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Senate's BCRA Includes Major Changes to Medicaid and the ACA

Premium Tax Credits 1
Cost Sharing Reductions 3
Insurance Market Reforms 4
Section 1332 Waivers 4
State Stability and Innovation Program 5
Medicaid Per Capita Cap 6
Medicaid Flexibility "Block Grant" 6
Medicaid Expansion 8
Other Changes to Medicaid 8
Other Provisions of the BCRA 9
Next Steps 10

June 29, 2017

Health Care

Last week, Senate Republican leadership released the Better Care Reconciliation Act of 2017 (BCRA), which would repeal and replace the Affordable Care Act (ACA). While Senate Republicans do not yet have the requisite votes to pass the legislation, and did not start the debate this week as planned, the bill is still very much alive. Senate Republicans continue to consider changes to the BCRA to get the votes needed for passage.

This advisory analyzes the provisions of the BCRA, including the amendments to the BCRA released Monday. Among other things, the BCRA would: make major changes to the federal subsidies provided to purchase individual market health plans; roll back several of the ACA's health insurance market reforms; expand State flexibility under Section 1332 waivers; phase-out increased federal funding for the Medicaid expansion; and impose a per capita cap on state Medicaid expenditures.

Premium Tax Credits

The BCRA makes a number of changes to the tax credits that low-income individuals and families can use to purchase private coverage in the individual market. Unlike the House's American Health Care Act (AHCA), which offers means- and age-based tax credits that did not vary based on the price of insurance, the BCRA tax credit system follows the ACA's general

framework for calculating means-based premium tax credits that account for the cost of plans available to the individual. Nonetheless, the overall result of the changes made in the BCRA will reduce the amount of support available to most individuals.

Eligibility for Premium Tax Credits

Under the ACA, individuals are eligible to receive premium tax credits if they have a household income between 100% and 400% of the federal poverty level (FPL). 26 U.S.C. § 36B(c)(1)(A), (b)(3)(A)(i). Effective January 1, 2020, the BCRA reduces this maximum income level to 350% of the FPL, making individuals with income between 350% and 400% of the FPL ineligible for premium assistance tax credits. BCRA § 102(a)-(b). However, the BCRA also makes tax credits available to individuals below 100% of the FPL, a modification that is presumably designed to expand access to coverage in the States that have not expanded Medicaid (or in expansion States that eliminate their Medicaid expansion once the federal government ends the increased match for that population, as provided for in the BCRA and the AHCA).

The BCRA expands the number of individuals ineligible for premium tax credits due to their eligibility for an employer-sponsored health plan or a small employer health reimbursement arrangement. Under the ACA, individuals are not eligible to receive tax credits if their employer-sponsored plan provides "minimum value" and "affordable coverage," which means the employee's contribution to the employer-sponsored plan is less than 9.69% of household income. 26 U.S.C. § 36B(c)(2)(C). The BCRA removes all exceptions related to the value or affordability of the employer-sponsored coverage; that is, all individuals who are eligible to receive employer-sponsored coverage are ineligible for premium tax credits, regardless of the value or affordability of the employer-sponsored coverage. BCRA § 102(c)(1).The BCRA also changes the definition of a "qualified health plan" for which tax credits may be used to exclude any plans offering abortion services, except in cases where there is a danger to the mother's life or in instances of rape or incest. BCRA § 102(d). Thus, individuals purchasing plans that cover abortion services will not be eligible to receive a premium assistance tax credit.

The Amount of the Premium Tax Credit

Under the ACA, premium tax credits are calculated by comparing an individual's household income against the cost of premiums for a "benchmark" plan in that individual's area. 26 U.S.C. § 36B(b). The ACA establishes an upper limit, or "premium cap," on the amount that any individual must pay in premiums for a "benchmark" plan. This "premium cap" is expressed as a percentage of the individual's annual income, which varies based on an individual's income level. If the cost of the enrollee's "benchmark" plan exceeds that individual's premium "cap," the government pays a tax credit that covers the difference:

$$\text{the amount of the tax credit} = \text{cost of premiums in the benchmark plan} - \text{individual or family's premium cap}$$

Although premium assistance amounts are calculated by comparison to the benchmark plan, the amount received in tax credits need not be spent only on the benchmark plan; they can be used towards any qualified health plan available on the Exchange.

