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Better Care Reconciliation Act Overview

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HEALTH REFORM POLICY BRIEF

August 2017

BETTER CARE RECONCILIATION ACT OVERVIEW

On July 26, 2017, the U.S. Senate leadership's legislation to repeal and replace the Affordable Care Act (ACA), the Better Care Reconciliation Act (BCRA; H.R. 1628 substitute, as amended), was defeated by a vote of 43-57. What follows is an overview of the BCRA, corresponding estimates from the Congressional Budget Office (CBO), a summary of other unsuccessful attempts by the Senate to repeal and replace the ACA, and possible next steps.

KEY FEATURES:

- Individual mandate and tax penalty replaced with a waiting period to purchase insurance following a continuous coverage lapse
- Health care tax credits for certain individuals at 0%-350% of the Federal Poverty Level (FPL)
- Insurers allowed to charge older individual market purchasers five times, instead of three times, as much as younger purchasers
- States allowed to designate essential health benefits (EHBs), but insurers must offer at least one plan that meets state EHB requirements
- State Stability and Innovation Program established to fund reinsurance programs and promote market stabilization
- Repealed most of the ACA's taxes, but kept the Medicare health insurance payroll tax
- Established per capita cap funding structure for Medicaid and allowed states to impose work requirements on certain Medicaid-eligible populations

CHANGES TO MEDICAID

Per Capita Caps and Block Grants

Starting in fiscal year (FY) 2020, the BCRA would have changed Medicaid funding to per capita caps and optional block grants. Per capita caps would have applied to five eligibility groups: elderly, blind and disabled, children (under 19), expansion adults, and other nonelderly, nondisabled, nonexpansion adults.¹ States could have elected block grant financing for expansion enrollees or nonexpansion adults under age 65 years.

Prior to FY 2025, per capita cap growth rates for children, expansion enrollees, and nondisabled adults under 65 years would have increased based on the medical care component of the Consumer Price Index for All Urban Consumers (CPI-U). Growth rates for the elderly and disabled would have been based on the medical care component of the CPI-U plus 1%. For FY 2025 and after, growth rates for all groups would have been based on the CPI-U only.

Beginning in FY 2020, certain states could have received positive or negative adjustments to per capita target amounts between 0.5% and 2% if expenditures in the prior year were 25% above or below the national average. Actual amounts would have been determined by the Health and Human Services (HHS) secretary with a requirement to be budget neutral. The BCRA also would have provided for a maximum of \$5 billion for public health emergencies between January 2020 and December 2024.

¹ Payment adjustments made for administrative costs, disproportionate share hospitals, Medicare cost-sharing, and safety net provider payment adjustments in nonexpansion states are excluded from total expenditures. Medicaid members enrolled under the Children's Health Insurance Program, Indian Health Service beneficiaries, breast and cervical cancer enrollees, and partial-benefit enrollees are excluded from the enrollee count.

Medicaid Expansion

The BCRA would have phased out the enhanced Federal Medical Assistance Percentage (FMAP) for expansion states (those expanding prior to March 1, 2017) by calendar year (CY) 2023. The enhanced FMAP would have been reduced to 85% in CY 2021, 80% in CY 2022, and 75% in CY 2023. States that expanded after Feb. 28, 2017, would have received the state's regular FMAP for expansion enrollees.

Work Requirements

States would have been able to institute work requirements for nondisabled, nonelderly, nonpregnant adults as a condition of receiving Medicaid coverage. States implementing the work requirement would have received a 5% administrative FMAP increase.

Safety Net Funding for Nonexpansion States

Nonexpansion states would have been able to apply for a portion of \$2 billion each year for FY 2018-2022 to help fund the health care safety net. Payments to states would have been funded at 100% by the federal government in FYs 2018-2021 and at 95% in FY 2022.

Medicaid disproportionate share hospital (DSH) allotment reductions would have applied only to expansion states. Moreover, nonexpansion states would have received increased Medicaid DSH allotments in FY 2020 if their per capita FY 2016 DSH allotment had been below the national average.

