Client Update
The Senate's Healthcare Bill– What's in It?

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On Thursday of last week, Senate Majority Leader Mitch McConnell unveiled the "Better Care Act." On Monday, Mr. McConnell issued several amendments to the bill. This bill is the Senate Republican leadership's response to the American Health Care Act ("AHCA") passed by the House on May 4, 2017. Both the AHCA and Better Care Act would accomplish many of the same core objectives, including repealing the Affordable Care Act's ("ACA") tax provisions, reducing government subsidies to support the purchase of health insurance, restraining the growth of federal Medicaid spending and giving states more flexibility to regulate health insurance. As described below, the ways in which the bills would achieve these objectives differ in many respects.

The Better Care Act is likely to be amended in the coming days or weeks as a number of Republican senators have already expressed concern about the bill in its current form. If the Senate ultimately passes a healthcare bill, both houses of Congress will have to attempt to reach agreement on a bill that can pass both houses.

WHAT WOULD HAPPEN TO THE ACA'S SUBSIDIES TO PURCHASE HEALTH INSURANCE?

The ACA provides for two types of subsidies: Premium Tax Credits and Cost-Sharing Reductions. The AHCA would abandon these subsidies in favor of annual tax credits of between $2,000 and $4,000 depending on age and income. The Better Care Act, by contrast, would modify the Premium Tax Credit and maintain the Cost-Sharing Reduction as is for three more years.

Under the ACA, Premium Tax Credits are available to everyone with an income between 100% and 400% of the federal poverty level. The size of the Premium Tax credit is determined by subtracting a percentage of income—the "income contribution"—from the cost of a healthcare plan intended to cover 70% of the

healthcare costs that insureds are likely to incur (a "Silver" plan), regardless of whether an individual actually purchases a more expensive plan (a "Platinum" or "Gold" plan) or a cheaper plan (a "Bronze" plan).

The Better Care Act would restrict the availability and size of the Premium Tax Credits:

- The Premium Tax Credit would be available only to people with an income up to 350% of the federal poverty level and would also be adjusted for age.
- The size of income contributions would rise for everyone but the poorest households (those aged 50 and above would face the largest increases). A larger income contribution would result in a correspondingly smaller Premium Tax Credit.
- The Premium Tax Credit would be calculated based on subtracting the income contribution from the cost of a plan that covers only 58% of the healthcare costs that insureds are likely to incur (a "Bronze" plan). As the starting point for the Premium Tax Credit is the cost of a cheaper plan, the size of the Premium Tax Credit would be correspondingly smaller.
- The Premium Tax Credit would no longer be available to anyone who has the option of receiving health insurance from an employer.

Under the ACA, the Cost-Sharing Reductions cover many out-of-pocket expenses for people with incomes between 100% and 250% of the federal poverty level. House Republicans have challenged the constitutionality of the Cost-Sharing Reductions on the basis that there was no Congressional appropriation for their funding. Insurers, in turn, have expressed concern that, without Cost-Sharing Reductions, many people will stop purchasing insurance altogether. The Better Care Act would address this uncertainty in the short term by appropriating money for Cost-Sharing Reductions until the end of 2019. At that time, the Cost-Sharing Reductions would be abolished.

The Better Care Act would create a new program: the State Stability and Innovation Program. It has two components.

A "Short-Term Assistance" fund would provide appropriations of $15 billion for each of 2018 and 2019 and $10 billion for each of 2020 and 2021. This money is to be used by the Department of Health and Human Services to make direct payments to health insurers to improve healthcare access and to address urgent healthcare needs. These funds would likely be used to address the problems created by insurers that have stopped providing coverage to individuals and small groups on the Exchanges.

A "Long-Term State Stability and Innovation Program" would appropriate federal funds to support state programs designed to meet objectives such as providing assistance to high-risk individuals with costly health conditions who do not have employer-provided insurance; stabilizing state insurance markets; making payments to healthcare providers for providing services; and reducing out-of-pocket costs incurred by low-income people enrolled in the individual market. The program would appropriate $8 billion for 2019; $14 billion for each of 2020 and 2011; $6 billion for each of 2022 and 2023; $5 billion for each of 2024 and 2025; and $4 billion for 2026.

WHAT WOULD HAPPEN TO THE ACA'S TAX PROVISIONS?

Like the AHCA, the Better Care Act would repeal many of the ACA's tax provisions. For budgeting reasons, not all of the repeals would occur immediately, and one major tax would be reinstated in 2026. The provisions to be repealed include:

- The individual mandate, which is a requirement to purchase health insurance, backed up by penalties assessed on certain people who do not purchase health insurance (repeal effective immediately);
- The employer mandate, which is a requirement that certain employers provide health insurance to their employees, backed up by penalties if those employers do not comply (repeal effective immediately);
- The "Cadillac tax" on high-cost health insurance plans. This tax is part of the ACA but has been repeatedly postponed. Under the Better Care Act, the Cadillac tax would be reinstated in 2026;
- The so-called "medicine cabinet tax," which is actually a prohibition against using money set aside in Health Savings Accounts or Flexible Savings Accounts to purchase over-the-counter drugs unless prescribed by a doctor (repeal effective immediately);
- Annual taxes of approximately $3 billion imposed on the branded pharmaceutical industry (repeal effective in 2018); and
- The excise tax on medical devices (repeal effective in 2018).

The Better Care Act would allow individuals to make larger pretax contributions to Health Savings Accounts and Flexible Savings Accounts.

WHAT WOULD HAPPEN TO MEDICAID?

The Better Care Act, like the AHCA, would make significant changes to the Medicaid program that would ultimately slow the growth of federal spending under the Medicaid program.