Benchmark Plan. Under the ACA, the "benchmark" plan is the "second-lowest cost silver plan" offered in the individual's area. 26 U.S.C. § 36B(b)(2), (b)(3)(B). Silver plans must have a 70% actuarial value. ACA § 1302(d)(1).

The BCRA changes the definition of benchmark plan to the median of all plans offering a 58% actuarial value. BCRA § 102(b)(1)(B). Where no plan offers the exact median of all plans, the benchmark plan would be targeted to the plan with premiums closest to, but not exceeding, the median premium. *Id.*

Premium Cap. The BCRA also changes the calculation of the premium cap for individuals and families. The BCRA's calculation of the premium cap depends on the individual's age and income. Older individuals will have a higher percentage cap, and thus will pay more for their insurance than younger individuals at the same income level if they have income in excess of 150% of the poverty level.

The table below compares the premium cap percentages available under the ACA and BCRA:

Premium Cap (ACA: Max percentage of income for second lowest plan offering 70% AV) (BCRA: Max percentage of income for median plan offering 58% AV)						
Income (%of FPL)	**ACA**	**BCRA**				
	All ages	**Up to Age 29**	**Age 30-39**	**Age 40-49**	**Age 50-59**	**Over Age 59**
Up to 100%	--	2%	2%	2%	2%	2%
100% - 133%	2.04%	2% - 2.5%	2% - 2.5%	2% - 2.5%	2% - 2.5%	2% - 2.5%
133% - 150%	3.06% - 4.08%	2.5% - 4%	2.5% - 4%	2.5% - 4%	2.5% - 4%	2.5% - 4%
150% - 200%	4.08% - 6.43%	4% - 4.3%	4% - 5.3%	4% - 6.3%	4% - 7.3%	4% - 8.3%
200% - 250%	6.43% - 8.21%	4.3% - 4.3%	5.3% - 5.9%	6.3% - 8.05%	7.3% - 9%	8.3% - 10%
250% - 300%	8.21% - 9.69%	4.3% - 4.3%	5.9% - 5.9%	8.05% - 8.35%	9% - 10.5%	10% - 11.5%
300% - 400% (BCRA: only up to 350%)	9.69%	4.3% - 6.4%	5.9% - 8.9%	8.35% - 12.5%	10.5% - 15.8%	11.5% - 16.2%

Cost Sharing Reductions

The ACA provides cost sharing reductions to decrease the out-of-pocket costs for individuals and families between 100% and 250% of the FPL.

Section 208 of the BCRA repeals the ACA's cost sharing reductions, effective January 1, 2020.

However, Section 209 of the BCRA explicitly authorizes appropriations for the cost-sharing reduction program for taxable years 2018 and 2019, addressing a major uncertainty that has been facing the insurance industry.

Insurance Market Reforms

The BCRA makes a number of changes to the ACA's insurance market reforms, including the following:

- Section 104 eliminates the ACA's individual mandate, effective immediately. Unlike the House's AHCA, the BCRA did not initially include any provision that would discourage individuals from simply waiting until they need health care to enroll in insurance coverage. However, an amendment added to the bill on Monday requires health insurers to "impose a 6 month waiting period . . . on any individual who enrolls in such coverage and cannot demonstrate 12 months of continuous creditable coverage," even if the individual submits an application to enroll during an open enrollment period. BCRA § 206. There are exceptions to the mandatory six-month waiting period for a newborn enrolled within 30 days of birth, and for a child who is adopted before age 18 and placed in coverage within 30 days of the date of adoption. *Id.*
- Section 105 eliminates the requirement that large employers provide health insurance coverage to their full-time employees, effective immediately.
- Section 204 gives insurers more flexibility to set premiums based on age, effective January 1, 2019. Under the ACA, the age rating ratio is 3:1; the BCRA's age rating ratio is 5:1. In addition, the BCRA allows States to set a different age rating ratio requirement.
- Section 205 sunsets the ACA's Medical Loss Ratio (MLR) requirement, effective January 1, 2019. Instead of a federal standard, Section 205 provides that "each State shall" set an MLR. The BCRA does not say what happens if a State declines to set an MLR.

