June 23, 2017

Senate GOP's Health Care Plan Reshapes House's Bill to Repeal and Replace the Affordable Care Act

When the House of Representatives narrowly passed H.R. 1628, the American Health Care Act (AHCA), and shipped it across the Capitol for the Senate's consideration, key senators said they intended to write their own bill instead. The discussion draft of the now renamed Better Care Reconciliation Act revealed by Senate Republican leaders on June 22 does differ from the House bill on many details, but it follows the same contours.

Notably, first, the Senate proposal undoes core provisions of the Affordable Care Act (ACA) while leaving many of that law's lesser-known features intact. Second, it picks up the House's fundamental redesign of the half-century-old Medicaid program even though the ACA's principal change to Medicaid was to expand benefits to a group of non-disabled low-income adults.

An initial impression of the Senate's outline is that it smooths some of the rougher edges of the AHCA, those features that apparently led President Trump to call the House bill "mean." Yet, in order to garner the votes of the most conservative Republican senators, the proposal does seek to deregulate many aspects of the health insurance market while reducing federal subsidies and eliminating taxes, as well as to impose rigid fiscal discipline upon the Medicaid program.

The Senate proposal's effects on Medicaid—which covers more than one of every five Americans, many of whom are the most vulnerable—could prove to be the deeper ones. As a result, industry stakeholders that rely upon Medicaid will need to gird for possible fiscal challenges ahead should Congress enact a bill that upholds the central features of this draft.

Insurance Market Reforms

The Senate leadership would alter the ACA's insurance market provisions in these important ways:

- The mandates on employers to cover workers and on individuals to secure health insurance would be eliminated. Unlike H.R. 1628, the Senate proposal does not replace this provision with an alternative incentive for individuals to maintain continuous insurance coverage.

- Subsidies to lower-income individuals to purchase health insurance would continue to be offered. However, these subsidies would be lower than the ACA's subsidies for most people because they will be tied to the price of less generous health plans. The proposal would also cap eligibility for subsidies at an income level of 350 percent of the federal poverty level (FPL)—in contrast to the ACA's 400 percent—while removing the eligibility floor for subsidies, allowing them to go to individuals with income below 100 percent of the FPL.

- Cost-sharing reduction subsidies for low-income individuals would be preserved through 2019 and then completely eliminated.

- Protections for people with pre-existing conditions are addressed in some ways that the H.R. 1628 would not, such as by preserving aspects of the ACA's essential benefits provisions and a requirement for community rating of premiums. However, the Senate proposal would allow for states to apply for waivers from certain insurance requirements, which may impact what insurers are required to cover.

- The pathway for states to seek so-called Section 1332 waivers to create home-grown mechanisms to prop up the non-group insurance market, such as reinsurance programs and high-risk pools, would be eased.

- The ACA's taxes on health insurers, medical device companies, tanning salons, and high-income individuals would be rescinded; the Senate proposal also defers implementation of the excise tax on high-value employer health plans until 2025.

Little Change to ACA Medicare Provisions

Provisions of the ACA that neither the House bill nor the Senate proposal would alter include, for example, a number affecting Medicare: promotion of value-based purchasing innovations such as accountable care; changes to the Medicare Advantage payment formula to bring that program's costs more in line with the per capita costs of

original Medicare; and the not-yet-launched Independent Payment Advisory Board meant to impose changes, as needed, to limit the growth of Medicare spending.

The Senate proposal, like the House bill, does cut off one of the funding sources for Medicare that the ACA created; the taxes on net investment income and high wages are to be eliminated.

Restructuring Medicaid Financing

On the Medicaid front, the Senate leaders' proposal would start by removing the ACA's enhanced federal matching percentage for the expansion population of non-disabled adults having incomes up to 133 percent of the FPL. This provision differs from the House bill only in its timing: The House's plan ended the enhanced funding in 2018 and forbade any new states from expanding immediately upon passage. The Senate's version would phase down enhanced funding over four years, beginning in 2020. It would, in effect, let any of the 19 states that have yet to take up expansion do so through 2019, though without the benefit of the enhanced federal match.

The Senate outline, like H.R. 1628, would terminate the original Medicaid program's open-ended entitlement whereby the federal government pays a share of states' Medicaid costs without any dollar limits. In its place would be a per capita allotment of federal dollars, plus an option for states to accept fixed block grants for some categories of beneficiaries in exchange for added flexibility.

We imagine that most states would opt for the per capita allotment, though states that are willing to reduce enrollment might prefer block grants. In the per capita allotment track, the Senate plan would define an allowable trend rate of federal payments per beneficiary equal to the medical component of the Consumer Price Index (M-CPI) for everyone except the aged and disabled, for whom the growth rate would equal M-CPI plus one percentage point. However, after 2024, the Senate would cut the inflator to the regular non-medical CPI, which tends to run well below M-CPI. Thus, the downward inflection of federal Medicaid spending would be very significant at that time.

The timing of computation of the baseline for per capita allotments is a significant sub-element. The Senate discussion draft lets states choose a baseline period of eight straight quarters between the first quarter of fiscal year (FY) 2014 and the third quarter of FY 2017, all now in the past. This will prevent states from running up Medicaid costs in order to pump up their baselines. Instead, it should inspire states to begin immediately to pare down Medicaid spending per beneficiary to create headroom for the day when per capita allotments take hold.

One might speculate that the Senate proposal is designed to yield a Congressional Budget Office (CBO) score that will remove fewer people from the insurance rolls within 10 years than the 23 million—of which 14 million were Medicaid beneficiaries—that CBO estimated would lose coverage under H.R. 1628. At the same time, with the change to plain CPI indexing of federal Medicaid funding after the CBO's scoring window will have closed for the most part, the longer-range outlook is that Medicaid will become seriously constrained. States will have to achieve peak efficiency in Medicaid

administration and care delivery, or ask more of state taxpayers, lest the program serve an even smaller population than would be the case under the House bill.

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