

Summary of the Better Care Reconciliation Act

Discussion Draft Revised by the U.S. Senate July 13, 2017

On July 13, 2017 Senate Republican leaders released a revised discussion draft of the Better Care Reconciliation Act (BCRA). The changes made in this version of the Senate proposal do not substantively change the basic features of the original BCRA proposal. The discussion draft leaves in place the dramatic restructuring of the federal Medicaid program. In addition, the new discussion draft also includes language that could destabilize the individual insurance market.

The new Title III in the draft allows insurers that offer specific products inside of the exchange marketplaces to offer products outside of the exchange that are not subject to Affordable Care Act (ACA) standards and consumer protections. This title will allow for low-benefit plans that appeal to and can selectively enroll younger and healthier individuals. Older individuals and those with pre-existing health conditions who need comprehensive coverage can only remain siloed in products that will become increasingly costly as the risk pool deteriorates. This latest version of the BCRA threatens to return the market to the pre-ACA discriminatory practices that left out those with less than perfect health status.

Provisions added or amended in the July 13 revision are *italicized*.

Medicaid

Starting in 2020, like the American Health Care Act (AHCA) passed by the House on May 4, 2017, BCRA ends Medicaid as an entitlement that guarantees coverage to all eligible individuals and, in its place, implements formula-based, fixed funding for states using a “per capita cap model.” States also have the option to adopt a block grant model for adults covered in Medicaid.

- **Medicaid Per Capita Cap.** Establishes state Medicaid funding levels under the per capita cap program by requiring states to identify eight consecutive fiscal quarters as the state’s “per capita base period.” Requires the federal Department of Health and Human Services (DHHS) to calculate the percentage of a state’s total Medicaid expenditures for the base period for specified beneficiary categories to determine the state’s per capita cap allocation.

Includes in the calculation Medicaid expenditures associated with specific beneficiary categories – the elderly, blind and disabled, children, expansion adults and other adults. Excludes Children’s Health Insurance Program, Indian Health Service, Breast and Cervical Cancer Services and partial benefit beneficiaries (e.g., beneficiaries dually eligible for Medicare and Medicaid and pregnant and emergency-only immigrant populations). Excludes from the per capita cap calculation blind and disabled children for whom states will continue to receive their traditional federal match. Generally, adjusts a state’s total Medicaid expenditures for the selected base period to exclude certain payments, such as Disproportionate Share Hospital (DSH) payments, Medicare cost-sharing payments *and Medicaid expenditures to address a public health emergency*.

Until 2025, annually adjusts state per capita cap allocations based on the medical component of the consumer price index (CPI) for urban areas and establishes the adjustment for elderly, blind and disabled beneficiary categories as the medical CPI plus 1 percentage point. For 2025 and thereafter, sets the adjustment factor for all beneficiary categories at CPI for urban areas. If a state's per capita costs for a beneficiary category are 25 percent higher or lower than the mean for all states for those beneficiaries, DHHS will reduce or increase the outlier state's allocation for that category. These adjustments do not apply to predominantly rural states and the adjustments cannot result in a net increase in federal Medicaid payments.

- **Medicaid Block Grant.** States have the option to receive a block grant in lieu of implementing the per capita cap for Medicaid nonelderly, nondisabled, adult beneficiaries. The BCRA grants states choosing the block grant significant flexibility in adjusting Medicaid program design and eligibility. The initial block grant amount would generally parallel the amount the state would have received under the per capita cap model for adults, with some adjustments. In subsequent years, the block grant amount would be adjusted annually using the CPI for urban areas (not medical CPI).

Under a block grant, states must continue to serve mandatory, nonelderly, nondisabled, adult populations *but have the option to add the Medicaid adult expansion population to the block grant.* States must provide the following services: hospital inpatient and outpatient, laboratory and X-rays, nursing facility, physician, home health care, rural health clinic, federally-qualified health center, family planning, nurse midwife, certified pediatric and family nurse practitioner, freestanding birth center, emergency medical transportation, non-cosmetic dental and pregnancy-related. Benefits must include mental health and substance use services that meet mental health parity requirements. State block grant programs can adopt enrollee cost sharing, including premiums and deductibles, providing the charges do not exceed five percent of family income.

