American Hospital Association

Special Bulletin

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Senate Leaders Unveil Revised Health Bill

Summary of Changes

Senate Republican leaders today unveiled a revised version of the Better Care Reconciliation Act (BCRA), legislation to repeal and replace parts of the Affordable Care Act (ACA). An estimate of the impact of the revised bill from the Congressional Budget Office (CBO) is anticipated Monday, and Senate Majority Leader Mitch McConnell (R-KY) has indicated he could initiate a series of key votes as early as Tuesday.

"Last month, we urged the Senate to go back to the drawing board after its original proposal included dramatic cuts to the Medicaid program and the loss of health care coverage for tens of millions of Americans," said AHA President and CEO Rick Pollack. "If enacted, BCRA would mean real consequences for real people – among them people with chronic conditions such as cancer, individuals with disabilities who need long-term services and support, and the elderly. Unfortunately, in the latest update released today, the unacceptable flaws of BCRA remain unchanged, and there are no significant changes to the massive Medicaid reductions. Instead of merely tweaking a proposal that would harm our most vulnerable, we again call on the Senate to advance a solution aimed at protecting coverage for all Americans who currently have it. Instead of merely putting forth an update, we again call on the Senate to put forth an upgrade."

Highlights of the revised bill follow. Watch for additional updates and alerts.

CHANGES TO MEDICAID PROVISIONS

- **Changes the Temporary Medicaid DSH "Bump" for Eligible Non-expansion States.** The revised bill makes two significant changes to the provision providing a temporary increase in Medicaid Disproportionate Share Hospital (DSH) payments. The changes relate to the methodology used to calculate the temporary increase in DSH payments and the definition of "expansion" and "non-expansion" states. Under the revised legislation, the methodology for calculating the increase would be based on the number of uninsured in a non-expansion state, not the number of Medicaid enrollees. The change in definition of "expansion" and "non-expansion" state would allow expansion states (including

states that expanded through the 1115 waiver authority) to be treated as "non-expansion" for purposes of eliminating the ACA DSH cuts, as well as determining eligibility for the temporary DSH increase, if the state ends Medicaid expansion. The intent of this provision appears to be to increase the number of states eligible for repeal of the ACA DSH cuts, as well as the temporary increase in DSH funding.

- **Adjusts the Per Capita Cap for Late Expanding States and Public Health Emergencies.** The revised bill would adjust how the base year is determined for late Medicaid expansion states to use four quarters of expenditures rather than eight. In addition, state expenditures for public health emergencies would be excluded from the per capita cap calculation (or block grant if the state has elected this option) for expenditures falling between January 1, 2020 and December 31, 2024.

- **Establish New Demonstration Project for Home and Community-based Services.** The legislation would require the Secretary of Health and Human Services (HHS) to establish a four-year demonstration project for the purpose of continuing and/or improving home and community-based services for the aged, blind and disabled populations. The demonstration project would run from January 1, 2020 through December 31, 2023 for 15 states selected through a competitive process.

- **Expand Availability of Block Grants.** The revised bill expands the block grant option by allowing states to add the expansion population.

- **Enhance the Federal Match for Eligible Members of Indian Tribes**. The revised bill would provide a 100 percent federal match for services provided by any provider under the state's Medicaid state plan to eligible members of an Indian tribe that are also eligible for Medicaid.

CHANGES TO INSURANCE MARKET PROVISIONS

- **Allow Certain Consumers to Use Pre-tax Dollars to Pay Health Insurance Premiums.** The revised bill would modify the rules related to the use of Health Savings Accounts (HSAs) to allow consumers purchasing high-deductible health plans in the private market (not employer-sponsored plans) to use pre-tax dollars to pay for health insurance premiums. This is in addition to the number of provisions included in the earlier draft of the bill to incentivize the use of HSAs.

