

Draft Senate Health Bill Finally Revealed—Vote Could Take Place as Early Next Week

Introduction

On June 22, 2017, Republican Senators released a “discussion draft” of the Better Care Reconciliation Act (BCRA). The draft is the first public glimpse at the Senate version of the American Health Care Act bill, which narrowly passed the House this past May with the objective of repealing and replacing certain portions of the Affordable Care Act (ACA). The Senate bill has been drafted outside the regular order, without hearings and with limited participation from much of the Republican caucus.

Despite early signals that the Senate planned to completely rewrite the House version of the bill, the circulated draft is largely a refinement rather than a wholesale redrafting.¹ The bulk of the Senate draft closely mirrors the House version of the bill. Several changes in the Senate bill are, however, significant.

A. Next Steps

Republican Majority Leader Mitch McConnell has indicated that a vote on the bill will be held next week. If that happens, Senators may have less than one full week to study the bill’s provisions in the lead-up before the vote.

Only limited changes may be possible before the draft is finalized. The bill is being drafted under special reconciliation rules, which impose a variety of procedural requirements and limitations. One such limitation is the Byrd rule, under which, among other things, the bill as a whole cannot increase the deficit after ten years and, with narrow exceptions, any provision that does not directly affect spending or revenue can be subject to exclusion as extraneous. This could pose a potential risk for some of the bill’s provisions. For example, it is unclear whether the Parliamentarian could strike as “extraneous” the Senate bill’s proposals to reform the age rating and medical loss ratio requirements under the ACA (discussed below).

The immediate practical upshot of the deficit neutrality requirement is that the Congressional Budget Office (CBO) must review and score the Senate bill before a final vote can be held. CBO is a non-partisan agency that produces a cost estimate or “score” of most legislative proposals. CBO is expected to produce a score of the Senate bill early next week.

Senate Republican leadership will need to maintain tight discipline over their caucus to secure Senate passage. No Democrats are expected to support the Senate bill, and three Republican defections in the Senate would be enough to scuttle a successful vote (given that Vice President Mike Pence would be expected to break any tie).

Four conservative Republican Senators, Rand Paul (R-KY), Ted Cruz, (R-TX), Ron Johnson (R-WI), and Mike Lee (R-UT) have issued a statement that, as of June 22, they “are not ready to vote for [the] bill,” but they have expressed their openness to ongoing negotiation with their

¹ Our previous summaries of the House bill are *available at* <https://www.hoganlovells.com/publications/republicans-release-much-anticipated-aca-repeal-and-replace-bill-but-will-it-fly-under-the-byrd-rule> and <https://www.hoganlovells.com/en/publications/health-care-reform-bill-clears-the-house-but-could-hit-a-wall-in-the-senate>.

Republican Senate colleagues.² The initial reaction from some moderate Republican Senators also has been tepid. For instance, Senator Lisa Murkowski (R-AK) issued a statement saying that she will do her “due diligence and thoroughly review” the bill and that while health care needs to be reformed, “it needs to be done right.”³ Senator Susan Collins (R-ME) also issued a similar statement, which stated that she had “a number of concerns” about the bill and that she planned to “carefully review” the text of the bill and CBO’s eventual analysis,⁴ which will include estimates about Senate bill’s impact on insurance coverage and insurance premiums, as well as the bill’s overall expected costs or savings.

B. Medicaid Changes

Similar to the House version of the bill, the Senate bill proposes a rollback of the Medicaid expansion that was authorized under the ACA, as well as fundamental reforms to the federal Medicaid financing structure more generally. In general, relative to its counterpart in the House, the Senate bill proposes to phase in reductions more slowly but ultimately reduce federal monetary support for Medicaid more deeply.

Currently, federal funding matches 95 percent of state Medicaid expansion costs of covered services for the expansion population. For states that implemented Medicaid expansion as of March 1, 2017, the Senate bill maintains the ACA’s current federal matching rate through 2020. In 2021, the federal matching rate for the expansion population would begin to incrementally phase down until Medicaid expansion is fully repealed in 2024. Certain non-Medicaid expansion states would see an increase in their disproportionate share hospital (DSH) allotment beginning in 2020.

