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The Better Care Reconciliation Act of 2017 vs. The American Health Care Act Summary of Key Differences

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On June 22, 2017, Senate Republicans released a discussion draft of their proposal to repeal and replace the Affordable Care Act (ACA), titled the "Better Care Reconciliation Act of 2017" (BCRA). The proposal retains a number of provisions from the House-passed American Health Care Act (AHCA). Beyond the title change, there are notable differences in the Senate's bill, including a slower phase-out schedule for the Medicaid expansion, retention of the ACA's premium subsidy structure, somewhat reduced state waiver flexibility and delayed implementations of effective dates for certain ACA tax provisions.

The Congressional Budget Office is expected to release its cost estimate for the BCRA shortly. Senate Majority Leader Mitch McConnell (R-KY) aims to get a floor vote before the July 4 recess, but early resistance from a handful of moderate and conservative senators (including Sens. Ted Cruz (R-TX), Rand Paul (R-KY) and Dean Heller (R-NV)) threatens the BCRA's passage. Several additional senators who expressed concerns during the drafting process have yet to publicly comment on the discussion draft. Changes and floor amendments to the discussion draft are expected.

Like the AHCA, the BCRA would not repeal the ACA in its entirety—partially due to conscious policy decisions, but also because of procedural limits within Senate Budget Reconciliation rules. For instance, both the AHCA and the BCRA would maintain some of the "popular" insurance market reforms in Title I of the ACA, such as rules requiring issuers to offer dependent coverage until age 26; prohibitions on annual and lifetime limits; and prohibition of discrimination based on race, nationality, disability or sex. Further, neither bill proposes changes to any Medicare provisions from Title III of the ACA, such as those implementing quality and value-based provider payment reforms (many of which are budget neutral), the Center for Medicare and Medicaid Innovation, and provider rate cuts (repeal of which would add to the deficit outside of the 10-year budget window in violation of procedural rules).

The BCRA's reforms fall into the three broad categories described below.

Coverage and Affordability in the Individual and Small Group Market

While the BCRA's market-based provisions mirror many of those in the AHCA, they also include several significant changes. For instance, the BCRA maintains the AHCA's increase in the maximum premium variation based on age from 3:1 to 5:1 in 2019, with the option for states to provide for other age-rating requirements. Like the AHCA, the BCRA also would repeal the ACA's individual and employer mandates. Notably, however, the BCRA does not include the

AHCA waivers that would allow states to engage in health-status underwriting for individuals who do not maintain continuous coverage. Below is a brief summary of the differences between the House and Senate bills:

- *Tax credits* – The AHCA created a system of age-based tax credits. The BCRA instead relies on the existing ACA system of federal tax credits. However, the BCRA's credits are based on age, income and geographic location. Eligibility for the subsidies is scaled back to include households with incomes under 350 percent of the federal poverty level (FPL), and, like the ACA, the subsidies are tied to a benchmark plan. However, the BCRA benchmark provides much less coverage—under the ACA, the benchmark plan was based on an actuarial value (average percentage of annual health expenses covered) of 70 percent, while the BCRA benchmark plan would have an average actuarial value of 58 percent.

- *Health Savings Accounts (HSAs)* – The BCRA would maintain three Health Savings Account (HAS) expansion provisions from the AHCA, including (1) increasing contribution limits from the current $3,400 for individuals and $6,750 for families in 2017 to the out-of-pocket maximum amounts (currently $6,550 for an individual and $13,100 for a family); (2) allowing both spouses to make catch-up contributions to the same HSA; and (3) allowing individuals up to 60 days to establish an HSA upon enrolling in HSA-eligible coverage to be reimbursed from their accounts for medical expenses. These changes would be effective in January 2018.

- *Continuous-coverage incentive* – The AHCA replaced the ACA's individual mandate with a continuous-coverage incentive that resulted in a penalty for individuals who did not maintain continuous insurance coverage. The BCRA repeals the individual mandate, but it also eliminates any penalties for failing to purchase health insurance. This is an area where the draft may be modified before it reaches a final version.

- *Cost-sharing subsidies* – Unlike the AHCA, the BCRA extends cost-sharing subsidy payments, which reduce premiums and deductibles for low-income individuals, until December 31, 2019.

