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Better Care Reconciliation Act – Legislative Summary

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Overview:

House Republicans passed health care legislation, the American Health Care Act (AHCA) on May 4, 2017. Senate Republicans released a discussion draft of their own bill to "repeal and replace" the Affordable Care Act (ACA) on Thursday, June 22, with an updated bill released on June 26. The draft legislative text – the Better Care Reconciliation Act (BCRA) of 2017 – proposes several changes to the AHCA, but substantially mirrors the approach taken by the House. The BCRA is expected to be amended before being finalized as negotiations continue this week in the Senate. Discussions among Republican lawmakers are ongoing in their effort to secure the 50 votes needed to pass the bill using the budget reconciliation process.

The Better Care Reconciliation Act:

Medicaid – The Senate bill repeals the ACA's expansion of the Medicaid program and ends the ACA's enhanced funding for expansion adult, phasing down funding between 2021 and 2024.

Like the House bill, the BCRA would allow states to choose between two formulas for federal Medicaid funding - either 1) per-capita allotments or 2) a block grant. While the BCRA caps federal spending on Medicaid in a way that is similar to the AHCA, a key difference between the two is the inflation rate, which is slower in the Senate bill. Certain Medicaid enrollees – including people with disabilities and children – would not be subject to the spending caps.

Like the AHCA, the BCRA would allow states to implement optional work requirements for non-disabled, non-elderly and non-pregnant Medicaid beneficiaries. It also provides an additional $10 billion in safety net funding from FY2018 – 2022 (no more than $2 billion per year) for states that did not expand their Medicaid programs.

The Senate bill would also deny hospitals the ability to continue using presumptive eligibility determinations for ACA Medicaid expansion populations beginning in 2020.

Additionally, beginning in FY 2021, the bill would place additional limits on the use of provider taxes to fund state Medicaid programs phasing the 6 percent threshold down to 5 percent by 2025.

DSH Payment Reductions – The BCRA would repeal the ACA's scheduled Medicaid Disproportionate Share Hospital (DSH) payment reductions for states that did not expand Medicaid under the ACA. Beginning in FY 2020, the Senate bill would also provide a 3-year DSH payment increase for non-expansion states whose Medicaid enrollment is below the national average. In addition, certain states that did expand Medicaid could potentially see other payment increases based on a number of factors.

Insurance Market Reforms – The BCRA ends the individual mandate requirement that individuals purchase insurance or pay a fine. It also ends the employer mandate requiring that employers with 50 or more employees must offer meaningful insurance coverage or pay fines.

The BCRA maintains some key protections offered under the ACA, including requiring insurers to cover individuals with preexisting conditions and allowing young adults to remain on their parent's insurance plan until age 26. While the initial BCRA draft did not address the issue, the Senate added a provision that will provide for a 6-month lockout period, where an individual would not be able to access benefits for six months if coverage lapses. The House bill would have allowed a 30 percent premium penalty if an enrollee does not maintain continuous insurance coverage.

Like the House bill, the Senate draft provides funding in order to stabilize the health insurance markets. For two years, a share of those stabilization funds would be dedicated to continuing to provide cost-sharing reduction subsidies that were offered under the ACA, but are subject to an ongoing legal challenge. The bill also offers a pool of funding designed to help states lower premiums for high-cost insurance enrollees and potentially lower premium payments in the non-group market. States would be required to provide matching payments to receive these funds.

In order to address Republicans' concerns about overly proscriptive regulations under the ACA, the BCRA provides options for states to seek broad waivers from requirements around essential health benefits, which would be automatically granted if the state could show the waiver would lower premiums. However, unlike the AHCA, the bill would not permit waivers from several of the ACA's insurance market reforms that could allow for increased insurance charges for individuals with pre-existing conditions.

Notable Repealed Provisions – Similar to the AHCA, the BCRA also proposes to end or delay many of the ACA's taxes, including the medical device, insurance plan, indoor tanning, and pharmaceuticals taxes, as well as the additional tax on Medicare for high-earning individuals – in some cases retroactively.