Beyond rolling back Medicaid expansion, Medicaid funding in general would be reshaped. As is true of the House version, the Senate bill would restructure the currently open-ended system of federal funding for Medicaid. Beginning in 2020, the default Medicaid funding system would be a per-capita funding system, whereby states receive a capped payment from the federal government for each Medicaid enrollee in the state. The specific amount of the capped payment will depend on a number of factors and could vary depending on each Medicaid enrollee’s individual characteristics. By 2018, states would need to choose a per-capita base period of 8 consecutive fiscal quarters between fiscal year (FY) 2014 and FY 2017. Data from this period would be used pursuant to a statutory formula to set base per-capita funding levels. Like the House version of the bill, the amount of federal funding would rise annually relative to the base rates by a fixed percentage regardless of actual health care cost growth. But, relative to the House version, the Senate bill would result in lower reimbursement to states beginning in 2025.

Starting in 2020, the Senate bill, like the House bill, also would permit states to opt into a block grant funding program rather than the default per capita funding system. Block grant funding is a flat payment to states. Under this option, states would have specified targeted spending

² Joint Statement from The Honorable Paul, Cruz, Johnson, and Lee (June 22, 2017), *available at* <https://www.paul.senate.gov/news/press/sens-paul-cruz-johnson-and-lee-issue-joint-statement-on-senate-health-bill>.

³ Senator Lisa Murkowski (@lisamurkowski), Twitter (June 22, 2017, 3:19 PM), *available at* <https://twitter.com/lisamurkowski/status/877984382425812997>.

⁴ Elise Viebeck, Washington Post, Sen. Susan Collins has ‘a Number of Concerns,’ Her Office Says (June 22, 2017), *available at* https://www.washingtonpost.com/politics/2017/live-updates/trump-white-house/gop-health-care-bill-the-latest-news-and-reactions/sen-susan-collins-has-a-number-of-concerns-her-office-says/?utm_term=.41b50571e68d.

amounts, and if a state's spending exceeds the targeted aggregated amount, the state would receive reductions to its Medicaid funding the next fiscal year.

The Senate bill does include carve-outs from its funding reductions for children with medically complex disabilities. Other changes to the Medicaid program include a 2020 sunset provision for Medicaid essential health benefits. This would end the ACA's guaranteed coverage of certain health benefits for individuals who receive coverage as a result of Medicaid expansion, including, but not limited to, prenatal, maternity, and postnatal care; emergency services; hospitalizations; prescription drugs; and preventive services. Notably, the Senate bill also would introduce new restrictions on states financing Medicaid through provider taxes. It also would impose new penalties upon states with high per capita spending levels and states that have relied on high levels of local funding to finance Medicaid.

C. Changes to Health Insurance Plans

Elimination of the individual and employer mandates

Like the House bill, the Senate bill would eliminate the ACA's individual and employer mandates retroactively, beginning for the 2016 plan year. The individual mandate requires individuals to purchase insurance or face a tax penalty. The employer mandate, likewise, requires large employers to offer coverage for full-time employees and their dependents.

Unlike the House bill, however, the Senate bill does not contain a provision that encourages individuals to maintain continuous coverage. The House bill allowed insurers offering plans in the individual market to increase premiums by a 30 percent penalty for one year, if an individual had a gap in coverage of at least 63 continuous days during the previous year. The CBO estimated that the House bill's continuous coverage provision would effectively induce 1 million individuals to purchase insurance in 2018. The provision's absence in the Senate bill is one example of a change that could affect CBO's estimates of the insurance coverage consequences of the Senate bill. Such distinctions mean there may be notable differences in the projected insurance coverage consequences of the two versions of the bill.

In many other respects, however, the House and Senate bills are parallel. Like the House bill, the Senate bill keeps the ACA's guaranteed issue requirement. Without a mechanism to encourage healthy individuals to maintain continuous coverage, some critics have charged that individuals may opt out of purchasing insurance until they become sick—leaving an insurance pool that is too sick and too small to effectively spread cost, thus creating an insurance market “death spiral.”⁵ On the other hand, if Senate Republicans had proposed to remove the popular provision, it could have imperiled the prospects of securing the bill's passage.

Changes to premium subsidies

Under the Senate bill, premium subsidy support for lower- and middle-income people to purchase insurance generally would decline, with certain exceptions.

⁵ See Larry Levitt & Gary Claxton, Henry J. Kaiser Foundation, *Is a Death Spiral Inevitable if There is No Mandate?* (June 19, 2012), available at <http://www.kff.org/health-reform/perspective/is-a-death-spiral-inevitable-if-there-is-no-mandate/>.

