Under PPACA, the maximum amount that can be contributed in 2017 to an HSA by both a beneficiary and an employer is \$3,400 for an individual and \$6,750 for a family. BCRA increases the maximum HSA contribution amounts to \$6,500 and \$13,100 for individuals and families, respectively.

In a major change designed to improve access to coverage, the revised BCRA discussion draft now permits beneficiaries to use of pre-tax HSA dollars to pay for health insurance premiums associated with any health plan, rather than solely for expenses associated with high deductible plans.

State Stability and Innovation Fund

The BCRA proposals also provide considerable funding to help stabilize the individual insurance marketplace in both the short and long-term. More specifically, the initial Senate Republican plan

provides \$50 billion in funding through the Children’s Health Insurance Program (CHIP) over four years (2018-2021) to the Administrator of the Centers for Medicare and Medicaid Services (CMS) to fund arrangements with health insurance issuers to address disruptions in health coverage and access, as well as to respond to urgent health care needs within states. The statutory language for the short-term funding appears to be intentionally broad in order to grant CMS maximum flexibility to pursue various activities to stabilize the individual market. No state matching funding is required for the short-term pool of money.

The original Senate Republican legislation also allocates an additional \$62 billion in funding over an eight-year period to create a Long-Term State Stability and Innovation Program. *The revised BCRA discussion draft, however, adds an additional \$70 billion in funding thus increasing the total figure for just the Long-Term State Stability and Innovation Program to \$132 billion over eight years.* This additional pool of money is designed to help high-risk beneficiaries who do not have access to employer-based coverage get health insurance coverage in the individual market, stabilize insurance markets, pay health care providers for health care services, and provide assistance to reduce out-of-pocket costs in the individual market. States must submit applications to CMS to obtain a portion of this funding and are explicitly prohibited from using these resources to finance their share of Medicaid payments or for intergovernmental transfers. It also appears that states are responsible for contributing a portion of the cost of the Long-Term funding program. *In total, the revised Senate legislation allocates approximately \$182 billion over 12 years for the State Stability and Innovation Program (i.e. short and long-term programs).*

By way of comparison, the AHCA allocates \$123 billion to its own “Patient and State Stability Fund,” which is primarily dedicated to resuscitating dormant high risk pools as a key way to cover patients with pre-existing conditions, but also premium assistance, and out-of-pocket expenses. It also includes funding to combat the opioid crisis and for maternal and child health care.

Medicaid Reform

Each BCRA proposal also closely mirrors the AHCA in that the discussion drafts seek to make changes to Medicaid and PPACA’s Medicaid expansion policy. Medicaid, an entitlement program that provides health care to lower income Americans, pregnant mothers, children, blind or disabled individuals, and impoverished elderly citizens, is traditionally administered by the states while the financing is divided between the state and federal government. Under the ACA, states have the option to expand Medicaid eligibility to able-bodied (childless, non-disabled, non-elderly, non-pregnant) adults with incomes below 138 percent of the Federal Poverty Level in return for enhanced Federal financial match (90 to 95 percent depending upon the year), and, to date, 32 states have expanded Medicaid.

First and foremost, both BCRA proposals and the AHCA eliminate the mandatory PPACA requirement that states expand Medicaid to 138 percent of FPL (this provision was essentially rendered moot by *NFIB v. Sebelius*). Each bill also limits the applicability of the enhanced federal Medicaid funding to those states that expanded their coverage as of March 1, 2017. In addition, the House and Senate legislation permits *non-expansion states* to offer expanded Medicaid coverage for individuals up to 138 percent of

the FPL at the enhanced federal matching figures through December 31, 2017. Each bill, however, terminates the states' ability to expand Medicaid coverage to adults *above* 133 percent of the FPL, effective December 31, 2017. It also appears that the two BCRA proposals reinstate, effective January 1, 2020, the option for states to cover "able-bodied" adults up to 138 percent of FPL but only at pre-PPACA federal matching rates. Medicaid's Essential Health Benefit (EHB) requirement is also repealed, effective 2020, in both BCRA versions and the AHCA.