Section 1332 Waivers

Under Section 1332 of the ACA, States can apply to the federal government for a waiver of the ACA's provisions, including those governing the individual mandate, the employer mandate, Qualified Health Plans, Exchange operations, premium tax credits, and cost sharing subsidies. States can develop and implement a waiver program in which these ACA rules are supplanted with rules that the State negotiates with the Centers for Medicare & Medicaid Services (CMS) and/or the Secretary of Treasury, financed with direct federal payments to the State, up to the amount that would otherwise be paid to individuals in the State for tax credits and subsidies to purchase Exchange coverage under the ACA.

The BCRA significantly increases state flexibility to implement Section 1332 waiver programs. Under the ACA, the federal government "may" approve a waiver only if the State (1) provides coverage that is at least as comprehensive as Essential Health Benefits offered through the Exchanges; (2) ensures out of pocket costs are at least as affordable as they would be under the ACA; (3) provides coverage to a "comparable" number of residents as would be covered under the ACA; and (4) will not increase the federal deficit. The BCRA eliminates the first three of these requirements, and instead provides that the federal government "shall" approve a Section 1332 waiver "unless" the State's plan would increase the federal deficit.

State Stability and Innovation Program

Section 106 the BCRA creates a "State Stability and Innovation Program," which has two components:

1. "Short-Term Assistance to Address Coverage and Access Disruption and Provide Support for States." This provides $15 billion annually to CMS in calendar years 2018 and 2019, and $10 billion annually in 2020 and 2021, "to fund arrangements with health insurance issuers to address coverage and access disruption and respond to urgent health care needs with States." This program will "fund arrangements with health insurance issuers to address coverage and access disruption and respond to urgent health care needs within States." CMS is given broad authority to develop and implement the program, including developing a methodology for distributing the funds.
2. "Long Term State Stability and Innovation Program." This program will provide funding to States to establish programs to do one of the following: "provide financial assistance to help high risk individuals, including by reducing premium costs"; stabilize premiums and promote state health insurance market participation and choice in the individual market; make payments to health care providers; and/or provide assistance to reduce out-of-pocket costs for individuals enrolled in plans in the individual market. In contrast to the AHCA's Patient and State Stability fund, the BCRA does not expressly provide that the Long Term State Stability and Innovation Fund is a "state health care program" subject to the anti-fraud provisions in Section 1128, 1128A, and 1128B of the Social Security Act.

   The BCRA provides the following federal funding for this program:

Year	Appropriation
2019	$8 billion
2020	$14 billion
2021	$14 billion
2022	$6 billion
2023	$6 billion
2024	$5 billion
2025	$5 billion
2026	$4 billion

   The amount a State will receive will be determined based on a system to be established by CMS, which the agency has broad discretion to create.

   Beginning in 2022, States implementing a program pursuant to this authority must share in the cost of the program. The state share starts at 7% in 2022 and rises by 7% each year thereafter, such that it will be 35% in 2026. States are prohibited from using intergovernmental transfers or certified public expenditures to fund the state share.

Medicaid Per Capita Cap

Section 133 of the Senate bill proposes a per capita allotment for the Medicaid program. It is similar in many respects to the per capita cap proposed in AHCA (described in our advisory dated March 13, 2017), with the following differences:

