American Hospital Association

Special Bulletin

Thursday, June 22, 2017

Senate Health Bill Unveiled

Senate Republican leaders today unveiled a draft of legislation – the Better Care Reconciliation Act – to repeal and replace parts of the Affordable Care Act (ACA).

In a statement, AHA President and CEO Rick Pollack said, "From the onset of this debate, America's hospitals and health systems have been guided by a set of key principles that would protect coverage for Americans. Unfortunately, the draft bill under discussion in the Senate moves in the opposite direction, particularly for our most vulnerable patients. The Senate proposal would likely trigger deep cuts to the Medicaid program that covers millions of Americans with chronic conditions such as cancer, along with the elderly and individuals with disabilities who need long-term services and support. Medicaid cuts of this magnitude are unsustainable and will increase costs to individuals with private insurance. We urge the Senate to go back to the drawing board and develop legislation that continues to provide coverage to all Americans who currently have it."

A summary of the bill follows based on our initial review of the draft legislation. A Congressional Budget Office estimate of the impact of the draft is not yet available but is expected early next week.

Please watch for additional updates, as we anticipate a vote in the Senate next week. In addition, **please make plans to join AHA President and CEO Rick Pollack and Executive Vice President Tom Nickels on Monday, June 26 at 3 p.m. ET for a members-only advocacy call to discuss next steps. Click here to register.**

Medicaid

- **Medicaid Expansion.** The Senate bill would maintain the current enhanced federal match rate for expansion states through 2020. Beginning in 2021, there would be a three-year phase down of the matching rate, decreasing to 85 percent in 2021, 80 percent in 2022 and 75 percent in 2023. In 2024, the enhanced federal match would be eliminated. The House bill did not contain a phase down. The Senate bill also includes a safety-net fund for non-expansion states of $2 billion for 2018-2022 to make up for Medicaid shortfall and uncompensated care. This appears to replace the $10 billion fund included in the House bill for non-expansion states.

- **Per Capita Caps and Block Grants.** The bill would restructure the Medicaid financing system. State federal funding would be under a per capita cap payment

structure, unless the state elects a block grant option for children and non-disabled adults.

Per Capita-based Cap for Federal Medicaid Payments to States. The bill would replace the current federal Medicaid payment system with a per capita cap structure, as of October 1, 2019 (FY 2020). Each state would have a single overall per capita allotment that would be comprised of per capita allotments for five enrollee categories:

- Elderly
- Blind/disabled and disabled children age 19 and over
- Expansion adults
- Children under age 19
- Non-elderly/non-disabled adults

Certain populations would be excluded from the per capita cap funding structure, including Children's Health Insurance Program (CHIP) enrollees; blind and disabled children under age 19; Indian Health Service individuals receiving Medicaid; and breast and cervical cancer treatment eligible individuals.

Base Year Amount for Per Capita Cap. States can elect the base period amount based on a period of eight consecutive fiscal quarters. The consecutive quarters must fall between Quarter 1 of 2014 and Quarter 3 of 2017 and would include most medical expenditures. The HHS Secretary can make adjustments to a state's base year if the state attempts to make retroactive supplemental payments during the base year period. Adjustments would be made to the cap, including for non-disproportionate share hospital (DSH) supplemental payments.

The per capita allotments would be based on the state's base year average per capita Medicaid spending trended forward by the Medical Consumer Price Index (CPI) to FY 2019 and then multiplied by the number of enrollees in FY 2019. This calculation would establish the projected spending for FY 2019. Once the FY 2019 per capita allotments are established, each enrollee group would be trended forward to arrive at the FY 2020 per capita allotments.

The trend factor for the elderly and blind and disabled enrollee categories would be Medical CPI, plus one percentage point through FY 2024. The trend factor for the other three categories – expansion adults, children and non-elderly/non-disabled adults – would be Medical CPI until FY 2024. After FY 2024, the trend factor changes to CPI-Urban, which is lower, for all populations.

The Senate bill also includes an adjustment for states that spend a certain amount above or below their target spending amount. This provision is budget neutral and, therefore, would move money from higher-spending states to lower-spending states. States with low population density would be excluded from this adjustment.

Block Grant Option. The bill would provide states with an option to opt out of the per capita cap allotment and instead receive federal funds through a block grant beginning in FY 2020. This new Medicaid Flexibility Option allows states greater flexibility in the design of their program, subject to certain federal requirements including a list of services to be covered and maintenance of effort spending.