- *State innovation waivers* – The BCRA seeks to provide states with better and more efficient access to the ACA's Section 1332 state innovation waivers by eliminating the requirement that waivers be codified in state law. Section 1332 waivers include waivers of ACA requirements like essential health benefits, actuarial values and exchange requirements. The BCRA would allow states to waive these provisions if the state describes how it would "provide for alternative means of, and requirements for, increasing access to comprehensive coverage, reducing average premiums, and increasing enrollment," a lower standard than under the ACA.

  The BCRA also appropriates $2 billion for 2017 through 2019 to allow states to submit waiver applications and to use the long-term stability fund to carry out innovation waiver plans. The BCRA allows for an expedited approval process if the Secretary of Health &

Human Services (HHS) determines that it is necessary and requires all waivers to be approved, unless they will increase the federal deficit. Waivers are granted for an eight-year period, unless a state requests a shorter period, with automatic renewals upon application. Finally, the BCRA provides that 1332 waivers approved prior to enactment will be governed under the ACA parameters.

- *Pre-existing conditions* – The ACA's prohibition on charging higher premiums or denying coverage based on existing medical conditions seems to remain intact under the BCRA. However, this does not guarantee that someone will not be denied coverage for a pre-existing condition. The discussion draft grants states more flexibility with respect to other insurance rules, such as the establishment of basic benefits packages and minimum payments that insurers must make toward medical bills. To the extent that states modify essential health benefits under a waiver, this could weaken pre-existing condition protections if certain benefits are not included. However, the Senate does not maintain the AHCA provision that allowed states to request a waiver to engage in health-status underwriting for individuals who did not maintain continuous coverage.

- *Actuarial value standards* – Unlike the AHCA, the BCRA does not address the ACA's actuarial value standards. The AHCA would have repealed these standards (which establish mandatory actuarial values for bronze, silver, gold and platinum plans) after December 31, 2019.

- *Small business health plans* – The BCRA would amend the Employee Retirement Income Security Act of 1974 (ERISA) to allow for the creation of small-business health plans, which means "a fully insured group health plan, offered by a health insurance issuer in the large group market" whose sponsor meets specified requirements. The BCRA would require the Secretary of HHS to establish a certification process no later than six months after the date of enactment.

- *Opioid funding* – The BCRA appropriates $2 billion in 2018 for the Secretary of HHS to distribute grants to states to support substance-use-disorder treatment and recovery-support services. This is different from the AHCA, which earmarked $15 billion over 10 years for mental health, substance abuse and maternity care.

- *Prevention and Public Health Fund* – Like the AHCA, the BCRA would end the ACA's $1 billion in funding for the Prevention and Public Health Fund, but one year earlier than the AHCA on October 1, 2017 (FY 2018).

- *Stability funds* – Unlike the AHCA's "Patient and State Stability Fund," the BCRA would create two funds geared toward stabilizing insurance markets. First, the short-term stability fund would appropriate $50 billion over four years ($15 billion annually in 2018 and 2019 and $10 billion annually for 2021 and 2022) to the Centers for Medicare and Medicaid Services (CMS) to "fund arrangements with health insurance issuers to address coverage and access disruption and respond to urgent health care needs" with no state

matching requirement. Insurers would be required to apply for the short-term stability fund, with applications for 2018 due within 35 days of the BCRA's enactment.

The second fund, aimed at ensuring long-term stability, would appropriate $62 billion from 2019 to 2026. Funding would be front-loaded and allocated as follows:

Year	Long-Term Fund Appropriation	Total Appropriation (Including Short-Term Fund)
2018	$0	$15,000,000,000
2019	$8,000,000,000	$23,000,000,000
2020	$14,000,000,000	$24,000,000,000
2021	$14,000,000,000	$24,000,000,000
2022	$6,000,000,000	
2023	$6,000,000,000	
2024	$5,000,000,000	
2025	$5,000,000,000	
2026	$4,000,000,000	

Beginning in 2022, states would be required to match funding, initially at a 7 percent rate and increasing to 35 percent in 2026. The long-term fund dollars could be used to provide financial assistance to high-risk individuals, make payments to health care providers or to reduce cost-sharing. States would be required to complete a one-time application that is subject to automatic renewal. However, the entire short-term stability fund ($50 billion) and $15 billion of the long-term fund must be used to stabilize premiums and insurance markets.

