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Senate GOP Health-Care Bill Aims to Repeal and Replace the ACA. Does It Do That?

BY ROBERT F. ATLAS AND TIMOTHY J. MURPHY

Senate Majority Leader Mitch McConnell on June 22 released a ''discussion draft'' of the Better Care Reconciliation Act (BCRA), the Senate GOP's substitute for H.R. 1628, the American Health Care Act (AHCA) that narrowly passed in the House of Representatives on May 4. The BCRA largely follows the contours of the AHCA but, on close inspection, it diverges from the House bill on a number of key provisions.

As has been widely reported in the general media, the Congressional Budget Office (CBO) on June 26 released its score of the Senate bill. The CBO reported that 22 million fewer people would have health insurance in 2026 than under current law, close to the estimate of 24 million fewer insured under the House-passed bill. The CBO also projected the federal deficit would be lowered by a cumulative $321 billion over the ten-year scoring window, largely due to cuts both in Medicaid coverage and in subsidies granted to people buying plans on the individual market.

Here are some highlights of the Senate bill, some key differences from the House bill, and analysis of its effects.

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The Big Picture

Broadly stated, the two bills are intended to achieve three key Republican goals: (1) to lower taxes; (2) to reduce federal spending; and (3) to shift control over health care away from the federal government and to the states and the private market.

Both the House and Senate bills would undo core provisions of the Affordable Care Act (ACA) pertaining to the individual, or nongroup, insurance market. Both bills also propose wholesale restructuring of Medicaid financing, going well beyond rolling back the ACA's expansion of Medicaid benefits to a group of nondisabled low-income adults. And both bills leave intact some of the ACA's lesser known features, particularly ones affecting Medicare.

The Senate proposal's effects on Medicaid—which covers more than one of every five Americans, a diverse group that includes poor children and their mothers, people with serious mental illness and substance use disorders, and many frail elderly—appear to be deeper than its effects on the private insurance market. Accordingly, health-care providers, health plans and consumer advocates concerned about Medicaid, not to mention governors, are among the most vocal critics of the bill.

Tax Cuts

The Senate bill would rescind the ACA's taxes on health insurers, medical device companies, tanning salons, and high-income individuals. For the latter, under the ACA, there were both surtaxes on high wages and on net investment income above set levels. The bill also defers implementation of the excise tax on high-value employer health plans until 2026. CBO scored these and some related changes as reducing federal revenues by $541 billion over ten years.

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Insurance Market Reforms

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

Coverage Mandates The mandates on employers to cover workers and on individuals to secure health insurance would be eliminated. The House bill replaced the mandate with a provision stating that insurers could apply a 30 percent surcharge to first-year premiums for enrollees who had a gap in coverage. The Senate proposal, when first issued, was silent on this issue, stirring a fear that large numbers of healthy people would forgo purchasing insurance until they actually became ill or injured, thus throwing the entire risk pool out of balance. On June 26, the Senate version was amended to include a six-month enrollment lockout for any individual who had a gap in coverage greater than 63 days in the preceding 12 months.

Subsidies for the Purchase of Individual Plans Subsidies for lower-income individuals to purchase health insurance would be extended. However, these subsidies would be lower than the ACA's subsidies for most people because they would be tied to the price of less generous health plans. The proposal also would 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 FPL. Subsidies would be realigned so that, when combined with the age-band rating change to 5:1 from 3:1, older people would be disfavored. The CBO estimated, for example, that a 40-year-old with annual income of $56,800 (375 percent of FPL) buying a plan with 58 percent actuarial value—that is, a plan that would cover 58 percent of the average enrollee's total annual health costs—would pay an annual premium of $5,000. A 21-year-old in the same situation would pay $3,200. A 64-year-old would pay $16,000. Under current law, the 64-year-old's premium (for a plan having 60 percent actuarial value, the ACA's benchmark) would be $4,400 and the 21-year-old's would be $4,300.

Cost-Sharing Reductions The ACA also provides for the subsidization of cost-sharing associated with the use of health services—deductibles and coinsurance—for low-income individuals. The Senate bill would continue funding the cost-sharing reductions through 2019, after which these subsidies would simply terminate. The effect would be to raise significantly the effective cost of coverage for people of lower means.