- **ACA Adult Expansion.** On January 1, 2020 and thereafter, provides states with the option to cover expansion adults, conforming to prior federal court ruling that found the expansion could not be mandated on states. Allows states that expanded Medicaid to childless adults before March 1, 2017, such as California, to continue receiving enhanced federal matching funds until 2023. However, the BCRA gradually phases down the enhanced matching rate, now at 95 percent, and scheduled to phase down to 90 percent in 2020. BCRA further reduces the federal match to 85 percent in 2021, 80 percent in 2022 and 75 percent in 2023. By 2024, states that choose to cover childless adults in Medicaid will receive the same match rate as for other populations, which in California is generally 50 percent.
- **Provider Tax.** Introduces a new restriction on states' ability to finance Medicaid through provider taxes, a financing mechanism used by most states, including California.
- **Benefits.** Eliminates the essential health benefit requirement for the Medicaid adult expansion population after December 31, 2019.*
- **Retroactive eligibility.** Eliminates 90-day retroactive Medicaid eligibility as of October 1, 2017 *except for seniors and persons with disabilities.* For most Medicaid populations eligibility will be limited to the month in which the applicant applied.
- **Presumptive Eligibility.** After January 1, 2020, prohibits hospitals from administering presumptive eligibility for individuals likely to be eligible for Medicaid at the point of care.

- **Shifts Some Children from Medicaid to CHIP.** Reduces Medicaid income eligibility for children 6 and over to 100 percent FPL after December 31, 2019. Children in this group no longer eligible for Medicaid will be eligible for the Children’s Health Insurance Program (CHIP), presuming CHIP is reauthorized this year with similar eligibility criteria.
- **Home and Community-Based Services (HCBS).** Ends enhanced Medicaid match for Home and Community-Based Attendant Services and Supports (\$19 billion cut over ten years), which California currently uses to support the In-Home Supportive Services Program. Requires DHHS to implement procedures to encourage states to adopt or extend HCBS waivers. *Establishes an \$8 billion, four-year demonstration project providing state incentive payments for home and community-based services for the aged, blind, and disabled. States compete to secure funding and the 15 lowest population density states receive priority consideration.*
- **State Managed Care Waivers.** Allows states to use a state plan amendment, instead of a waiver renewal, to maintain existing managed care delivery system waivers in perpetuity. Requires federal approval for modifications to existing waiver terms.*
- **Institutions for Mental Diseases (IMDs).** On and after October 1, 2018, loosens some existing limitations on Medicaid coverage for certain inpatient psychiatric hospital services, as specified. The Medicaid IMD exclusion generally prohibits the use of federal Medicaid financing for care provided to most patients in mental health and substance use disorder residential treatment facilities larger than 16 beds, known as IMDs. Senate language allows for up to 50 percent match for IMDs if states meet specified conditions.
- **State Options: Increased Eligibility Redeterminations and Work Requirement.** Allows states to: (1) conduct six-month redeterminations of eligibility for expansion adults and provides a five percent enhanced federal match to assist states in covering the administrative costs of conducting the additional redeterminations, (2) impose a work requirement for nondisabled, nonelderly, non-pregnant adults. Under the work requirement, eligible low-income adults would have to participate in work activities, as defined, for a state-specified period to maintain Medicaid eligibility. States that adopt a work requirement will receive a five percent enhanced federal match to support the additional administrative costs.
- **State Performance Bonuses.** For 2023–2026, implements a Medicaid and CHIP quality performance bonus payment program for states that achieve lower than expected aggregate medical expenditures and meet specific quality measures. Appropriates \$8 billion dollars for this purpose.
- **Enhanced Medicaid Funding for Native Americans.** *Extends eligibility for enhanced federal Medicaid matching funds to any provider that serves specific Medicaid-eligible Native Americans.*
- **DSH Funding Calculation.** *Changes the DSH calculation for states that, unlike California, did not expand Medicaid coverage to childless adults.*

Insurance Market

- **Coverage Mandates.** Eliminates the ACA penalties for individuals and employers who do not comply with the mandate to obtain coverage, retroactive to December 31, 2015.
- **Late Enrollment Penalty.** Starting with enrollment effective on or after January 1, 2019, replaces the individual mandate with a late enrollment penalty (6-month waiting period for enrollment in the individual market) for individuals who fail to maintain “continuous coverage,” meaning they experienced a gap in health coverage of more than 63 days in the preceding 12 months.* (Included in the June 26 BCRA re-release.) *Adjusts the “look back” period when an individual applies for special*

enrollment. Eligibility for special enrollment is triggered by certain life events, such as marriage, divorce, or loss of job-based coverage. To avoid the penalty of a six-month waiting period, an individual applying for special enrollment must have at least one day of credible coverage during a 60-day "look back" period immediately preceding the date of application.