Medicaid Expansion and Federal Participation

The BCRA proposes many of the Medicaid changes included in the AHCA, such as the sunset of the essential health benefits requirements for Medicaid plans effective January 1, 2020. The BCRA also retains the conversion of Medicaid to a per capita cap system with optional block

grants for certain populations, as well as the AHCA's optional work requirement. Key differences between the BCRA and the House-passed bill are:

- *Presumptive eligibility* – Like the AHCA, the BCRA would allow state Medicaid plans to conduct eligibility determinations every six months, and it provides a 5 percent increase in the federal medical assistance percentage (FMAP) for states that elect this option. However, the BCRA gives states more flexibility by allowing them to make eligibility redeterminations after fewer months.

- *Medicaid expansion freeze* – The AHCA would freeze Medicaid expansion after March 1, 2017, by eliminating the state option to expand and receive enhanced FMAP payments. By contrast, the BCRA would not freeze Medicaid expansion, allowing states to enroll and cover individuals up to 133 percent FPL through December 31, 2017. States that had not expanded their programs as of March 1, 2017, could opt to do so, but would receive their regular matching rate to cover new enrollees.

- *Phase-out of FMAP* – Unlike the AHCA, the BCRA would provide a prolonged phase-out of enhanced federal Medicaid funding for states. Under the AHCA, states that have already expanded could keep the enhanced match for expansion enrollees until December 31, 2019, but, after that, they would receive an enhanced FMAP for only individuals enrolled as of December 31, 2019, who do not become disenrolled for more than a month ("grandfathered expansion enrollees"). The BCRA maintains the enhanced FMAP for the Medicaid expansion population until December 31, 2020, after which enhanced funding would be phased down from 85 percent to 75 percent over three years (2021-2023). No enhanced funding would be available to states after December 31, 2023.

- *Per capita cap* – Like the AHCA, the BCRA would convert federal funding for Medicaid to a per capita cap model, unless a state chooses to receive block grant funding for children and non-expansion adult enrollees, beginning in FY 2020. The BCRA also would maintain the five enrollee categories established by the AHCA: (1) elderly; (2) blind and disabled; (3) children; (4) expansion enrollees; and (5) other non-elderly, non-disabled, non-expansion adults.

  However, the BCRA includes several key differences:

  - Medically complex children would be carved out from the cap.
  - The baseline for the cap would no longer be based on state FY 2016 spending trended forward by the medical consumer price index (CPI-M) to 2019 in each enrollee category. Instead, the BCRA cap baseline is a period of eight consecutive quarters between 2014 and the second quarter of 2017 selected by the state.
  - The growth factor for the cap is altered. Under the BCRA, from FY 2020 to FY 2024, the per capita cap would increase annually by the CPI-M for expansion adults, children and other adult enrollee categories. The cap would grow annually by medical inflation plus 1 percent. Then, beginning in FY 2025, the per capita cap would grow more slowly for all enrollee categories at the general consumer

price index rate. The BCRA would impose deeper Medicaid cuts than the AHCA because it utilizes a slower annual growth rate for payments made to states.

- *Optional block grant, "Medicaid Flexibility Program"* – Similar to the AHCA, the BCRA would give each state the option to receive block grant funding for its "other adult" populations in 2020. Similar to the AHCA, states would be subject to minimum requirements, but they also would retain the ability to set eligibility and minimum benefits, and general funding would remain the same. A key difference is that, under the BCRA, before the Secretary of HHS may approve a block grant proposal, it must be made public for a 30-day notice-and-comment period.

- *Medicaid managed care waivers* – Unlike the AHCA, the BCRA permits states that have grandfathered managed care waivers to continue to implement the managed care delivery system that is subject to the waiver without reapplying to the Secretary, as long as the waiver's terms and conditions are not modified. A managed care waiver is deemed "grandfathered" if the provisions of the waiver or demonstration project under Section 1115 of the Social Security Act were approved as of January 1, 2017, and have been renewed by the Secretary of HHS no less than one time.

