CORNERSTONE
GOVERNMENT AFFAIRS

MEMORANDUM

TO:	INTERESTED CLIENTS
FROM:	CORNERSTONE GOVERNMENT AFFAIRS
SUBJECT:	SENATE REPUBLICAN PLAN FOR ACA REPEAL AND REPLACE
DATE:	JUNE 23, 2017

On Thursday, June 22nd, the Senate Republican leadership released their long-awaited bill to repeal and replace the Affordable Care Act (ACA). The bill has been named the "Better Care Reconciliation Act of 2017." The major points of the bill are outlined below.

Repeal Provisions:

The Senate GOP bill retroactively repeals the penalties associated with the individual and employer mandates to December 31, 2015. Without the threat of a penalty, there is no longer a financial incentive for individuals to purchase insurance through the ACA. And unlike the House bill, there is no continuous coverage requirement, or other such provision, to encourage individuals to purchase health insurance.

The ACA's cost-sharing reduction subsidies (CSRs), which help certain low-income individuals with out-of-pocket costs, would be funded through 2019. However, no further funding would be provided beyond that time. This provision was not included in the AHCA as the House of Representatives filed suit against the Obama Administration (*House v. Burwell*) alleging the Administration acted unconstitutionally in spending funds on the CSRs without an explicit appropriation from Congress. The case is currently on hold pending settlement discussions between the Trump Administration and the House.

Beginning in 2019, the bill allows the ACA age rating band to be loosened, at a state's discretion, from three-to-one to five-to-one. Additionally, states can set their own medical loss ratio beginning in 2019. The Senate bill amends the ACA Section 1332 waivers to permit a state's Governor or State Insurance Commissioner to authorize the waiver without the state codifying it in law. New waivers will almost certainly gain approval so long as the waiver does not increase costs to the

federal government. States with existing 1332 waivers will continue to operate under existing ACA guidelines, but state waivers currently pending in the queue may choose whether they want their waivers to be governed under the old or new parameters.

The bill would eliminate the following ACA taxes: the tax on health insurers, the tax on medical device manufacturers, the tax on pharmaceutical companies, the tax on tanning salons, the increased threshold for deducting medical expenses from your taxes, the surtax on investment income, the limitation on contributions to Flexible Spending Accounts (FSAs), the increased tax on non-medical distributions from Health Savings Accounts (HSAs), and the limitation on using money from FSAs and HSAs to purchase over-the-counter medications.

The bill restores the pre-ACA tax deduction for employers that provide prescription drug coverage to their retirees. The so-called "Cadillac Tax," a 40 percent excise tax on high cost employer plans, is not repealed. However, enforcement is deferred until 2026. Finally, the ACA small business tax credit is repealed in 2020 and its use is limited to insurance plans that do not cover abortion services beginning in 2018.

The Prevention and Public Health fund is repealed in fiscal year 2019 and all unobligated funds from FY2018 will be rescinded. Additionally, the bill imposes a one-year freeze on all federal funding for Planned Parenthood.

Changes to the Premium Subsidy Calculation:

As part of the ACA, certain individuals are eligible for a premium subsidy to purchase health insurance in the exchanges. The Senate GOP bill maintains the existing premium subsidy model but changes the eligibility parameters to 100-350 percent of the federal poverty level (as compared to 100-400 FPL in the ACA.) Further, whereas the ACA capped the percentage of an individual's income spent on premiums at roughly nine percent for all enrollees, the Senate bill would allow for variation based on age. Under this scenario, younger individuals could spend up to roughly six percent of their income on premiums and older enrollees could spend up to roughly 16 percent of their income on premiums. Finally, the Senate bill would no longer tie the value of the tax credit to the "second lowest cost silver plan," which has an actuarial value of 70 percent, but rather to the median benchmark plan, which is expected to have an actuarial value of 58 percent.

All citizens and lawful immigrants that do not have another offer of insurance either through an employer or a government-sponsored plan, such as Medicare, would be eligible to receive the premium subsidy. Unlike the ACA, the Senate bill would not prohibit a worker's family from qualifying for the premium subsidy even if the worker has employer-sponsored insurance. Under current law, individuals may provide their "estimated income" to qualify for premium subsidies. The Senate bill would both increase penalties for falsifying income data and remove the limitation of clawing back overpayments from individuals who were paid more subsidy than they actually qualify for.

Several changes to HSAs are also included in the GOP plan. First, the maximum HSA contribution amount would be amended to match existing out-of-pocket limits. For 2017, that would mean a maximum contribution of $6,550 for self-only coverage and $13,100 for family coverage. Second, the plan would newly allow qualifying spouses to make catch-up contributions to the same HSA. Finally, the plan would provide a 60-day grace period for expenses that occurred after the health plan start date but before the HSA was established.

The State Stability and Innovation Fund:

The Senate bill creates a new funding pool that is designed to shore up the health insurance marketplaces in the short term and also give states additional flexibility to implement health care reforms that address the needs of their populations of the long-term. Under the short-term scenario, payments would be made directly to insurers to help avoid disruption in the marketplace and address "urgent health care needs." The bill makes available a $15 billion annual appropriation in 2018 and 2019 and a portion of a $10 billion annual appropriation in 2020 and 2021. The second wave of money would be paid out to states to lower patient's costs and further stabilize state markets. States must submit a one-time application to receive a share of the funding, which amounts to: $8 billion in 2019, $14 billion in 2020 and 2021, $6 billion in 2022 and 2023, and $4 billion in 2026. Beginning in 2022, a state match is required: seven percent that year, followed by 14 percent in 2023, 21 percent in 2024, 28 percent in 2025, and 35 percent in 2026. Under the bill, states would be permitted to keep their allotments for two years, but unspent funds after that point could be re-allocated to other states.