- **Premium Tax Credits.** In 2020, reduces the income eligibility for premium tax credits from 400 percent to 350 percent FPL. BCRA limits eligibility to only "qualified" immigrants, a definition currently used to determine eligibility for federal public benefits and excludes some lawfully present groups. Revises eligibility for premium tax credits so that the subsidies vary by age as well as income; individuals under age 30, with incomes up to 350 percent FPL, would only have to spend up to 6.4 percent of income on health care premiums, while individuals above age 59 with incomes over 300 percent FPL would have to pay up to 16.2 percent of income. Under the ACA, premium payment limits vary by income, not age, ranging from 2 percent of income for individuals under 133 percent FPL to 9.6 percent of income for individuals at 400 percent FPL with no differential based on age. Starting in 2018, does not allow tax credits to subsidize coverage from plans that provide abortions services, except for in cases of rape or incest or where the mother's health is in danger. *For the first time, allows premium tax credits to be used to purchase catastrophic plans, provided the individual meets other eligibility requirements for the tax credits. Catastrophic plans are high deductible health plans that cover at least three primary care visits per year before the deductible is met. Catastrophic plans are subject to the federal limit on out-of-pocket costs.*
- **Tax Credit Benchmark.** Reduces the value and amount of premium tax credits by linking the credit to coverage with an actuarial value of 58 percent instead of the ACA benchmark of the second lowest cost silver plan, a 70 percent actuarial value plan. The actuarial value indicates how much of the cost of the benefits the health plan will cover; enrollees cover the remaining costs. Under BCRA, premiums will be lower, triggering lower tax credits, because the benchmark plan will cover a lower percent of the benefits. This means that under BCRA subsidized enrollees will experience significant increases in out-of-pocket costs at the point of care. The increases will no longer be offset by the ACA cost-sharing reductions that are also eliminated in 2020. *Authorizes the Secretary of the Treasury to increase the value of the BCRA benchmark plan in any rating area where no plan at 58 percent actuarial value is offered.*
- **Cost-Sharing Reductions.** As of 2020, repeals the cost-sharing reductions that help to lower copayments and deductibles for individuals up to 250 percent FPL enrolled in silver-level coverage (70 percent actuarial value) through exchanges.
- **Non-ACA Compliant Offerings.** *After 2019, allows an insurer that offers specified products in the exchange to also offer products outside of the exchange that do not meet ACA standards. Specifically, insurers must offer in the exchange:*
 - 1) *At least one gold level and one silver level ACA compliant plan (as the ACA is amended by the BCRA), and*
 - 2) *One premium tax credit benchmark plan. Under the BCRA the benchmark plan for premium tax credits is a plan with actuarial value of 58 percent. Generally, the actuarial value represents the percent of health services covered by the policy and the consumer pays the remaining costs (e.g., 42 percent).*

For the years an insurer meets these two requirements, BCRA allows the insurer to offer products outside the exchange that do not meet ACA market rules (non-compliant plans).

Non-compliant plans could avoid complying with any of the following ACA requirements:

- ✓ *essential health benefit requirements, including restrictions on out-of-pocket costs and the use of metal tiers (bronze, silver, gold, and platinum) to designate coverage level (actuarial value)*
- ✓ *rating restrictions including limitations on age rating*
- ✓ *guaranteed issue requirements*
- ✓ *open and special enrollment periods*
- ✓ *prohibition on pre-existing condition exclusions or other discrimination based on health status, medical condition, disability*
- ✓ *prohibition on excessive waiting periods to secure coverage*
- ✓ *requirements on coverage of preventive health services*
- ✓ *requirements to ensure that consumers receive value for their premium payments (medical loss ratio standards)*

The revised draft also states that insurers must comply with state requirements applicable to health insurance offered in the state.

The non-compliant plans are not eligible for premium tax credits and State 1332 Waivers cannot be used to redirect premium tax credits to non-compliant plans. Non-compliant plans are also ineligible for the ACA risk adjustment program. Health Savings Accounts (HSA) can be used to support premium payments if the non-compliant plan is otherwise HSA-eligible.

Non-compliant plans are not considered “credible coverage.” The BCRA imposes a six-month waiting period for individuals seeking coverage who failed to maintain continuous credible coverage, meaning they experienced a break in coverage of more than 63 days in the preceding 12 months. The BCRA six-month waiting period does not apply to an individual enrolled in a non-compliant plan that switches to an ACA compliant plan during annual and special enrollment periods without a gap in coverage.

The draft appropriates an additional \$2 billion in funding for states to offset the additional costs of regulating non-compliant plans.

- **Age-Adjusted Rates.** Beginning in 2020, allows states to change the ratio for health care premiums between the youngest and oldest adults to 5:1 instead of the 3:1 ratio in the ACA. Authorizes states to adopt a different ratio.*
- **Catastrophic Plans.** In 2019, allows any individual participating in the individual market to enroll in a catastrophic plan. Currently, enrollment in catastrophic plans is limited to individuals under 30 years of age and those with a hardship exemption from the requirement to maintain minimum essential coverage. (Hardships exemptions apply when financial situations and other circumstances keep an individual from securing comprehensive insurance coverage.)
- **Waiver for State Innovation.** Decreases the federal scrutiny on 1332 waivers and allows state waivers of significant ACA requirements, including essential health benefits, individual mandate,

cost-sharing subsidies, premium tax credits, qualified health plan standards, among others. DHHS can deny a state waiver request if it determines the state action would increase the federal deficit.