Home and Community-based Services

The BCRA would have established an \$8 billion home and community-based services (HCBS) demonstration project for CYs 2020-2023. States could have used the money to make payment adjustments that would provide and improve the quality of HCBS under Section 1915(c), (d), or (i).

CHANGES TO THE INDIVIDUAL MARKET

Individual Mandate

The BCRA would have repealed the individual mandate by retroactively reducing the tax penalty for not having health insurance to \$0 as of CY 2016. It also would have penalized individuals with a coverage lapse of more than 63 days by requiring them to wait six months before enrolling in a health plan.

Premium Tax Credits and Subsidies

The BCRA sought to repeal cost-sharing reduction subsidies for individuals with plans purchased on the exchange and would have modified the ACA's premium tax credit structure. Tax credits would have varied by age, income, and where individuals lived but would have been less generous than ACA tax credits. Individuals earning more than 350% FPL would have no longer been eligible for tax credits to purchase insurance, but those under

100% of the FPL would have qualified for tax credits for the first time. In addition, the BCRA would have lowered the actuarial value (AV) of policies used to determine credit amounts from 70% (silver plan) to 58% (bronze plan). Premium tax credits could have been used to purchase plans offering catastrophic coverage.

Essential Health Benefits

Under the BCRA, states would have been granted the authority to designate what EHBs insurers were required to cover.

Age Rating Bands

The legislation would have allowed insurers to charge older customers up to five times the amount younger customers paid for coverage, as opposed to the 3-to-1 ratio under the ACA.

Stability Funding

The BCRA would have included a State Stability and Innovation Program to fund reinsurance programs and promote market stabilization (\$182 billion divided into short-term and long-term funding over a decade). The Centers for Medicare & Medicaid Services would have administered \$50 billion in short-term funding for reinsurance (until 2021). The remaining \$132 billion would have been available to states from 2019-2026 for controlling insurance costs for high-risk purchasers, funding reinsurance programs, provider payments, and cost-sharing reductions.

OTHER BCRA CHANGES

Employer Mandate Repeal

The BCRA would have repealed the employer mandate, which requires employers with over 50 full-time employees (working over 30 hours a week) to offer full-time employees health insurance coverage that is of "minimum value" (pays at least 60% of the cost of covered services) and "affordable" (employee contributions for employee-only coverage do not exceed a certain percentage of an employee's household income).

Tax Repeals and HSAs

Effective 2017, the BCRA would have repealed a number of ACA taxes, including:

- Medical device tax
- Tanning bed tax
- High-income net investment tax
- Insurance provider remuneration tax
- Annual tax on certain health insurers
- Tax on certain brand pharmaceutical manufacturers

In addition, in 2017 the BCRA would have reinstated the business expense deduction for retiree prescription drug costs and repealed the ACA's increase in income threshold for deducting taxpayers' qualified medical expenses by lowering it from 10% to 5.8%, lower than pre-ACA requirements. The BCRA would also have delayed the ACA's Medicare tax increase on high-wage earners until 2023 and suspended collection of the "Cadillac" tax on high-cost employer-based health coverage from 2020 through 2025.

Furthermore, the BCRA would have made a number of tax adjustments to benefit health savings account (HSA) users, beginning in 2017. The BCRA would have increased annual HSA contribution limits to \$6,550 for individuals and \$13,100 for families, while decreasing tax penalties for spending HSA funds on unqualified expenses (from 20% to 10%). Furthermore, the BCRA would have added over-the-counter medicines as an HSA-reimbursable, qualified medical expense, allowed both spouses to make catch-up contributions to one HSA, and increased the time frame for qualified medical expenses incurred prior to HSA establishment. The BCRA also would have allowed HSA funds to be used to pay premiums for high-deductible health plans.