- **Allow Advanced Premium Tax Credits to Be Used for Catastrophic Plans.** The revised bill would change the rules related to the use of premium tax credits

to allow individuals to put the value of the credit towards a lower-cost catastrophic plan. Currently, individuals may only use the tax credit with "bronze" plans (60 percent actuarial value) or above. Catastrophic plans may have lower actuarial value but must cover at least three primary care visits annually.

- **Reinstitute a Federal Reinsurance Program for Marketplace Issuers.** The revised bill would implement a federal reinsurance program for certain insurers selling compliant ACA-health plans on the marketplace. The legislation would appropriate $70 billion for 2020-2026 ($10 billion/year) for the program.

- **Permit the Sale of Non-compliant Coverage Off-marketplace.** The revised bill, through the provision referred to as the "Cruz-Lee Amendment," would allow insurers that sell a minimum number of compliant health plans on the marketplaces to also sell non-compliant products off of the marketplaces. The non-compliant plans would not be required to meet many current consumer protections. Individuals would not be permitted to use their tax credits to purchase such non-compliant plans but they would be allowed to use their HSA contributions to pay the premiums. Such coverage would not be considered "creditable coverage" and, therefore, enrollees in such plans would be subject to the six-month lock-out period if they seek to enroll in compliant coverage in the future.

CHANGES TO OTHER PROVISIONS

- **Increases the State Stability and Innovation Program by $70 Billion.** The revised bill would establish pools of funds for both insurers and states to help ensure access to coverage and to improve the affordability of coverage. The short-term fund makes $50 billion available to the Centers for Medicare & Medicaid Services (CMS) between 2018 and 2022 to provide resources to insurers to help "address coverage and access disruption and respond to urgent health care needs." There are no state matching requirements for this fund.

  The long-term fund would be directed to states and would be worth $132 billion from 2019 to 2026 – $70 billion more than in the earlier draft. Beginning in 2022, states would be required to pay a portion of the annual allotment, starting with a 7 percent contribution in 2022, increasing to 35 percent in 2026, amounting to $20.2 billion in total. In other words, of the $132 billion, the federal government would contribute $112 billion and states would contribute $20 billion.

- **Increased Funding for Opioid Epidemic.** The revised bill increases the amount of funding available to states for substance abuse treatment and recovery to $45 billion from 2018 through 2026. The legislation specifically directs a portion of the funds to be spent on research on addiction and pain related to the substance

abuse crisis. The original Senate draft legislation included $2 billion to states for such purposes for 2018 only.

- **Maintain Certain ACA Taxes.** The revised bill would not repeal the Medicare payroll tax for high earners ($200,000 for individuals, $250,000 for married couples filing jointly), the 3.8 percent tax on net investment income, or the remuneration tax on executive compensation for certain health insurance executives.

MAJOR PROVISIONS THAT REMAIN THE SAME

The updated draft legislation does not change the following provisions of the original BCRA draft:

- Effectively repeal the ACA individual and employer coverage mandates by not penalizing individuals and employers who are not in compliance.
- Phase out of enhanced federal funding for the Medicaid expansion population with standard match in effect beginning in 2024.
- Transition of Medicaid financing to per capita cap model for most populations.
- Reduce the amount of provider taxes that states may use to help finance their Medicaid programs.
- Allow states to receive federal matching funds for qualified inpatient psychiatric hospital services for patients between 21 and 65 years of age.
- Modify the marketplace subsidies by changing the eligibility levels to 0 to 350 percent of poverty, increasing the amount that insurers may charge older individuals as well as increasing the amount older individuals must pay in premiums as a percentage of income, and decreasing the dollar value of the advanced premium tax credits.
- Appropriate funds for the cost-sharing reductions for two years and then repealing these subsidies for 2020 and beyond.
- Incentivize enrollment through a six-month “lock-out” penalty for individuals experiencing a gap in creditable coverage.
- Allow states to modify the insurance market rules through a streamlined 1332 waiver process.
- Repeal the federal medical loss ratio rules and directing states to develop their own.