Prior to the enactment of the ACA, states were required to offer Medicaid coverage only to certain types of low income people—principally, the disabled, elderly individuals needing long-term care and children and the parents of such children. The federal government reimbursed a percentage of the state's Medicaid expenses (between 50% to 70%, depending on the state). The ACA expanded Medicaid to cover low-income childless adults who were not eligible for "traditional" Medicaid. For the expansion population, the federal government currently reimburses 95% of the state's Medicaid costs (decreasing to 90% in 2020 and thereafter).

Under the AHCA, after 2019, the only people who would have been eligible for the expansion reimbursement rate were those who were enrolled in Medicaid at that time and continuously enrolled in Medicaid thereafter. By contrast, the Better Care Act would allow the Medicaid expansion to continue for longer—until 2023. But the "match" rate for the expansion population would decline over time: 85% in 2021; 80% in 2022; 75% in 2023; and thereafter at the state's normal matching rate (which in many cases is far lower than 75%). Starting in 2020, states would no longer be required to provide the relatively generous "essential health benefits" they are currently required to provide to the expansion population.

The Better Care Act would also restrain the growth of federal Medicaid spending through "per capita" grants. Currently, the federal government has an open-ended commitment to pay states for the federal government's share of Medicaid expenditures. Under the Better Care Act, the federal government's payments to each state would be capped based on a formula determined by multiplying the number of enrollees by a set reimbursement rate.

Until the start of 2025, the amount of the federal government's reimbursement would grow at the rate of medical inflation (plus 1% for the elderly and disabled). After 2025, however, the growth rate would be the overall consumer price index. Historically, the medical inflation rate has significantly exceeded the overall inflation rate. The effect, therefore, of allowing federal Medicaid spending to grow at only the overall inflation rate is that, over time, the states would become responsible for an increasing share of Medicaid expenditures. States are already struggling with Medicaid expenditures consuming an ever-larger percentage of

their budgets. If states had to incur substantially more Medicaid expenses, they would likely have to choose between the unpalatable options of raising taxes, reducing Medicaid benefits or cutting the number of Medicaid beneficiaries.

WHAT WOULD HAPPEN TO STATE PROVIDER TAXES?

Federal law currently permits states to fund their Medicaid programs by levying taxes on healthcare providers of up to 6% of their revenues. Nearly every state has enacted some form of provider taxes, although not necessarily to the full amount permitted by law. The Better Care Act would gradually reduce the cap to 5.8% in 2021 to 5% in 2025 and thereafter. The reduction in provider tax caps coincides with the Medicaid funding changes described above. This change in the provider tax cap would prevent states from addressing Medicaid funding shortfalls by increasing taxes on providers. To the extent states are already taxing providers at the limit, this reduction in the cap will exacerbate budgetary challenges faced by those states.

WHAT WOULD HAPPEN TO INSURANCE REGULATIONS?

The Better Care Act would maintain the ACA's requirements that insurers offer insurance to anyone who wishes to purchase it and that they not charge more for individuals with pre-existing medical conditions. The Better Care Act would also allow children to stay under their parents' health insurance plans until the age of 26.

The Better Care Act would make four major changes to the ACA's insurance provisions.

First, the Better Care Act would provide a new means of addressing the risk of adverse selection (people who purchase health insurance only after they become sick or are concerned that they may soon become sick). The ACA addresses adverse selection through the individual mandate, which penalizes people who did not purchase health insurance. The Better Care Act, by contrast, would provide that anyone who had a lapse of insurance coverage for more than 63 days and then sought to purchase insurance on the individual market would be subject to a mandatory six-month waiting period before coverage would begin on the newly purchased primary. The insured would not be responsible for paying premiums during this period.

It is highly uncertain whether the threat of a six-month waiting period provides a sufficient incentive for healthy people to purchase insurance. Many people—particularly those that are young and healthy—may conclude that they can avoid purchasing health insurance now and endure the waiting period later in life. This

waiting period is different from the ACA's individual mandate, which applies a penalty now for not purchasing health insurance and therefore provides a greater incentive to purchase insurance coverage. If the six-month period does not provide a meaningful incentive for healthy people to purchase health insurance, the health insurance risk pool is likely to become sicker. That in turn may cause premiums to rise.

Second, the Better Care Act would alter the ACA's requirement that premiums charged to the oldest population can be no more than three times the youngest population group. The Better Care Act, like the AHCA, would increase the permissible ratio for premiums charged to 5:1. The rationale for changing the ratio from 3:1 to 5:1 is to reduce the extent to which the youngest segment of the population effectively subsidizes health insurance for the oldest population segment. This should encourage more young people to purchase health insurance.

Third, the Better Care Act would allow states to set medical loss ratios beginning in 2019. A medical loss ratio is the percentage of premiums an insurer must pay out to cover expenses incurred by its beneficiaries. Under the ACA, the medical loss ratio is generally 80%. That means insurers can allocate only 20% of their premiums to administration, marketing, and profit. If states were allowed to set medical loss ratios, some states inevitably would reduce them. That would result in insurers potentially keeping a larger percentage of premiums as profits or spending them on marketing.

Finally, the Better Care Act would expand use of the ACA's Section 1332 waiver program. Section 1332 waivers allow the federal government to give states the money that otherwise would be used for subsidies to design their own healthcare programs. There are limitations on what the states can do, however. States that receive waivers are supposed to cover the same number of people, offer coverage that is as comprehensive and affordable as what is offered under the ACA and remain budget neutral. The Better Care Act makes minor changes to the 1332 programs that give states further flexibility in designing new healthcare programs. Moreover, the Better Care Act would allow for an expedited process for states that have an urgent situation with respect to insurance coverage. Section 1332 waivers could free certain states from some of the ACA's insurance provisions not otherwise addressed by the Better Care Act.

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Please do not hesitate to contact us with any questions.