Under each Senate discussion draft, states that elected to cover "expansion enrollees" before March 1, 2017 will continue to receive enhanced federal matching funds through 2019. Starting in 2020, the matching rate will be the higher of the state's standard federal matching rate OR 90 percent. This threshold continues to gradually decline over a period of three years (85 percent in 2021, 80 percent in 2022, and 75 percent in 2023). Effective January 1, 2024, the matching rate for "expansion populations" would be the state's standard matching rate prior to the passage of Obamacare.

The House bill, however, does not include a three-year "glide path" for enhanced federal matching through 2023. Effective December 31, 2019, enrollees in states that elected to expand Medicaid coverage are granted "grandfather" status and continue to receive enhanced federal matching funding (90 percent) so long as they remain enrolled in Medicaid and do not incur a break in coverage for more than 63 days. Because adult Medicaid recipients generally cycle on and off Medicaid as their incomes fluctuate, over time, this provision is designed to gradually phase out the enhanced federal matching rates. Otherwise, states resume their traditional pre-PPACA Medicaid matching funds effective in 2020.

Most importantly, the AHCA and the various BCRA versions include sweeping policy changes that transform Medicaid from its traditional practice of providing states with open-ended monetary resources to cover the cost of all beneficiaries to a program that only grants states fixed amounts of funding from the federal government regardless of enrollment numbers. Starting in 2020, the AHCA and both BCRA proposals grant states the option to pursue either per-capita funding caps or block grants to cover Medicaid costs.

Under per-capita caps, specific dollar amounts are calculated based on the number of beneficiaries and this amount is paid to the state on an annual basis. If Medicaid expenses exceed a state's per capita allotment, the state is responsible for covering the excess costs. The per capita payment is based on the average amount for beneficiaries in one of five enrollment categories: 1) the elderly; 2) blind and disabled individuals; 3) children; 4) adult expansion enrollees; and 5) non-expansion adults (pregnant women). Both Senate proposals explicitly exempt *disabled children* from the per-capita cap, while the House is silent on this subcategory.

While the House bill establishes the states' Medicaid population for Fiscal Year 2016 as the "baseline" for calculating per-capita caps, the BCRA proposals permit states to select spending data from any 8 consecutive quarters between 2014 and 2017 for the baseline cap. In addition, the rate of inflation for the per capita caps in each Senate bill is updated annually by Consumer Price Index Urban Medical through 2025 (blind and disabled category get CPI Urban Medical plus 1 percent). Effective in 2026, the each Senate proposal transitions to a less generous inflation factor of CPI-Urban. In comparison, the

House bill only uses CPI-Urban Medical or CPI Urban Medical plus 1 percent as its rates of inflation for the various population categories.

In lieu of the per capita cap, states can also elect to receive a Medicaid block grant, or lump sum payments with minimal federal restrictions on how the funding should be used, for specific populations. Both BCRA proposals permit states to receive block grant funding for non-elderly, non-disabled, non-expansion adults, while explicitly excluding *all children* from this policy proposal. The House legislation does not exclude children from the block grant. The revised Senate legislation includes new text which allows states to add Medicaid expansion populations to the block grant funding methodology. The latest BCRA draft also allows states that declare public health emergencies to exempt state medical assistance expenditures from the per capita cap or block grant allocations for the duration of the declared period of the emergency.

Finally, both BCRA proposals and AHCA permit states, effective October 1, 2017, to impose limited working requirements on “non-disabled, non-elderly, non-pregnant” Medicaid beneficiaries. The work requirements do not apply to children under the age of 19 or if an individual is the only parent/caretaker of a child under 6 or a child with disabilities. States are authorized to determine the length of the work requirements and, in turn, the federal government provides additional matching funding to help implement this new policy.

Section 1332 Waiver

Under Section 1332 of PPACA, states are permitted to seek waivers from certain requirements of the health care law beginning in 2017. Under these waivers, states can adopt alternative approaches that would offer insurance coverage that: 1) is at least as comprehensive (i.e. certified by the Actuary of the CMS) as products permitted by PPACA; 2) offers coverage and cost-sharing protections at least as affordable as PPACA; 3) covers a comparable number of residents; and 4) is budget neutral. The provisions of PPACA subject to 1332 waivers are EHBs, actuarial value, out-of-pocket limits (in the individual market), and other qualified health plan requirements, as well as PPACA’s exchange provisions and its premium tax credit concepts.

