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TO: The Council

FROM: Scott Sinder
Kate Jensen

RE: Overview of the Senate Better Care Reconciliation Act of 2017 – **as Amended**

Today, the Senate released an updated draft of the Better Care Reconciliation Act of 2017 ("BCRA"), its proposal to repeal and replace significant portions of the Affordable Care Act ("ACA") through the budget reconciliation process. Senator McConnell has stated that a vote on the revised package could be held as early as next week. It is not clear, however, that he is any closer to securing 50 Republican votes. In fact, minutes before the revised BCRA was publically revealed, Senator Graham (R-SC) released a press statement touting an alternative repeal and replace proposal he has developed with Senator Cassidy (R-LA).

Notably, like the prior draft, the newly-released legislation ***does not cap the employer-sponsored coverage tax benefit.*** The new draft contains the following notable changes from the version on which we previously reported:

- Additional HSA reforms, including: allowing payment of medical expenses for dependents through age 26; and allowing payment of HDHP premiums (only for amounts above any premium tax credit and only if the HDHP is not an employer-sponsored plan for which an income deduction is allowed under § 106); but prohibiting HSA funds from being used to pay for HDHPs that cover abortions;
- Retains certain taxes under the ACA (which are repealed in the House bill and would have been repealed under the old Senate bill): 3.8% net investment income tax; 0.9% additional Medicare payroll tax for high earners; and $500K cap on deduction insurers can take for salaries and other remuneration paid to top executives;

- Includes a continuous coverage incentive (in lieu of the individual mandate), which entails a mandatory 6-month waiting period for coverage if an individual has a 63+ day gap in creditable coverage during the last 12 months;
- Allows anyone to enroll in catastrophic coverage beginning in 2019 and makes premium subsidies available for such coverage in 2020; and
- Creates a new program for federally-funded high-risk individual plans.

Below is an overview of provisions in the updated BCRA that are of particular interest to Council members. Changes from the original bill are noted in ***bold italics***.

Employer-sponsored coverage and other tax-related provisions

Regarding The Council's top priority issues:

- The bill does not 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);
- prescription drug tax (***beginning 2021***); and
- medical device tax (beginning 2018).

The bill retains the following tax provisions from the ACA:

- ***Net investment income tax;***
- ***Additional Medicare payroll tax for higher-income earners; and***
- ***Cap on the allowable deduction insurers may take for top executive compensation.***

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).

Subsidy structure for the individual market

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). 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), ***but beginning in 2020, they will be available for catastrophic plans (in which anyone may enroll beginning in 2019).***

HSA Reforms

With respect to HSA reforms, 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;
- reverse the ACA's tax penalty increase on HSAs for non-qualified expenditures (taking it down from 20% ***to 15%***);
- ***allow payments for qualified medical expenses of dependents through age 26;***
- ***allow payment of HDHP premiums (only for amounts above any premium tax credit available, and only if the HDHP is not an employer-sponsored plan for which an income deduction is allowed under § 106); and***
- ***prohibit HSA funds from being used to pay for HDHPs that cover abortions.***

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). ***The bill stipulates that participating employers in such association health***

plans are not considered "plan sponsors." 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). The bill would require HHS (in contrast to the current discretionary approach) to approve a state waiver application, unless the state's application is missing a required element or 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). ***Unlike the current waiver structure under which waivers are limited to five years, unless a state applies for a continuation, waivers would now be effective for 8 years and HHS would not have authority to cancel a waiver within that 8-year period.***

The bill appropriates $2 billion (available until 2019) to fund state grants to develop waiver plans/applications.

Other notable 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;

- Beginning in 2020, 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;"

- ***Ends the ACA's Medicaid expansion by the end of 2019, but allows States to continue the expansion if they opt to do so (with phased out federal assistance for expansion enrollees between 2020 and 2023); sunsets Medicaid's essential health benefit requirement by end of 2019;*** calls for overall reform of the entire Medicaid system into a per capita cap model (with an option for states to choose a block grant program);

provides safety net funding for non-expansion states; and 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;

- Appropriates ***$5 billion*** to help states address the opioid crisis and other substance use and mental health initiatives, ***and dedicates a portion of those funds to addiction research;*** and

- ***Creates a program for federally-funded high-risk individual plans (with payments going to issuers who agree to issue such plans); appropriates $70 billion for 2020-2026 for the program (with some additional funding for states); if an individual enrolls in a federally subsidized high-risk plan, he/she is not eligible for a premium tax credit for an off-exchange plan, but HSAs may be used to pay premiums for such off-exchange plans; and off-exchange coverage under the program does not constitute creditable coverage.***