- Instead of using federal fiscal year 2016 as the "base year," States must choose a "per capita base period." The base period must be a period of eight (8) consecutive fiscal quarters that begins with a fiscal quarter earlier than October 1, 2013 (the first quarter of fiscal year 2014) or ends with a fiscal quarter later than June 30, 2017 (the third fiscal quarter of 2017).
- The 1903A categories subject to the per capita approach continue to be elderly, blind and disabled, children, expansion enrollees, and "other nonelderly, nondisabled, non-expansion adults," except that blind and disabled children through age 18 are now an excluded group. For States that expanded after fiscal year 2016, the target for "expansion enrollees" is equal to the target for "other non-expansion adults."
- The inflation factor for the 1903A enrollees continues to be the medical care component of the consumer price index for all urban consumers (CPI-U) (U.S. city average); there is a 1% increase for elderly and blind and disabled adult eligibility categories. However, after fiscal year 2024, the inflationary rate will decrease to the regular CPI-U, and the 1% increase for the elderly and blind and disabled groups will end.
- There is a new provision to "promote program equity across States," beginning in 2020. Under this provision, if a State's per capita categorical medical assistance expenditures in an eligibility category exceed the mean per capita expenditures for that category for all States by more than 25%, then the State's target per capita amount "shall be reduced by a percentage that shall be determined by the Secretary but which shall not be less than 0.5 percent or greater than 2 percent." Conversely, if a State's per capita categorical medical expenditures in an eligibility category is at least 25% less than the mean for that category for all States, than its target "shall be increased by a percentage" to be determined by the Secretary between 0.5 percent and 2 percent. This adjustment to the target per capita amount does not apply to "low-density" States that have a population density of less than 15 individuals per square mile.

Medicaid Flexibility "Block Grant"

Section 134 gives States the option of electing the "Medicaid Flexibility Program," in lieu of the per capita cap, but only for the non-elderly, non-disabled, non-expansion adults, beginning in 2020. While Senate Republicans call this a "block grant," States electing this option are subject to a number of federal constraints and requirements.

Eligibility. The State has flexibility in eligibility, but must still cover enrollees in the mandatory eligibility categories. If income is an eligibility factor, it must be measured using MAGI rules.

Benefits. The State has flexibility in benefits, but must provide at least:

- inpatient and outpatient hospital services
- laboratory and x-ray

- nursing facility services for individuals aged 21 and older
- physician services
- home health care services (including home nursing, medical supplies, equipment, and appliances)
- rural health clinic services
- federally qualified health center services
- family planning services and supplies
- nurse midwife services
- certified pediatric and family nurse practitioner services
- freestanding birth center services
- emergency medical transportation
- non-cosmetic dental services
- pregnancy-related services, including 12-weeks of postpartum services

The "targeted health assistance" provided by a State to any group of program enrollees must have an aggregate actuarial value that is at least 95 percent of the aggregate actuarial value of benchmark coverage described in Section 1937 of the Social Security Act (before benchmark coverage required essential health benefits).

The State can determine the amount, duration and scope of these benefits except that mental health and substance use disorder benefits must be covered and are subject to mental health parity rules. Moreover, if the State covers outpatient prescription drugs, then those drugs are subject to a rebate requirement and "any requirements applicable to medical assistance for covered outpatient drugs under a State plan." This would appear to include the requirement that a State must cover any drug for which a rebate agreement is in place.

Cost-sharing. The State can impose cost-sharing as long as it does not, "for all program enrollees in a family," exceed 5 percent of the family's income for the year involved.

Financing. The amount of the block grant is equal to the federal share of the target per capita medical assistance cap for the non-elderly, non-disabled, non-expansion adult category multiplied by the number of 1903A enrollees in that category. For purposes of the funding formula, the number of 1903A enrollees in the non-expansion category cannot exceed the number enrolled in the base period, inflated by State population increase from the base period (if any), plus 3 percentage points. Beginning in 2019 and each year thereafter, the Secretary will publish the amount of the "block grant" that a State would receive were it to elect the Medicaid Flexibility Program option.

Maintenance of effort. For each year in which it operates the Flexibility Program, the State must make expenditures that are equal to the block grant amount (*i.e.*, the federal share of the target for the non-expansion adults) multiplied by the enhanced FMAP that the State earns in the CHIP program. As long as the State makes expenditures in at least this amount, any leftover funds in the block grant that remain at the end of the year can be rolled over to the following year. The State can use leftover funds for "a program that is not related to health care" or "for

any other purpose" which is consistent with quality standards to be established by the Secretary.