Under both Senate proposals, all provisions subject to the Section 1332 waiver can be eliminated simply if a state describes how it would “provide for alternative means of, and requirements for, increasing access to comprehensive coverage, reducing average premiums, and increasing enrollment.” In addition, the Senate discussion drafts replace the budget neutrality standard with a requirement that a waiver not increase the federal deficit. Each BCRA proposal also removes the requirement that 1332 waivers be approved by a States’ legislature replacing it with a requirement that the waiver be authorized by the Governor or State Insurance Commissioner. Another added layer of flexibility contained in the Senate drafts is that HHS must approve any 1332 waiver request unless they increase the federal deficit and the waivers are approved for eight years with automatic renewal. In short, each BCRA proposal establishes greater flexibility by relying on much lower standards than PPACA for Section 1332 waivers.

The Senate drafts also provides \$2 billion in extra funding in 2017, to remain available through 2019, for grants to states to assist them with submitting and implementing waivers. States could also use their Long-Term State Stability and Innovation Program allotments for waiver programs.

Although they differ in a few key respects, the changes to the Section 1332 waivers are similar to provisions added to the AHCA via an amendment negotiated by Reps. Tom MacArthur (R-NJ) and Mark Meadows (R-NC). Under the MacArthur-Meadows amendment, states are given the option of increasing age rating bands (2018), as well as waiving PPACA requirements pertaining to community rating (2019) and EHBS (2020) as long as certain conditions are met. Community rating is the practice of charging one premium for the entire population of beneficiaries who buy health insurance in the individual or small group markets. Changes to community rating opened up the AHCA to critiques that the legislation will permit insurance companies to charge patients exorbitant premiums based on pre-existing health conditions.

Prior to PPACA, insurers principally relied on individual rating, which is the practice of charging beneficiaries varying premiums based on age, health status, behaviors or habits, past medical claims, gender and other factors. Individual rating was designed to help insurers to properly price the cost of a health policy based on estimates of the total amount of future care required by that individual. As a result, sicker people, who purchased insurance in either the individual or small group markets, paid much higher premiums than healthy beneficiaries.

To drive down insurance costs for sicker individuals, PPACA banned individual rating and instituted community rating. In exchange for greater access to health insurance for sicker individuals, community rating produces relatively higher insurance premium costs for healthier people.

As a result, the MacArthur-Meadows amendment allows states, effective in 2019; to opt out of the community rating requirements so long as the waiver application specifies that at least one of the following five conditions are met:

- Reductions in average premiums for coverage
- Increases in health insurance enrollment
- Greater stability in a state's health insurance marketplace
- More stable premiums for individuals with pre-existing conditions, or
- Increases in health plan choices within a state.

State waivers under the House bill are applicable for 10 years and are an automatically granted 60 days after the application is received unless the Secretary of the Department of Health and Human Services (HHS) specifies in writing that the conditions will not be met. States can also apply to renew the waivers after 10 years. It's largely unclear what standards HHS will set to ensure achievement of one of the five waiver conditions.

The amendment, however, does attempt to retain certain PPACA community rating consumer protections. In fact, the amendment specifically precludes insurance companies from raising premiums based on gender, age and health status.

Only individuals who live in states that received a waiver and successfully established a high-risk pool, either through the federal government or “patient and state stability funds” authorized in the AHCA, may be charged higher premiums for pre-existing conditions. In addition, individuals subjected to higher premiums because of pre-existing conditions must show they are seeking *replacement* health insurance following a 63-day or longer break in their previous coverage. The amendment is silent about charging higher premiums based on a beneficiary’s health status in the event they no longer receive employer-based coverage and now seek to purchase insurance in the individual or small business market.

With respect to EHBs, the MacArthur-Meadows compromise permits states to apply for waivers from this requirement effective Jan. 1, 2020. EHBs refer to a set of health services, such as for maternity or mental health, which must be provided to all beneficiaries who purchase health insurance in the individual or small business market from the exchanges. Similar to the community rating policy, state exemptions for EHBs must also certify that they meet at least one of the five general waiver conditions.