- *Home and community based service waivers* – The BCRA directs the Secretary of HHS to implement procedures to encourage states to adopt or extend waivers to make home and community-based services available.

- *Medicaid DSH allotments* – The AHCA would repeal the Medicaid disproportionate share hospital (DSH) payments for non-expansion states in 2018 and for expansion states in 2020. The BCRA instead would exempt non-expansion states from scheduled reductions in DSH payments from FY 2021 through 2024 and provide an increase in DSH payments for non-expansion states in FY 2020 based on each state's Medicaid enrollment.

- *Provider tax* – The BCRA reduces permissible Medicaid provider taxes from 6 percent under the ACA in 0.2 percent increments beginning in 2021 to ultimately reduce the tax to 5 percent in FY 2025. There was no such similar provision in the AHCA.

- *State performance bonus payments* – Unlike the AHCA, the BCRA would provide an $8 billion pool for bonus payments to state Medicaid and CHIP programs for FY 2023 through 2026. The Secretary of HHS could use these funds to increase federal matching rates for states that have lower-than-expected expenses under the per capita cap allotment, report applicable quality measures and have a plan to use the additional funds on quality improvement.

- *Optional assistance for certain inpatient psychiatric services* – The BCRA would provide optional state Medicaid coverage of inpatient psychiatric services for individuals between the ages of 21 and 65. The coverage would not exceed 30 days in any month or 90 days in any calendar year. To receive the assistance, a state must maintain its number of licensed psychiatric beds as of the date of the BCRA's enactment, and maintain current

levels of funding for inpatient services and outpatient psychiatric services. The BCRA also provides a lower match for such services (50 percent) furnished on or after October 1, 2018.

Revenue and Tax Provisions

Generally, the BCRA's tax provisions are similar to those included in the AHCA. However, the BCRA does make several changes, such as delaying the repeal of the Additional Medicare Tax. Below is a chart of key differences between the tax provisions in the House and Senate legislation.

	House Bill AHCA	Senate Bill BCRA
Cadillac Tax	Delays effective date to January 1, 2026	Delays effective date to January 1, 2026
Health Insurance Tax	Repeals tax, effective after December 31, 2016	Repeals tax, effective after December 31, 2016[1]
Medical Device Tax	Repeals tax, effective after December 31, 2016	Repeals tax, effective after December 31, 2017
Medicare Hospital Insurance Surtax	Repeals tax, effective after December 31, 2022	Repeals tax increase, effective after December 31, 2022
Pharmaceutical Manufacturer Tax	Repeals tax, effective after December 31, 2016	Repeals tax, effective after December 31, 2017
Deductions for Expenses Allocable to Medicare Part D	Reinstates deduction, effective after December 31, 2016	Reinstates deduction, effective after December 31, 2016
Medical Expense Deduction	Decreases AGI threshold, effective in 2017	Decreases AGI threshold, effective in 2017
Flexible Spending Accounts (FSA)	Repeals contribution limits, effective after December 31, 2016	Repeals contribution limits, effective after December 31, 2017

[1] Although there appears to be a drafting error in the text of the BCRA, the section-by-section of the bill makes it clear that the Senate intended to repeal the annual fee imposed on health insurers effective CY 2017.

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	House Bill AHCA	Senate Bill BCRA
Health Savings Accounts (HSA)	Returns to pre-ACA rate, effective after December 31, 2016 Increases yearly contribution limit, effective December 31, 2016 Repeals exclusion for over-the-counter drugs, effective after December 31, 2016	Decreases to 10 percent, effective after December 31, 2016 Increases yearly contribution limit, effective after December 31, 2017 Repeals exclusion for over-the-counter drugs, effective after December 31, 2016
Health Insurance CEO Deduction	Repeals tax, effective after December 31, 2016	Repeals tax, effective after December 31, 2016
Tanning Tax	Repeals tax, effective after June 30, 2017	Repeals tax, effective after September 30, 2017
OTC Tax	Repeals tax, effective after December 31, 2016	Repeals tax, effective after December 31, 2016

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