



Summary of Major Provisions of the “Better Care Reconciliation Act of 2017” Released on June 26, 2017

On June 22, the Senate leadership released a discussion draft of the “Better Care Reconciliation Act of 2017,” legislation that would repeal and replace several major provisions of the Affordable Care Act (ACA). A revised discussion draft was issued on June 26, along with a cost estimate of the revised bill by the Congressional Budget Office (CBO). A vote on proceeding to debate the Senate bill is expected this week, and, if the measure to proceed to debate is approved, a vote on the underlying bill is also expected.

Below is a top-line summary of the discussion draft and a bottom line analysis based on AMA policy and health system reform principles. This summary and analysis is subject to change upon release of the final bill language.

Top-line Summary of the Senate’s Discussion Draft

- Effectively repeals both individual and employer mandates retroactively beginning with calendar year 2016 (by zeroing out the penalties). Individuals would no longer have to pay a penalty if they do not have health insurance coverage. The updated bill also includes a continuity provision to encourage individuals to enroll in, and maintain, coverage. This provision would require individuals who go without health insurance for 63 days or more during the preceding 12 months to wait an additional six months until coverage bought through insurance exchanges takes effect. Unlike the House bill, however, there would be no premium surcharge imposed on individuals who have a lapse in coverage.
- Keeps current ACA premium tax credits for 2018 and 2019. Beginning in 2020, eligibility for tax credits would be scaled back from 400 percent to 350 percent of the federal poverty level (FPL), with the lower limit extended downward to zero percent of FPL, which would fill the current coverage gap to cover more low-income people who do not live in a Medicaid expansion state. Consequently, while more people at the lower end of the income range would be covered by the Senate tax credits, those above 350 percent of the federal poverty level would no longer be eligible.
- Changes benchmark plan used to determine the amount of the premium tax credit, which is currently the second-lowest cost silver plan with an actuarial value of 70 percent, to a benchmark plan with an actuarial value of 58 percent (i.e., close to bronze level rather than silver as under current law). As a result, lower tax credit amounts as such will be tied to the cost of a plan with higher deductibles and co-payments than under current law.
- Beginning in 2020, bases the formula for determining premium contributions on both age and income, with premiums ranging from 2 percent for those in the lowest income band, regardless of age band, to 16.2 percent for those in the highest income band and the oldest age band. Within each income bracket above 150 percent FPL, older individuals would contribute more than younger individuals. While the CBO score is not yet available, it appears that older individuals could pay a much higher percent share of

their income for premiums than under present law and insurance could become unaffordable for them.

- Eliminates the affordability test for employer-sponsored coverage, so that individuals with access to any employer coverage would be ineligible for premium tax credits, even if coverage is unaffordable.
- Establishes an age rating ratio of 5:1 for adults for plan years beginning on or after January 1, 2019, and states would have the option to implement a ratio for adults that is different from the 5:1 ratio. This could make it much more expensive for older consumers.
- Repeals medical loss ratio requirements beginning January 1, 2019, and transfers authority to determine such requirements to the states.
- Repeals cost-sharing subsidies beginning in 2020.
- State Stability and Innovation Program:
 - Short-term stabilization fund for reinsurance and to address coverage and access disruption and respond to urgent health care needs within states—for 2018-2021 (\$15 billion in 2018 and 2019; \$10 billion in 2020 and 2021).
 - Long-term stabilization and innovation fund for 2019-26 (\$8b in 2019; \$14b in 2020 and 2021; \$6b in 2022 and 2023; \$5b in 2024 and 2025; \$4b in 2026) to: help reduce premiums for high-risk individuals; create reinsurance programs; provide payments for health care providers; and provide assistance to reduce cost-sharing for individuals in the individual market. At least \$5b must be used for each of 2019-2021 for reinsurance.
- Medicaid:
 - Maintains Medicaid expansion for three years. Beginning in 2021, Medicaid expansion would be phased out over three years, reducing the Federal Medicaid Assistance Percentage (FMAP) from 90 percent to 75 percent in 2023. The expansion state enhanced FMAP would not be available to states after CY2023.
 - Provides \$2 billion for the HHS Secretary to issue grants to states to support substance use disorder treatment and recovery support services, but repeals the enhanced essential health benefit provisions for expansion populations after December 31, 2019, thereby eliminating mental health and substance use disorder treatments that states have been able to provide.
 - Establishes a per capita cap funding model, beginning in 2020 (as in House bill). The enrollee categories would be: elderly; blind and disabled adults; children; expansion enrollees; and other non-elderly, non-disabled, non-expansion adults. Populations carved out from the cap include individuals covered under a CHIP Medicaid expansion program; in Indian Health Service facilities; eligible for Medicaid coverage of breast and cervical cancer treatment; blind and disabled children under the age of 19; and certain partial-benefit enrollees, including aliens entitled to emergency care, TB-infected individuals, individuals who only receive family planning services, dual-eligibles, or individuals, including children, receiving a subsidy for an employer plan. Under the per capita cap model, states can choose their base years based on eight consecutive quarters from first quarter of 2014 through second quarter of 2017. The payments would increase annually by CPI-medical (except that for the elderly and disabled categories, it would be CPI-M plus one percentage point); beginning in 2025, the growth rate would be reduced to the urban CPI, which is lower than what the House bill provides. Beginning in FY2020, any state with spending higher than their specific target would receive reductions to their Medicaid funding for the following year.

- Gives states the option to apply for block grant waivers instead of per capita cap under a new Medicaid State Flexibility Program for non-disabled, non-expansion adults. .
- Optional work requirements: Gives states the option to impose work requirements, beginning October 1, 2017, on non-disabled, non-elderly, non-pregnant beneficiaries, as a condition of receiving Medicaid.
- Allows for limited coverage of inpatient hospital treatment for opioid addiction for 30 days, not to exceed 90 days in a calendar year, but the FMAP for these services is reduced to 50 percent.
- Repeals the Prevention and Public Health Fund starting in Fiscal Year 2018.
- Includes one-year freeze on federal funding to Planned Parenthood.
- Provides \$2 billion fund to incentive states to apply for an ACA section 1332 waiver; states could seek waivers for any requirements, including essential health benefits and subsidies off-exchange; changes the criteria for approving waivers to that most will be approved unless they increase the federal deficit.

Rev. 6/27/17