Medicaid Expansion

Like the House's AHCA, BCRA sunsets the increased federal match for the Medicaid expansion population, but allows States to continue to cover that population at the regular match rate. Specifically, States that have expanded Medicaid prior to March 1, 2017, will continue to receive the higher federal medical assistance percentage (FMAP) that was included in the ACA only through 2020; after that, the increased FMAP will start to decline to 85% in 2021, 80% in 2022, 75% in 2023, and the State's regular FMAP beginning in 2023. States that have not expanded by March 1, 2017 will not be eligible for any increased FMAP.

Unlike the House bill, the increased FMAP through 2023 applies to the entire eligibility category, and not only to individuals that are enrolled in that category as of the date of enactment. This means that all individuals eligible through the expansion enrollees group will receive the increased FMAP set out in the bill through 2023, regardless of when they enrolled in Medicaid.

Other Changes to Medicaid

The BCRA includes several other changes to the Medicaid program:

- Disproportionate Share Hospital (DSH) Allotments. The ACA DSH reductions -- now scheduled to take effect beginning in 2018 -- remain in place, except for non-expansion States. Non-expansion States' DSH reductions are repealed. Further, the allotments for some non-expansion States are increased. The Secretary will determine for each State a ratio equal to the 2016 DSH allotment divided by Medicaid beneficiaries (i.e., DSH dollars per beneficiary), and determine the "national average" of those ratios. States that are below the national average will have their DSH allotment increased to bring them up to the average. The increase is only for fiscal year 2020 through the first quarter of fiscal year 2024 (until January 1, 2024).
- Safety Net Funding. Like the House's AHCA, Section 129 of BCRA addresses "Safety Net Funding" and creates a $2 billion dollar pool to be distributed among non-expansion States to pay increased reimbursement to providers for services to Medicaid beneficiaries and the uninsured. The pool is distributed among non-expansion States based on percentage of population with income below 138% of the poverty line in 2015. Like DSH payments, these payments cannot exceed the cost of providing services to these populations. Unlike DSH payments, they qualify for a higher FMAP (100% for fiscal years 2018-21, and 95% in fiscal year 2022).
- Work Requirements. Section 131 enables States to condition the provision of medical assistance to nondisabled, non-elderly, non-pregnant individuals on satisfaction of a work requirement. States implementing such a requirement would receive a 5% increase in FFP for administrative activities associated with implementing this provision.
- Provider taxes. Section 132 addresses provider taxes. The 6% "indirect hold harmless" test is phased down to 5% over several years as follows:

2021:	5.8%
2022:	5.6%

2023:	5.4%
2024:	5.2%
2025 and thereafter:	5.0%

- IMD Exclusion. The Act includes a new state option to cover "qualified inpatient psychiatric hospital services" for individuals between the ages of 21 and 65, for a period not to exceed 30 consecutive days in any month and not to exceed 90 days in a calendar year. These services are matched at a 50% match rate. The State would only qualify for matching funds if it maintained at least the number of licensed beds at state-operated psychiatric hospitals as were licensed on the date of enactment, and it would have to maintain on an annual basis the "level of funding expended by the State (and political subdivisions thereof) . . . from non-Federal funds for inpatient services" at state institutions and "for active psychiatric care and treatment provided on an outpatient basis." This exception to the Institutions for Mental Diseases (IMD) exclusion is only for inpatient psychiatric hospital services, and not non-hospital IMDs.
- Defunding Planned Parenthood. Section 124 prohibits State from making payments, either directly or through a managed care organization, for a one-year period beginning upon enactment to a "prohibited entity." A prohibited entity is an essential community provider primarily engaged in family planning service and reproductive health, which provides abortion services in cases that do not meet the Hyde Amendment exception, and that received more than $350 million in Medicaid expenditures in FY 2014. These criteria only apply to Planned Parenthood.