While the Senate bills do permit the Section 1332 waivers to be used to change EHBs, actuarial values, out-of-pocket limits, and other exchange funding, the BCRA discussion drafts prohibit this section from altering health status underwriting/community rates rules. **Furthermore, relaxed Section 1332 waiver provisions make it easier for states to eliminate key EHBs.**

Title III, Section 301, Establishing Funding for the Individual Market

In an attempt to mollify more conservative members of the upper chamber, Senator Ted Cruz (R-TX) added a new section to the most recent Senate discussion draft which permits insurers, effective January 1, 2020, to offer non-PPACA compliant individual market insurance plans so long as they offer, at a minimum, one gold, silver, and premium PPACA-compliant plan on the health insurance exchanges. The compliant plans are required to adhere to all of the insurance mandates found in Title 1 of PPACA, including Section 2713 which requires individual **and** group (employer) insurance plans to provide certain preventive screening services as determined by a variety of federal government agencies and advisory bodies, including the USPSTF, without any form of patient cost-sharing (e.g. copayments, coinsurance, and deductibles). The skimpier, less expensive non-compliant plans are designed to target younger, healthier beneficiaries in the individual market. The latest BCRA draft explicitly states that Section 2713 would not apply to non-compliant PPACA policies

It appears that Section 2713, however, is only removed from non-compliant plans within the individual market. As a result, employer-based health insurance plans would still be required to provide beneficiaries cancer screens approved by the relevant government agencies and advisory bodies without cost-sharing. Since the vast majority of Americans receive health insurance through their jobs, this is an important potential silver lining to this policy.

The American College of Radiology (ACR) is closely monitoring this particular change to the latest BCRA version to ensure patients are not responsible for any cost sharing associated with receiving life-saving cancer screening services such as mammograms, low-dose CT screens for lung cancer, and CT Colonographies for Colon Cancer. In addition, it is likely that the Senate parliamentarian will not permit

the addition of Title III, Section 301 to the latest BCRA version due to violation of the complicated Byrd Rules governing bills considered under reconciliation.

Next Steps

As of publication, Senate Majority Leader Mitch McConnell announced that the latest version of BCRA would likely receive a vote during the week of July 17th. To date, many prominent Republican Senators, including Rand Paul (R-KY), Ron Johnson (R-WI), Susan Collins (R-ME), Dean Heller (R-NV), Shelley Moore Capito (R-WV), Bill Cassidy, MD (R-LA), and Lisa Murkowski (R-AK), have either formally expressed their opposition to or are undecided on BCRA in its latest format. Senate Majority Leader McConnell cannot lose more than two Republican Senators in order to pass the legislation under reconciliation and the politics surrounding BRCA remain quite fluid.

In addition, the Senate awaits a revised Congressional Budget Office (CBO) projection on the impact of the revised BCRA discussion draft on insurance coverage rates, Medicaid, the deficit, etc. The non-partisan CBO projected in their June 26th [analysis](#) of the previous discussion draft that premiums for individuals who purchase health insurance via the exchanges would be 20 percent higher in 2018 and 10 percent higher in 2019 in comparison to current law. Although the earlier discussion draft is expected to result in steep short-term price increases, CBO also projects that by 2020 premiums would be 30 percent *lower* in comparison to current law. In addition, CBO's initial analysis predicts that the combination of eliminating the individual mandate, transitioning from government subsidies to refundable tax credits, and substantial Medicaid reforms will result in approximately 22 million more uninsured by 2026. CBO estimated that the House's AHCA would increase the number of uninsured by 23 million by 2026. The initial BCRA discussion draft is also expected to lower the federal deficit by \$321 billion dollars over 10 years, which equates to \$202 billion more in net savings in comparison to the House health care bill.

If either version of BCRA regains legislative momentum and ultimately passes the Senate in the near future, it is expected that the House will then pass this new legislation so it can then be sent to President Donald Trump to be signed into law. There is a possibility that, rather than pass BCRA, the House will instead request a conference committee to iron out the differences between the two bills. Under this scenario, the conference committee will produce a compromise piece of legislation which will then have to be passed by both the House and Senate prior to being sent to the President to be signed into law. The compromise bill produced by the conference committee could still be passed in the Senate with a simple majority vote. It is widely expected that House and Senate Republican leaders will forego a conference committee because it will take several weeks to select bicameral participants, develop a compromise bill, and then pass the legislation through the two chambers.