While the House bill delays, but does not repeal, the effective date on the excise tax on high-value insurance plans until 2025 (i.e., the Cadillac tax), the Senate proposal takes a different approach by suspending it until 2026, when it would go back into effect.

Value-based Delivery System Reforms – Like the AHCA, the Senate bill does not make any changes to the ACA provisions designed to enhance value-based payments and transition away from fee-for-service payments. In addition, the proposed bill does not include any changes to the Center for Medicare and Medicaid Innovation (CMMI).

Subsidies/Tax Credits to Purchase Insurance – The Senate bill would continue income-based subsidies under the ACA, but reduce eligibility levels to 350 percent of federal poverty level (compared with 400 percent under the ACA). The BCRA would also add an age-based adjustment to the subsidies and reduce the overall value relative to the cost of insurance plans.

One key difference between the BCRA and the ACA is that low-income individuals would be eligible to receive subsidies if they make less than 100% of federal poverty level. That change would allow individuals in states that have not expanded Medicaid, but were previously ineligible for subsidies, to potentially access insurance plans – though the cost of such plans would likely still be substantial relative to their income.

Other Provisions – Like the House bill, the Senate legislation increases the ratio that insurers can charge older Americans compared with younger individuals to 5 to 1 (compared with 3 to 1 under the ACA). The legislation prohibits federal funding to Planned Parenthood for one year. It also permits a higher contribution limit to Health Savings Accounts (HSAs). Under the BCRA, states would be allowed to determine their own medical loss ratio requirements for insurers. The

Senate bill would offer $2 billion to combat the ongoing opioid epidemic compared with $48 billion in the House-passed legislation.

CBO Analysis:

The Congressional Budget Office (CBO) released its estimate or "score" of the expected cost and coverage impact of the BCRA on June 26. CBO found the bill would increase the number of uninsured Americans by 22 million by 2026 – with 15 million losing coverage in 2018. It also estimated that the proposed changes to the Medicaid program under the bill would reduce funding relative to current law by $772 billion (or 26%) over the next 10 years. CBO also found that the bill's changes would produce an estimated reduction in federal spending of $321 billion (compared with $119 under AHCA).

Hospital Implications:

Like the legislation passed by the House last month, the BCRA could have a significant negative impact on hospital finances across the country. It would dramatically reduce long-term funding for Medicaid by an estimated $772 billion. The transition to a Medicaid per-capita cap system and the end of the Medicaid expansion would reduce funding for state Medicaid programs, particularly in the 31 ACA expansion states. While the bill would offer some new flexibility to states to administer their own programs, with cuts of that magnitude, it seems likely that state Medicaid programs would be forced to reduce reimbursement for and/or add further restrictions to Medicaid eligibility.

The bill is estimated to increase the number of uninsured Americans by 22 million. A dramatic increase in the number of uninsured would do damage to the nation's health and have a significant negative financial impact on both patients and hospitals. The combined impact of Medicaid cuts and dramatic increases in the number of uninsured, particularly in areas with a high Medicaid population, could be devastating for hospitals.

Process:

As of the date of the release of the CBO score there were still too many Republican senators who opposed the legislation, for various reasons. This means that further changes to the legislation are expected before the bill is likely to advance to the floor for a vote. The bill will then face parliamentary scrutiny to ensure that its provisions comply with the limitations under budget reconciliation. There is still the potential for major changes to key provisions for not complying with the "Byrd Rule" that prohibits provisions unrelated to federal spending.

If the Senate makes additional changes to what the House passed, there are two realistic options to complete the legislative process. Most likely both chambers will hold a conference committee to reconcile the differences in the legislation and produce an identical bill. The negotiated conference committee bill would then be voted on again by both chambers before the bill would be sent to the White House for the President's signature. Alternatively, the House could directly take up and vote on the bill that passed the Senate, negating the need for a conference committee.

Vizient has expressed opposition to BCRA in its current form, due to the concerns about the negative impact the legislation would have on providers. We will continue to monitor the developments as the legislation makes its way through Congress.