In order to incent the purchase of insurance coverage, the ACA provides premium subsidies to lower- and middle-income people who are ineligible for Medicaid. Instead of completely restructuring the premium subsidies offered under the ACA, as the House bill proposed, the Senate bill would retain the basic structure of the ACA's premium subsidies.

Under both the ACA and the Senate bill, premium subsidies increase at lower household income levels and as the price of plans goes up. Although the Senate bill does not depart from this basic structure, the bill proposes to make premium subsidies less generous overall, relative to the ACA. The ACA allows premium subsidies for individuals with household incomes between 100 and 400 percent of the federal poverty level (FPL). By contrast, the Senate bill would reduce the availability of premium subsidies to individuals with household incomes of up to 350 percent of the FPL.

For one group, the premium subsidies under the Senate bill would be more generous than under the current system. As a result of the Supreme Court's first ACA opinion, which made Medicaid expansion voluntary⁶—a “coverage gap” was created. A subset of individuals who reside in non-Medicaid expansion states with household incomes below 100 percent of the FPL make too much money to qualify for their state's Medicaid coverage but too little to qualify for federal subsidies. Over 2.5 million individuals fall in this coverage gap.⁷ By making premium subsidies available to all individuals with household incomes under 350 percent of the FPL, the Senate bill would eliminate this coverage gap, as well as make premium subsidies an option for low-income people more generally.

For most other individuals, the premium subsidies would be less generous than those offered under the ACA. Individuals with household income between 350 and 400 percent FPL would lose their premium subsidies in their entirety. Other individuals would see declines in the generosity of their premium subsidies because of how premium subsidy amounts are actually calculated. The ACA's premium subsidies are based on 70 percent of the actuarial value of a plan, which generally means that the plan is expected to pay for 70 percent of the cost of covered items and services. By contrast, under the Senate bill, premium subsidies would be based on only 58 percent of the actuarial value of a plan. In practice, this distinction reduces the generosity of the premium subsidies offered under the Senate bill when compared to the ACA.

The Senate bill also amends the “applicable percentage” schedule under the ACA, which is another component used to determine premium subsidies, by introducing an age component. The Senate bill amendment would provide comparatively more assistance for younger people and less assistance for older people.

Cost-sharing subsidies

Beginning in 2020, the Senate bill would end the ACA's cost-sharing reductions (CSRs), which reduce copayments, coinsurance, and deductibles for individuals with household incomes between 100 percent and 250 percent of the FPL. The bill does, however, expressly authorize

⁶ *Nat'l Federation of Indep. Bus. v. Sebelius*, 567 U.S. 519 (2012) (also upholding the ACA's individual mandate provision from various constitutional and statutory challenges).

⁷ Rachel Garfield and Anthony Damico, Henry J. Kaiser Foundation, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid* (Oct. 19, 2016), available at <http://www.kff.org/uninsured/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/>.

funding for CSRs for 2018 and 2019. This is notable because, in the ACA, Congress did not explicitly authorize appropriations for CSR payments. The Trump Administration has threatened to stop making CSR payments to insurers in the absence of an explicit Congressional appropriation.

State adjustment of age bands

The Senate bill would also allow states to increase the variation in rates insurers charge individuals based upon their age. The ACA currently allows insurers to charge older individuals up to three times more than they charge younger individuals based upon age. The Senate bill would allow states to increase this age band ratio to up to five-to-one. This would make coverage more expensive for older individuals.

Stabilization funds

The Senate bill includes \$50 billion to be used from 2018 to 2021 to fund arrangements with insurers that address coverage disruptions and to respond to other urgent health care needs. The Senate bill also includes an additional \$62 billion to be used from 2019 to 2026 to fund “long term stability and innovation allotments,” such as high risk pools. The total amount of money included in the Senate bill for stabilization funds is less than the \$138 billion included in similar funds provided for in the House bill.

Medical loss ratio (MLR) set by states

Beginning in 2019, the Senate bill modifies the ACA’s federal MLR requirement, which currently requires individual and small group plan issuers to spend at least 80 percent of their premium revenue on health care claims and quality improvements, or pay a rebate to its customers. Under the Senate bill, states would be allowed to set the MLR to be met by insurers within their borders, starting in 2019.

Abortion coverage

The Senate bill would prohibit plans offered on the exchanges from covering abortions.