Other Provisions of the BCRA

The BCRA includes a number of additional provisions, including:

- Repeal of small employer tax credits. The BCRA sunsets the small employer health insurance credit credits available for small employers with less than 25 full-time employees that provide health insurance for their employees, effective January 1, 2020. BCRA § 103(a). Although small employers may continue receiving these tax credits for the 2018 and 2019 taxable years, they will not be eligible for the tax credits if the insurance offered by the employer provides coverage for abortions, except where the life of the mother is in danger, or in cases where pregnancy resulted from rape or incest. *See* BCRA § 103(b).
- Creation of Small Business Health Plans. The BCRA would allow insurers to sell "small business health plans" to small employers. These Small Business Health Plans would be subject to ERISA, which preempts certain state regulations, and regulated by the Secretary of Labor. BCRA also allows Small Business Health Plans to be sold through professional associations. *See* BCRA § 139.
- Authorizing substance use disorder grants to States. The BCRA provides $2 billion for make grants to States "to support substance use disorder treatment and recovery support services." BCRA § 202.
- Changes to Health Savings Accounts (HSAs). The BCRA makes several changes to the regulation of HSAs. First, it increases the contribution limitation for HSAs, effective January 1, 2018. Each spouse would also be able to make "catch-up" contributions to the HSA effective in 2018. In addition, the Senate bill would permit qualified medical

expenses that arose before the creation of the HSA to be paid by the HSA if the account was created within 60 days of acquiring high-deductible coverage.

- Repeal of the ACA's tax increases. The BCRA repeals the taxes in the ACA, including by:
  - Repealing the tax on expenditures from health saving accounts ("HSA"), Archer MSAs, and health reimbursement arrangements for over-the-counter drugs.
  - Repealing the $2,500 annual limit on tax-free contributions to flexible spending plans.
  - Repealing the tax on brand-name prescription drug manufacturers and imported medicine.
  - Delaying the excise tax on high cost employer-covered insurance plans referred to as "Cadillac plans", until 2026.
  - Repealing the tax on medical devices.
  - Repealing the tax on health insurance providers.
  - Reducing the ACA's threshold for deducting medical expenses from 10% to 7.5%.
  - Repealing the 1.45% Medicare payroll tax for individuals who earn over $200,000 annually or joint filers who earn $250,000 annually, effective January 1, 2023.
  - Repealing the tanning tax.
  - Repealing the net investment tax.

Next Steps

The BCRA is a "budget reconciliation" bill, which means it is not subject to the filibuster and needs only 51 votes to pass (Vice President Pence would break a 50-50 tie). While reconciliation allows the bill to pass with only a simple majority, several rules constrain the budget reconciliation process and the measures that may be enacted through it. Under the "Byrd rule," any Senator may raise a "point of order" to strike from a reconciliation bill any provision that:

1. Has no budgetary effect and does not produce any change in outlays or revenues;
2. Has a budgetary effect, but that budgetary effect is "merely incidental" to the nonbudgetary components of the provision;
3. Increases the deficit in an "out year," i.e., a fiscal year beyond the budget "window" (which is generally the 5 to 10 years covered by the budget resolution);
4. Increases outlays or decreases revenue and the Committee reporting the provision is not in compliance with its budgetary target;
5. Is outside the jurisdiction of the Committee that reported the provision; or
6. Changes the Social Security program.

See Congressional Budget Act §§ 310, 313 (2 U.S.C. §§ 641, 644). The Senate Parliamentarian decides whether a provision survives a Byrd Rule point of order.

The Senate Parliamentarian is currently reviewing BCRA to determine whether provisions violate the Byrd Rule and must be removed from the bill. Even with that analysis, Democrats are likely to raise Byrd Rule objections to provisions in the bill during the floor debate.

The BCRA suffered a setback this week, as Senator Mitch McConnell (R-KY) was forced to postpone the process for consideration of the bill and may have to postpone a final vote until after the July 4 recess. However, the BCRA is far from dead; Senate Republican leadership continues to negotiate with members on changes to the BCRA to expand support for the bill.

If you have any questions concerning the material discussed in this client alert, please contact the following members of our Health Care practice:

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