Some examples of how the money could be utilized are: providing financial assistance to high-risk individuals, including by reducing premium costs, providing payments to health care providers, or reducing patient cost-sharing. However, all of the $50 billion in short-term stability funds—and $15 billion of the long-term funds ($5 billion each in 2019, 2020, and 2021)—must be used to stabilize premiums and insurance markets.

Changes to Medicaid:

The GOP plan would maintain the ACA Medicaid expansion until 2020 and allow expansion states to grandfather in eligible adults. Expansion states will receive a 90 percent federal match for grandfathered adults until 2021 when it begins to gradually phase down to the state's traditional (i.e. pre-ACA) federal matching rate. Expansion states will be required to confirm the continued eligibility of their adult enrollees every six months. Enhanced funding will be available to help with the costs of carrying out more frequent eligibility determinations.

Non-expansion states will have the cuts to hospital Medicaid Disproportionate Share (DSH) payments restored in 2018. Then beginning in FY20, non-expansion states are eligible for another increase in their DSH payments if the state's FY16 DSH allotment is lower than the national average. Any such increase would be equal to the difference between the state's DSH payment and the national average. Non-expansion states will also be eligible for additional safety net

funding to adjust payments to providers. The enhanced funding is available in FY18-22 and is capped at $2 billion per year, for a total of $10 billion. This money will be divided among the non-expansion states based on a ratio of adults below 138 percent of poverty in the state and total number of adults below 138 percent of poverty nationwide.

The Senate bill adds an option for states to implement a work requirement for non-disabled, non-pregnant adults. Additional administrative funds are available for states that implement a work requirement. Another provision in the bill reduces the existing provider tax threshold from 6 percent to 5 percent over a five-year period.

Additional changes to the Medicaid program include: repealing the requirement that Medicaid plans meet the ACA essential health benefits requirement, repealing provisions regarding presumptive eligibility, restricting retroactive eligibility to the month in which an individual applies, and eliminating a six percent increase in the Medicaid match rate for some home and community-based services provided through the Community First Choice Option.

In fiscal year 2020, the GOP plan calls for a significant restructuring of Medicaid financing. States may choose between a per-capita allotment or a block grant. If a state chooses the per capita allotment, the state will receive funding based on the state's average Medicaid spending in each of five categories – elderly, blind and disabled, children, expansion adults, and non-expansion adults. To set the allotment amount for each category, states must look at average Medicaid spending over eight consecutive quarters of their choosing (the quarters must fall between FY14 and the third quarter of FY17). Once the average Medicaid spending amount is calculated, it will be multiplied by the number of enrollees in each category. There are a few expenses that are not counted in the cap, such as DSH payments and administrative payments. Additionally, some enrollees will be excluded from the capped allotment, including (but not limited to) individuals covered under the CHIP program, individuals who receive medical assistance through an Indian Health Service facility, dually eligible individuals who qualify for Medicare cost sharing assistance, and medically complex children. Any state that exceeds their per capita allotment will have it reduced the following year.

Initially, the per capita amount will be increased annually by the medical care component of the Consumer Price Index (CPI-M) for children and both traditional and expansion adults. The inflation rate for the elderly, blind and disabled will be CPI-M plus 1 percent. However, beginning in FY25, the inflation rate for all populations will be tied to the consumer price index for urban consumers, or CPI-U.

If a state chooses the block grant option, they will receive a lump sum for the care provided to the non-elderly, non-disabled, non-expansion adults in their Medicaid program. Interested states must submit an application that provides a description of the proposed program, eligibility requirements, scope of services and benefit design, among other things. States will be required to set goals related to quality, access to care, and outcomes. Each block grant will last for five years. The value of a state's block grant will be determined through a calculation based on the state's

traditional federal matching rate, the target per capita allotment, and the number of expected enrollees. Future growth in the block grant amount is tied to CPI-U.

Certain Medicaid waivers would be grandfathered into the new financing structure, including existing managed care waivers and waivers for home and community based services. States would also be given a new option to offer qualifying inpatient psychiatric hospital services to individuals over the age of 21 and under the age of 65. States that choose this option would be eligible for a 50 percent federal match so long as certain conditions are met. Finally, a new $8 billion bonus payment pool will be made available to states whose Medicaid and CHIP programs have lower than expected costs and report applicable quality data. Bonus money must be reinvested in the programs.

Congressional Budget Office:

The Congressional Budget Office (CBO) has yet to publish the score for the Senate bill. However, it should be released early next week. The CBO score is vital to determining whether all of the provisions of the BCRA pass the "Byrd" rule for reconciliation. If any provision fails to pass the budgetary test, it must be moved in separate legislation, requiring a 60 vote majority for passage.

Future Action and Outlook:

Senate Majority Leader Mitch McConnell has repeatedly stated his desire to bring the repeal and replace bill to the Senate floor for a full vote before the July 4th recess. With only two votes to give, Leader McConnell will need to convince 50 of the 52 GOP Senators to vote for the bill in order to secure passage. At this time, there are four GOP Senators who have indicated they will not vote for the bill in its current form. It remains to be seen what changes could be made to the bill to secure more support. However, changes could be made to both appease weary Members and to ensure the bill meets all the requirements of the Byrd rule, should the Parliamentarian rule any of provisions are non-germane. Only time will tell.

If the bill passes the Senate, it is anticipated that the House would take up the bill and try to pass it without any changes. A traditional conference committee is highly unlikely given the difficulty both chambers have had in securing passage of a repeal and replace bill.