Population Health

The BCRA would have increased funding for the Community Health Center Fund in 2017 by \$422 million and repealed funding for the Prevention and Public Health Fund, which supports public health initiatives in areas such as diabetes, heart disease, suicide prevention, and immunization (2017 budget of \$931 million). The BCRA would also have added \$24.86 billion in grants for substance use disorder treatment for FY 2018-2026, as well as \$50.4 million in annual funding for related research in FY 2018-2022.

FEDERAL COST AND COVERAGE ESTIMATES

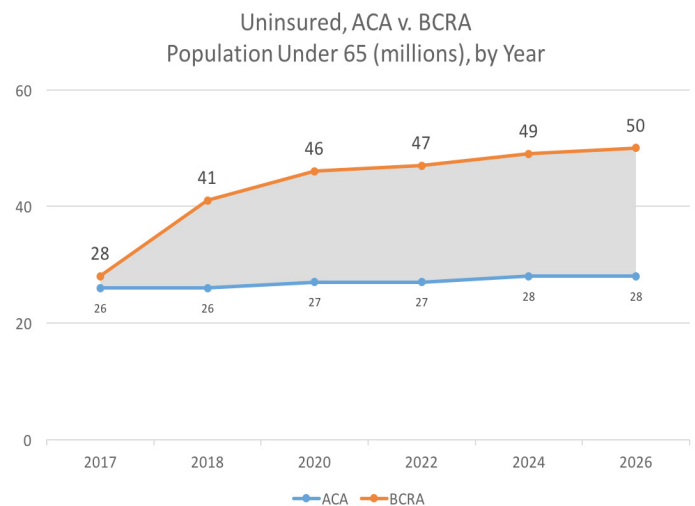
The nonpartisan CBO estimated that over the next 10 years (2017-2026), the BCRA would have reduced federal deficits by \$420 billion by reducing direct spending by \$903 billion and decreasing revenues by \$483 billion.² The majority of the savings would have come from the \$756 billion reduction in Medicaid funding and the \$427 billion reduction in insurance subsidies. The majority of spending would have come from the \$364 billion cost of eliminating most of the ACA taxes and the \$209 billion cost of eliminating the employer and individual mandates.

Estimated BCRA Costs

BCRA PROVISION	SAVINGS V. SPENDING / REVENUE REDUCTION
Medicaid cuts	\$756 billion
Insurance subsidy elimination/modification	\$427 billion
Small employer tax credit elimination	\$6 billion
Employment-based health insurance coverage shifts	\$8 billion
Individual/employer mandate penalty elimination	-\$209 billion
Individual market stabilization/state funds	-\$158 billion
Medicare DSH cuts elimination	-\$43 billion
Tax repeals	-\$364 billion
Other provisions	-\$3 billion
Net savings	\$420 billion

Source: Congressional Budget Office²

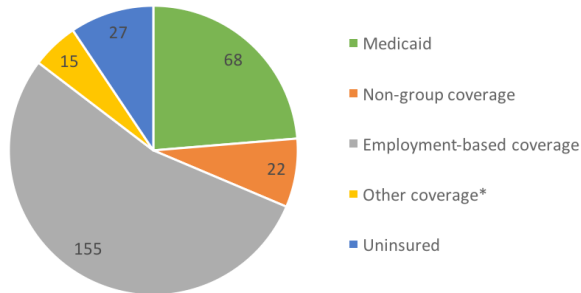
The CBO also estimated that the BCRA's provisions would have had the net effect of increasing the uninsured by an additional 15 million people by 2018 and 22 million people by 2026.



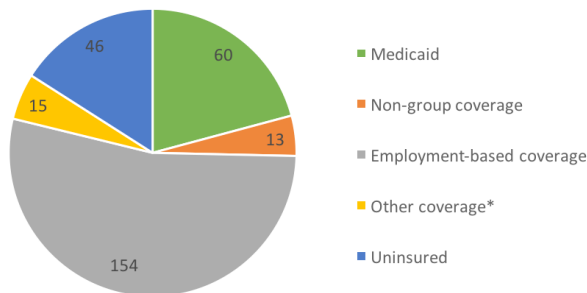
Source: Congressional Budget Office²

² Congressional Budget Office. (July 20, 2017). Re: H.R. 1628, the Better Care Reconciliation Act of 2017: An Amendment in the Nature of a Substitute [ERN 17500], as posted on the website of the Senate Committee on the Budget on July 20, 2017. Accessed from <https://www.cbo.gov/publication/52941>.

