

## PERSPECTIVES ON HEALTH CARE & LIFE SCIENCES



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### **Senate Health Care Bill 2.0: Implications for Health Care Stakeholders**

The new version of the Senate Republicans' draft bill to repeal and replace the Affordable Care Act (ACA), known as the Better Care Reconciliation Act (BCRA), was released July 13. This second pass includes changes meant to mollify both conservatives who wanted to make the bill less like the "ObamaCare Lite" that some had dubbed the previous version as well as moderates who wanted more protections for lower-income populations, in particular Medicaid beneficiaries.

The proposal does contain things that both camps will appreciate, though on balance it appears slanted more toward the conservatives' preferences. This judgment is based on the bill's preservation of the original draft's deep long-term cuts to federal Medicaid contributions. Overall, though, political reporters are saying the odds are very low that 50 GOP senators will sign on, because some moderates and some conservatives remain dissatisfied.

#### **Key Changes Since BCRA 1.0**

The revised bill is very similar to the original bill but uses 27 more pages to accomplish its changes. Here are a few highlights:

## *Taxes*

All the industry taxes are still rescinded. The taxes on higher-income individuals—the net investment tax and the add-on Medicare Health Insurance Tax—would remain in effect. These funds are needed to pay for subsidies not found in the original bill; plus, the optics of cutting taxes on the wealthy while cutting benefits for the poor were not favorable.

## *Health Insurance Market*

The revised bill retains the original version's elimination of ACA coverage mandates, replacement of ACA subsidies with less-generous tax credits, and easy pathway for states to receive waivers of provisions such as essential health benefits.

A new feature, offered as an amendment by Sen. Ted Cruz (TX), would allow insurers selling plans on the exchanges to sell non-compliant plans—ones with less complete coverage—as long as they also offer ACA-compliant plans. Recognizing that the compliant plans would no doubt attract a sicker population while healthier people would be drawn toward the non-compliant, lower-priced plans, the revised bill does offer some limited funding to help insurers cover the costs of higher-risk individuals selecting the comprehensive plans.

The health insurance industry, which heretofore was rather muted in response to the House-passed bill and the first Senate proposal, has come out loudly saying this would destabilize the individual insurance market by splitting it into healthy and sick groups, violating the concept of risk pooling that underlies the concept of insurance.

The new draft also provides an extra \$70 billion, on top of the \$112 billion proposed in the first version, for a long-term market stabilization fund, now specifically designated to subsidize the costs of high-need individuals enrolled in exchange plans.

BCRA 2.0 also allows individuals to use health savings accounts to pay their health insurance premiums in a tax-advantaged manner. Further, it permits individuals under age 30 to use premium tax credits to purchase catastrophic policies that have high deductibles and limited first-dollar coverage for primary care. Beginning in 2019, the revised bill would allow premium tax credits to be used to purchase a catastrophic policy, regardless of age.

## *Medicaid*

The revised bill keeps the same fundamental changes to Medicaid that appeared in the first draft. These include the phase-out of enhanced matching for the expansion population and the imposition of per capita caps on federal contributions to states' Medicaid costs, with trending limited to the medical component of the Consumer Price Index (CPI) through 2024, then dropping to the regular CPI for urban consumers in 2025.

This provision met with strongly negative responses from hospitals and state governors when the first bill was released, and given that it remains unchanged now, those stakeholders' sentiments are unlikely to change.

One provision of the new bill meant to appease governors is the insertion of \$45 billion to combat the opioid crisis, replacing the \$2 billion worth of funding offered for this purpose in the original bill. Compared to the nearly \$800 billion worth of Medicaid reductions, however, the opioid funding may not sway many opinions.

A few new Medicaid features do appear: limited lifting of per capita allotments in cases of localized public health emergencies, funded up to \$5 billion in total; an option for states that elect the block-grant track to include the expansion adults in the block-grant package; and an \$8 billion demonstration project to spur more use of home- and community-based services for the aged and disabled populations, especially in states with lower population densities. The bill also would change the calculation method for Disproportionate Share Hospital payments from per Medicaid beneficiary to per uninsured person.

### **Takeaways for Stakeholders**

As noted, health insurers are wary of the new bill's effects on the stability of the individual insurance market. Advocates for the chronically ill and people with other pre-existing conditions are worried that they will be priced out of the market altogether. Hospitals, other providers, and governors remain concerned that Medicaid funding will become too limited to sustain decent coverage and payment in the long run.

The Congressional Budget Office (CBO) is set to release a fresh score of the bill early next week. It is conceivable that the CBO will lower by a small amount the number of newly uninsured from the 22 million the agency said would be created by the first bill. However, much depends on whether the CBO judges the skimpier plans created by this bill to be adequate coverage at all. If not, the CBO may say that the number of uninsured will be the same or greater. That number could sway undecided senators one way or another in their votes on moving the bill forward.

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