Pre-Existing Conditions, Essential Health Benefits, Lifetime Limits, Etc. The Senate bill addresses protections for people with pre-existing conditions in some ways that H.R. 1628 does not, such as by preserving aspects of the ACA's essential health benefits (EHB) provisions and a requirement for community rating of premiums. However, the Senate bill creates a very easy pathway for states to obtain waivers of such requirements. For instance, states could opt to delete some services from the list of EHBs, or to adjust minimum actuarial values of plan coverage, in the interest of allowing insurers to sell lower-priced products. While the bill does not explicitly eliminate the ACA's prohibition on lifetime benefit limits, any of these changes that states adopt could have the effect of reinstating such limits as they may apply to services not classified as EHBs.

Small-Group Health Plans The Senate bill would amend ERISA to allow for small-business health plans, plans that could lash together multiple affiliated small employers. Such plans would be certified by the Department of Labor and sold to participating employers, potentially across multiple states, without necessarily meeting the state insurance regulations in every state where covered members live.

Some ACA Provisions Unchanged

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 may be needed in the future to limit the growth of Medicare spending.

Neither of the Republican bills would do away with the popular ACA provision allowing children to remain on their parents' health insurance plans until age 26.

Restructuring Medicaid Financing

The Senate bill, much like the House's version, makes two major changes to Medicaid, one related to an ACA-initiated provision, the other going directly to the core of the original Medicaid entitlement created in 1965 as one of the pillars of the Great Society initiative.

The Senate GOP proposal would start by removing the ACA's enhanced federal matching percentage for the expansion population of nondisabled adults having incomes up to 133 percent of the federal poverty level. This provision differs from the House bill only in its timing: The House's plan would end the enhanced funding abruptly in 2018 and forbid any new states from expanding immediately upon passage. The Senate's version would phase down enhanced funding after 2020; the federal contribution would be 85 percent in 2021, 80 percent in 2022, 75 percent in 2023, and then the regular federal matching percentage for nonexpansion beneficiaries, which ranges between 50 percent for states with high per capita incomes to 80 percent for low-income states. It would, by silence, let any of the 19 states that have yet to take up expansion do so through 2019, though without benefit of the enhanced federal match.

The Senate bill, as well as the House version, 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, beginning in 2020, 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.

Most states would likely opt for the per capita allotment because it is less risky to do so, though states that are willing to reduce Medicaid 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 compo-

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nent of the Consumer Price Index (M-CPI) for everyone except the aged and disabled; for those categories the annual growth rate would equal M-CPI plus one percentage point. However, after 2024, the Senate would cut the inflator to the regular CPI.

The CBO noted that the Medicaid per capita cost trend under current law is projected to be 4.9 percent per year, whereas the M-CPI would be 3.7 percent and the regular CPI would be 2.4 percent. Thus, the downward inflection of federal Medicaid spending would be very significant right away and would become dramatic starting in 2025.

The timing of computation of the baseline for per capita allotments is a significant sub-element. The Senate bill lets states choose a baseline period of eight consecutive quarters between the first quarter of FY 2014 and the third quarter of FY 2017. This specification of the baseline period would inspire states to begin immediately after the bill's passage to pare down Medicaid spending per beneficiary to create headroom for 2020 when per capita allotments take hold.

Owing to these changes to Medicaid, the CBO, in its score, noted that of the 22 million additional people who would be uninsured in 2026, 15 million would come off of Medicaid. At the same time, with the change to plain CPI indexing of federal Medicaid funding after the CBO's scoring window will have mostly ended, 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 they be compelled to cut benefits, reduce eligibility, and/or lower rates of payments to participating health plans and providers.

What Happens Next?

Ahead of the July 4 recess, the Senate leadership could not muster the votes of the minimum number of senators needed to pass a bill under budget reconciliation rules. Reportedly, work continued over the holiday and a revised bill is due to be released on or about July 13. It is said that the tax cuts on higher-income taxpayers may be removed in response to concerns that the bill appeared to take from the poor to give to the rich. Also, a proposal by Sen. Cruz may be adopted. It would segment the market into heavily regulated subsidized plans for people with high cost conditions and less regulated, less comprehensive plans for people currently healthy. Senate Majority Leader McConnell intends to push for a vote very soon and may delay the start of the August recess by two weeks to allow time for that to happen. If the Senate does pass a bill, it will need to be reconciled with the House version and then both chambers would need to vote upon the final product. Or, the House could decide simply to adopt the Senate bill in full in the interest of getting this legislation out of the way.