Health Insurance Coverage 2016
Population Under 65 (millions)



Health Insurance Coverage 2020 - BCRA
Population Under 65 (millions)



*Other coverage includes: Medicare, Basic Health Program, and other categories such as student plans, foreign coverage, and Indian Health Service coverage.

Source: Congressional Budget Office²

The CBO made several predictions for premium costs under BCRA for the next 10 years, largely based on the reduction in actuarial value for benchmark plans (from 70% under ACA to 58% under BCRA) and the elimination of the ACA mandates. For 2018, the CBO predicted that average premiums for a benchmark plan would have increased by 20% because the elimination of the mandate would have induced fewer healthy people to enroll. In 2019, the CBO predicted, costs would have been 10% higher due to funding to reduce premiums and changes in the rating bands for younger versus older patients. By 2020, however, the CBO predicted that premiums for a benchmark plan would have been 30% lower than under the ACA, largely due to the change in the AV of benchmark plans. Finally, by 2026, premiums for benchmark plans would have been 25% lower than under current law. It is important to note, however, that because the new benchmark plans would have had a lower AV than the benchmark plans used under current law, lower premiums would have been paired with much higher deductibles and fewer covered benefits. For single policy holders who purchase a benchmark plan in 2026, the CBO predicted that their annual deductible would have been \$13,000, compared to \$5,000 for a benchmark plan under current law. For plans that provide for some coverage before the deductible is met, the deductible would have been even higher.

Other Attempts at Repeal

Obamacare Repeal Reconciliation Act

The Obamacare Repeal Reconciliation Act (ORRA; H.R. 1628 substitute, July 19, 2017) was defeated by the U.S. Senate on July 26, 2017, by a vote of 45-55. The ORRA would have repealed the individual and employer mandates, marketplace premium tax credits and cost-sharing subsidies, most of the ACA's tax increases, the Medicaid expansion, the Public Health Prevention Fund, and the reductions in DSH payments. The CBO predicted that passage of ORRA would have increased the uninsured by an additional 17 million people by 2018 and 32 million people by 2026.

"Skinny Repeal"

Another ACA repeal bill (H.R. 1628 substitute, July 27, 2017), commonly known as "skinny repeal," was defeated by the U.S. Senate on July 28, 2017, by a vote of 49-51. This version of repeal would have only repealed the ACA's individual and employer mandates and most of the ACA's taxes. The CBO did not issue an official score for this bill; however, it did score a mock-up of the bill put together by Senate Democrats. According to the CBO, those proposed changes would have increased the uninsured by an additional 15 million people by 2018 and 16 million people by 2026.

Next Steps

Although attempts to repeal and replace the ACA have so far been unsuccessful, congressional leaders have emphasized that the reconciliation process was only one part of a three-pronged approach at health reform: reconciliation, regulation, and regular order. The administrative agencies charged with enforcing the ACA, particularly HHS, have broad leeway to change the regulations put in place by the prior administration, as well as approve waiver applications (1115 Medicaid expansion or 1332 ACA Marketplace) that may have been previously denied. There may be future reform attempts through regular legislation that may tweak certain aspects of the ACA or make other changes to the health care system, such as allowing the purchase of insurance across state lines and tort reform.

The Health Reform Work Group at the Georgia Health Policy Center will continue to track the development of health reform, and translate and disseminate information to stakeholders, through policy briefs, presentations, panel discussions, toolkits, and webinars. For further health reform updates, please visit GHPC's website at <http://ghpc.gsu.edu/project/health-reform/>.

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