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June 22, 2017

TO: The Council

FROM: Scott Sinder
Kate Jensen

RE: Overview of Senate Better Care Reconciliation Act of 2017

Today, the Senate released a draft of the Better Care Reconciliation Act of 2017 ("BCRA"), its first comprehensive proposal to repeal and replace significant portions of the Affordable Care Act ("ACA") through the budget reconciliation process. Recent news reports suggest a vote could be held on the bill as early as next week, but it is far from clear whether the current draft will get the support of 50 Republic Senators. Politically speaking, the following issues will be front and center in the coming days:

- The proposal's Medicaid reforms and cuts (which are being billed in early reports as harsher than the House proposal in the long-term);
- Federal funds/programs (e.g., premium subsidies, small business tax credits, etc.) tied to prohibitions on abortion coverage;
- Whether the proposal goes far enough to repeal the ACA structure (e.g., market reforms, exchanges, etc.);
- Less generous premium subsidies for individual market participants;
- Absence of a CBO score (expected early next week); and
- Lack of a continuous coverage requirement/penalty.

Below is an overview of provisions in the BCRA that are of particular interest to Council members.

Employer-sponsored coverage and other tax-related provisions

Regarding The Council's top priority issues:

- ***The bill does <u>not</u> cap the employee tax benefit for employer-sponsored coverage***.
- The individual and employer mandates are effectively eliminated by making the penalties $0 for tax years starting after December 31, 2015.
- Like the House bill, the Cadillac tax is eliminated for years 2020 through 2025, leaving the possibility that the tax could be imposed beginning in 2026.

The Senate proposal eliminates the small business tax credit for tax years after 2019, and in the meantime, prohibits eligibility for the credit for plans that cover abortion services. The bill also repeals the following ACA taxes and fees (among others):

- annual provider fee (will not take effect again following the current 2017 moratorium);
- net investment income tax (beginning in 2017);
- prescription drug tax (beginning 2018);
- medical device tax (beginning 2018); and
- additional Medicare payroll tax for higher-income earners (for tax years after 2022).

Like the House bill, the PCORI fee is not among the fees repealed in the bill (but that fee terminates in October 2019, per the terms of the ACA).

<u>Subsidy structure for the individual market</u>

The BCRA retains the ACA's premium subsidy structure, but makes notable changes to eligibility criteria and the subsidy calculations. Overall, individual market subsidies would be less generous under the Senate bill than the ACA.

First, subsidy amounts will be tiered by income (generally available for those with income at or below 350% of the federal poverty line, instead of 400% under the ACA) and age. Additionally, subsidy amounts will be pegged to a new, less generous "median cost benchmark plan" (rather than the ACA's second lowest cost silver plan)—a QHP offered in the individual market in the rating area that provides a 58% AV and has a premium which is the median premium of all 58% AV plans offered in that market.

Like the ACA, subsidies are ***not*** available to individuals who are eligible for a group health plan (including employer plans). The bill eliminates, however, the ACA's requirement that such group coverage be affordable and provide minimum value (60% AV). Subsidies also are not available for plans that cover abortions (other than abortions necessary to save the life of the mother or abortions with respect to pregnancies that resulted from an act of rape or incest).

<u>HSA Reforms</u>

With respect to HSA reforms, the BCRA largely mirrors the House bill. Specifically, the bill would:

- eliminate the prohibition on over-the-counter drugs as qualified medical expenses;
- raise the contribution limit to the out-of-pocket cost for high deductible health plans;

- allow spouses to make catch-up contributions to the same HSA; and
- reverse the ACA's tax penalty increase on HSAs for non-qualified expenditures (taking it back down from 20% to 10%).

New association health plans for small businesses

Notably for the agent and broker community, the Senate bill introduces a new construct for small business risk sharing pools. Specifically, it amends ERISA to provide for "small business health plans"—defined as fully insured group health plans offered by issuers in the large group market and sponsored by an HHS-certified sponsor—which are treated as large group plans (with corresponding large group relief from various ACA requirements like community rating and provision of essential health benefits). State laws that would preclude issuance or offering of such plans are preempted.

Sponsors of such plans must be permanent entities maintained in good faith (with constitution, bylaws, periodic meetings, etc.) and established for a purpose other than providing health benefits, and they cannot condition membership on the basis of minimum group size. The bill specifically references bona fide trade associations and franchisor-franchisee arrangements as eligible entities.

Employers participating in these plans must be members of the sponsor, the sponsor, or an affiliated member of the sponsor (including, for professional associations or other individual-based associations, if an officer/director/partner in an employer is a member or affiliated member of the sponsor). Individuals with coverage under the plan must be active or retired owners (including self-employed individuals), officers, directors, employees, or partners in participating employers, or be dependents of such individuals. Participating employers may not provide coverage in the individual market for any employee not covered under the plan (if such exclusion of the employee from the plan is based on a health status factor and the employee is otherwise eligible for coverage under the plan).

State innovation waivers

Rather than creating new state waivers for ACA requirements (as the House's AHCA did via the MacArthur amendment), the Senate bill substantially liberalizes the existing waiver structure contained in ACA section 1332. That provision allows HHS to waive various market reform requirements (including QHP definition/requirements, essential health benefit requirements, premium subsidy payments, and the mandates) with respect to health insurance coverage within the approved state for years beginning in 2017.

Specifically, the Senate proposes to relax the 1332 waiver application and approval requirements (e.g., allows a state certification, rather than having to have a law in place, to effectuate the state's waiver plan; provides for an expedited application and approval process if HHS deems it necessary, etc.). The bill would ***require*** HHS (in contrast to the current discretionary approach) to approve a state waiver application, unless the plan would increase the federal deficit (removing current mandatory HHS determinations regarding comprehensiveness of coverage, cost-sharing protections, and overall number of insureds/uninsured under a state's application).

Other major provisions

Other issues covered in the bill which may be of more general interest to Council members include –

- Beginning in 2019, requires the states to set their own MLR and rebate amounts;

- Adjusts the permissible age bands for premium rates from 3-1 to 5-1 for adults, and allows "such other ratio for adults as the State may determine;"

- Proposes to phase out the ACA's Medicaid expansion beginning in 2021; and then, beginning in 2025, it calls for reform of the entire Medicaid system into a per capita cap model (with an option for states to choose a block grant program); contains an option for states to institute a work requirement for non-disabled, non-elderly, non-pregnant adults eligible for Medicaid coverage;

- Creates a short-term stabilization fund run through CMS that allows payments to insurers to respond to "urgent health care needs" within the states; and creates a long-term state stabilization fund (states may opt in) that provides support to states to reduce cost burdens on high-risk individuals, among other approved purposes; and

- Appropriates $2 billion to HHS for 2018 to provide grants to states to address the opioid crisis and other substance use and mental health initiatives.