- **Provider Taxes.** The Senate bill would reduce the allowable provider tax limit from 6% to 5% over a five-year period – taking 0.2 percentage points off for each year beginning with 2021; with the final reduction in 2025. The cap would then be 5% in 2025 and beyond. The House bill had no provider tax provision.

- **Medicaid DSH Payments.** The Senate bill maintains the ACA's Medicaid DSH cuts for expansion states. However, the Medicaid DSH reductions would not be implemented in non-expansion states, which would also be eligible for new DSH allotments between 2020 and the first quarter of 2024 if their DSH spending evaluated on a per capita basis is below "national average."

Individual and Employer Coverage Mandates

Beginning with tax year 2016, the Senate bill would effectively repeal the ACA individual and employer coverage mandates by not penalizing individuals and employers who are not in compliance. Unlike the House bill, the Senate bill does not include penalties for individuals who fail to maintain continuous enrollment.

Coverage Subsidies

The Senate bill would keep but restructure the ACA's advanced premium tax credits. Individuals between 0% – 350% of poverty would be eligible for a tax credit, a change from the ACA's eligibility levels of 100% – 400% of poverty. This has the effect of offering a tax credit to individuals below 100% of poverty who currently fall into the "coverage gap" in non-expansion states; however, middle class individuals earning between 350% and 400% of poverty would no longer receive any financial assistance for coverage. The bill also would adjust the dollar value of the tax credit to account for the cost of coverage in a region, something the House bill did not do. The tax credits would be pegged to the ''applicable median cost benchmark plan'' in the region with an actuarial value of 58% (meaning that the insurer is responsible for 58% of expected costs through the premium payments with the consumer responsible for the remaining 42% through co-pays, deductibles and other out-of-pocket cost sharing). Such a plan would qualify today as a bronze plan. This has the impact of reducing the value of the tax credit because the tax credits today are pegged to silver plans, through which insurers are responsible for 70% of costs. Finally, the tax credits are also adjusted by age, with younger individuals responsible for a smaller proportion of the cost of coverage than older individuals. The bill also would repeal the cost-sharing reductions

as they are currently structured for 2020 and beyond; however, the “Long Term State Stability and Innovation Program,” described below, could be used to assist patients with cost sharing in other ways.

State Stability and Innovation Fund

The Senate 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 fund is split into “short-term” and “long-term” components. The short-term fund makes $50 billion available to the Centers for Medicare & Medicaid Services 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 portion of the funding. The long-term fund would provide states with access to $62 billion from 2019 to 2026 to implement high-risk pools, establish premium stabilization programs, make payments to providers, and assist individuals with premiums and cost sharing, among other potential uses. States would be required to contribute toward program costs, starting with a 7% contribution beginning in 2022, increasing to 35% in 2026.

1332 Waivers

The bill would modify the 1332 waiver provision to increase flexibility for states to provide alternative coverage options, reduce premiums, or increase enrollment in coverage. States would no longer need to ensure that alternative coverage options provided the same coverage and cost-sharing protections as under current law. The bill also would expedite the 1332 approval process. For example, states would no longer be required to pass a state law to be eligible to apply for such a waiver. Our initial read is that these changes could allow states to waive the essential health benefit standards, among other insurance standards.

Community Rating

The bill would increase the permissible age-rating bands for qualified health plans to 5:1 from 3:1 and give states the authority to select the range for their state. The bill does not include the waiver of the health status component of community rating that was included in the House bill. This was one of the provisions that could have increased the cost of coverage significantly for individuals with pre-existing conditions who experienced a gap in coverage.

Federal Medical Loss Ratio Repealed

The bill would sunset the federal medical loss ratio (MLR) requirement for health plans beginning in 2019. States would establish MLRs beginning in 2019.

Incentives for Health Savings Accounts (HSAs)

The bill would incentivize the use of HSAs by increasing the maximum amount an individual could contribute to his or her HSA, among other provisions.

Opioid Funding

The Senate bill would remove the Medicaid exclusion for treatment of opioid addiction for stays up to 30 days, not to exceed 90 days in a calendar year. The bill also includes $2 billion in 2018 for states battling the opioid crisis.

ACA Taxes

The bill would repeal most taxes authorized by the ACA for 2018 and beyond, including the fees on insurers, and prescription drug and medical device manufacturers, among others. The increase in the Medicare payroll tax for high earners ($200,000 for individuals, $250,000 for married couples filing jointly) would be repealed beginning in 2023. The legislation would repeal a 3.8% tax on net investment income in 2017. The tanning tax would be repealed October 1, 2017. The bill also would delay the excise tax on certain high-value plans, known as the “Cadillac tax,” until 2026. The bill would not otherwise tax employer health coverage.