- **Market Stabilization State Grants.** Establishes a *\$182 billion* State Stability and Innovation Fund available to states starting in 2018 thru 2026 (*\$70 billion added in the July 13, 2017 BCRA revisions.*) The Fund provides grants to states to address health care needs of high-risk individuals, help stabilize premiums and reduce out-of-pocket costs in the individual market. *Reserves one percent of funds annually for insurers in states where the cost of insurance premiums is at least 75 percent higher than the national average.*
- **Medical Loss Ratio.** In 2020, sunsets the ACA minimum medical loss ratio of 80 percent and allows states to determine a state-specific medical loss ratio. Medical loss ratio is generally the percentage of total premiums that the health insurer pays for medical care and services.*
- **Unaffordable Employer-Sponsored Coverage.** Eliminates premium tax credit eligibility for employees unable to afford the employer-based coverage available to them because the cost exceeds 9.5 percent of an employee's household income. Under the ACA, individuals offered unaffordable employer coverage, as defined, could enroll in exchanges and receive tax credits if eligible.
- **Small employer tax credits.** In 2020, eliminates the ACA small employer tax credit and eliminates the credit for insurance expenses for employee coverage in health plans that cover abortion services.
- **Health Savings Accounts (HSAs).** *Allows HSAs to be used for health insurance premiums. Prohibits HSAs to be used to pay premiums for high deductible health plans if they cover abortions except where necessary to save the life of the mother or in the case of rape and incest.* Increases the maximum contribution limit for HSAs. Allows both spouses to make "catch-up" contributions to the same HSA if both spouses are at least 55 years old. For individuals age 55 and over, the HSA contribution is increased by \$1,000 ("catch-up" contribution). Currently, only the account holder can make this contribution. Allows HSAs to pay for medical expenses incurred 60 days before the HSA was established if the account holder was in a high deductible health plan during that time.
- **Small Business Health Plans.** Allows for small business health plans (SBHPs), enabling multiple small businesses to jointly purchase large group coverage through associations that would generally be exempt from state insurance regulation. Sponsors for SBHPs are associations with a constitution and bylaws established for a purpose other than providing health benefits to its members, such as a trade association. SBHPs need to be certified by DHHS.*

Other Provisions

- **Women's Health Services.** After 2018, redefines qualified health plans to exclude plans that provide abortion services beyond those to save the life of the mother or in cases of rape or incest.* Imposes a one-year moratorium on states providing any federal funds to Planned Parenthood clinics.*
- **Opioid Crisis.** *Provides \$45 billion over the next decade to help states combat abuse of drugs, including opioids. The BCRA originally allocated \$2 billion for state grants to support substance use disorder treatment and recovery support services for 2018.*
- **Community Health Centers.** For 2017, allocates \$422 million for community health centers nationwide.
- **The Prevention Fund.** Repeals the ACA Prevention and Public Health Fund, an \$18.75 billion program to fund public health activities (2010-2022 and \$2 billion annually thereafter).

- **ACA Taxes.** Repeals ACA taxes, including tax penalties associated with the individual and employer mandates, taxes on health insurers, pharmaceutical manufacturers and medical devices. Extends the delay in the 40 percent excise tax on high-cost employer health benefit plans, known as the “Cadillac tax,” from the current scheduled implementation in 2020 until 2026. *Retains the 3.8 percent levy on investment income for high income earners, individuals with investment incomes over \$200,000 and couples with investment incomes over \$250,000 and the ACA 0.9 percent Hospital Insurance payroll tax on these high income earners.*
 - **Federal administration.** Establishes a \$500 million Better Care Reconciliation Implementation Fund for federal administrative expenses associated with BCRA implementation.
- * Provision the Senate Parliamentarian ruled violates Senate rules for reconciliation bills. Known as the “Byrd rule,” the rule limits what can be done through 51 vote reconciliation bills. Depending on what specific health reform proposal the Senate ultimately considers, provisions identified by the Senate Parliamentarian would require 60 votes to pass the Senate. The Senate Parliamentarian identified several other provisions still under review including: whether insurers can offer non-ACA compliant plans and waivers for state innovation.

Insure the Uninsured Project (ITUP) is a nonpartisan nonprofit, 501(c)(3) organization, founded in 1996, based in Sacramento, California. ITUP’s mission is to advance creative and workable policy solutions that expand health care access and improve the health of Californians. ITUP conducts policy-focused research and convenes broad-based stakeholders on health policy topics, acting as an honest broker among diverse health care leaders in the state. To assist with implementation of health reform in California, ITUP hosts an annual statewide conference in Sacramento and facilitates regional and statewide workgroups on topics affecting health and health care in the state.

For more information on this report, contact ITUP Executive Director, Deborah Kelch, at 916-226-3899.

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