State innovation waivers expanded

One of the most of the critical parts of the Senate bill as it applies to private health insurance is the significant expansion of the ACA’s section 1332 state innovation waivers. Under section 1332, the ACA allows states to seek waivers from certain requirements of the law, if certain guardrails are met, including a requirement that the waiver must provide coverage that is at least as comprehensive and affordable to a comparable number of individuals as it would provide under the waived requirements, and not increase the federal deficit. The Senate bill would remove these guardrails, except for the requirement that the waiver not increase the federal deficit.

Under a section 1332 waiver, a state could waive the ACA’s essential health benefits, out-of-pocket limits, actuarial value requirements, the financial assistance individuals receive in the form of premium subsidies and CSRs, and certain plan requirements applicable to exchange plans. States would not be permitted to waive the requirements for coverage of preventive

services, coverage of pre-existing conditions, coverage of children up to age 26 on their parents' plans, the prohibition on annual and lifetime caps, and other market rules.

Importantly, the Senate bill would replace the permissive provision that the Secretary of the Department of Health and Human Services (the Secretary) "may" grant waiver requests that meet the specified requirements with a mandatory provision that the Secretary "shall" do so. Therefore, it appears that the Secretary would be required to grant any allowable waiver request. Furthermore, under the Senate bill, waivers would not need to be enacted by state legislatures. Rather, the signature of a governor or a state insurance commissioner would suffice.

D. Changes to ACA Taxes

As is true of the House version of the bill, the Senate bill would repeal most of the taxes and annual fees established under the ACA going forward. They include, but are not limited to, the Medical Device Excise Tax, the Prescription Drug Tax, and annual fees on health insurers.

The bill also would temporarily repeal the so-called "Cadillac" tax, which imposes a 40 percent tax on any "excess" benefits above a certain dollar threshold. The tax already is subject to a moratorium through the end of 2019, and, effective on January 1, 2020, the Senate bill would repeal the tax entirely. But the bill would then reinstate the Cadillac tax effective January 1, 2026.

For the most part, the Senate bill's rollback of the ACA's tax provisions are not significantly different from the changes proposed in the House bill, though in some cases the effective dates of the repeals have been changed. Notably, the Senate bill would repeal the annual tax on branded prescription drugs effective January 1, 2018. The House bill would have retroactively repealed the annual excise tax on branded prescription drugs effective January 1, 2017. The medical device excise tax would also be repealed effective January 1, 2017 under the Senate bill, the same date as under the House bill. The medical device excise tax is already current subject to a moratorium for January 1, 2016 through December 31, 2017.

Another significant amendment is a change to the threshold above which medical, dental, and other related expenses may be deducted for income tax purposes. Under the ACA, individuals generally may deduct such expenses if they exceed 10 percent of adjusted gross income, if the individual (or their spouse) is under 65. The House bill would reduce this percentage to 5.8 percent of gross income. By contrast, the Senate bill would fix the percentage at 7.5 percent, which was the universal threshold before the ACA's enactment.

E. Other Changes

Defunding of Planned Parenthood for one year

The ACA designates certain safety net clinics and hospitals as essential community providers (ECPs). Identical to the House bill, the Senate bill would defund certain ECPs that offer abortions. The one year defunding period would start from the date of the enactment of the Senate bill. The defunding would not apply if abortions are provided by the ECP only in cases involving pregnancies resulting from rape or incest or cases where the woman suffers from a physical disorder, injury, or illness that her physician certifies would put her at risk of death

without an abortion. The defunding would apply only to ECPs that receive funding in excess of \$350,000,000. Only Planned Parenthood appears to meet this threshold.

Repeal of limitation on non-taxable contributions to flexible spending accounts

Similar to the House bill, the Senate bill would delete the ACA provision that establishes a cap on salary contributions to flexible spending accounts at an inflation-adjusted \$2,500. The Senate bill, however, would delete the cap effective on January 1, 2018, whereas the House bill would do so retroactive to January 1, 2017.

Increase in cap on contributions to health savings accounts (HSAs)

Under the Senate bill, effective January 1, 2018, the ACA's cap for contributing money to HSAs would increase. For self-only coverage, the HSA contribution cap would increase from \$2,250 to \$5,000. For family coverage, the HSA contribution cap would increase from \$4,500 to \$10,000. This provision also was included in the House bill.

Appropriation of funds to address the opioid epidemic

The Senate bill would appropriate \$2 billion in funding to address the opioid epidemic for FY 2018. The Secretary would be directed to use these funds to provide grants to states for the purpose of addressing substance use disorder treatment. Appropriated funds would remain available until used. The House bill included an appropriation for a \$45 billion fund over 10 years to address the opioid epidemic.