

# Health Care Reform Management Alert Series



## Senate Efforts at Health Care Reform

## Issue 110

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*This is the one hundred and tenth issue in our series of alerts for employers on selected topics on health care reform. (Click [here](#) to access our general Summary of Health Care Reform and other issues in this series.) This series of Health Care Reform Management Alerts is designed to provide an in-depth analysis of certain aspects of health care reform and how it will impact your employer-sponsored plans.*

**Seyfarth Synopsis:** *The epicenter of the health care repeal and replace effort has moved from the House of Representatives to the Senate. After several weeks of drafting behind closed doors, the Senate introduced the Better Care Reconciliation Act (BCRA) a few weeks ago, which faced immediate and heavy criticism. Seeing that he did not have enough votes to move the BCRA forward, Senator Mitch McConnell pulled the bill back to consider certain amendments to appease objections from various law makers. That effort has resulted in BCRA 2.0 released on Thursday, July 13th.*

In early May, the House passed the baton to the Senate on the Republicans' repeal and replace efforts. The Senate was almost uniformly disdainful of the House efforts that produced the [American Health Care Act \("AHCA"\)](#). Even President Trump labelled it a "mean" bill. A small group in the Senate quickly went to work conducting their legislative efforts in secrecy (from fellow Republicans as well as Democrats) and many were holding out hope that the Senate would scrap the AHCA and create meaningful reform. However, the iterations of the Senate health care reform bill eventually released (the latest version of their Better Care Reconciliation Act, or "BCRA", just this week) continue a similar approach as the House bill. The deep cuts to Medicaid remain and the Congressional Budget Office (CBO) score of the (first version of the) BCRA predicts 22 million fewer Americans will have coverage in ten years (as compared to the ACA) -- just slightly better than the 23 million under the AHCA.

Almost immediately Republican Senators were publicly stating their opposition to the BCRA. A few were concerned with the loss of Medicaid coverage that would impact their states, others concerned that the opioid epidemic was not addressed, and still others felt the roll back of the ACA provisions did not go far enough. BCRA 2.0 was released on Thursday, July 13th, to try to meet some of those objections and retain the 50 Republican votes needed to pass.

An updated (and necessarily simplified) chart comparing the ACA against the AHCA and BCRA is below.

## What Changed from BCRA 1.0 to BCRA 2.0?

Notable changes to the originally-drafted BCRA include:

- *Cruz Amendment.* Most notably, BCRA 2.0 includes a controversial amendment drafted by Senator Ted Cruz that creates a two-track structure -- one for policies offered on the Exchanges and another for insured policies not on an Exchange. Insurers will be allowed to issue policies that do not cover all essential health benefits and that take into account a person's health status, claims history, and disability condition (that is, take into account pre-existing conditions) as long as they also maintain compliant plans on the Exchanges. As a result, individuals with pre-existing conditions may not have affordable access to coverage except perhaps through the Exchanges. This change could certainly impact the individual market but it also has the potential to impact the group market (e.g., for employers fully-insuring health insurance coverage). BCRA 2.0 attempts to handle this concern by allocating funds to the Exchanges for high-risk claims -- a risk pool approach. What remains unclear is whether this proposal creates two risk pools or a single risk pool (covering both compliant and non-compliant plans). A last minute revision appears to have modified the Cruz amendment to lump both populations into the same risk pool. This change has led to some confusion among insurance carriers and even Senator Mike Lee (who was an ardent supporter of this amendment as originally proposed) as to how this might work.
- *Retention of ACA's Taxes on High Earners.* BCRA 2.0 also keeps some of the taxes in place that supported the ACA structure. The 3.8% tax on investment income and the 0.9% Medicare tax on high wage earners will remain in place, as will the deduction limit on salaries for insurance company executives.
- *Opioid Funding.* BCRA 2.0 increases the funding pool for addressing the opioid epidemic from \$2 billion to \$45 billion.
- *Use of HSAs for Premiums.* BCRA 2.0 would permit persons to use health savings account balances to pay health insurance premiums.

## What's Not Changing from BCRA 1.0?

Notably, in what could be a potential sticking point for moderate Republicans, the funding cuts to Medicaid and per capita cap system stay in place under BCRA 2.0. However, in the event of a public health emergency, state spending on related costs would not count towards the caps. It's unclear whether this tweak would be enough to win over moderate holdouts.

## What Happens Next?

The CBO score on BCRA 2.0 has not come out yet. Some in the Senate are suggesting that the Department of Health and Human Services (HHS) should score the bill (or, at the very least, the Cruz Amendment) instead of the non-partisan CBO as it will be a faster process. That suggestion has met with pushback.

If enough Republicans are swayed by the changes in BCRA 2.0 to get 50 votes, the Senate will likely vote next week (or before their August recess). If the 50 votes are not there, Senator Mitch McConnell may be forced to work with Democrats to get a meaningful reform effort off the ground.

As of today, two Senate Republicans (conservative Rand Paul and moderate Susan Collins) have indicated they would not vote to move the bill to the floor for debate. This procedural vote will be crucial, because once the measure moves to the floor, Senator McConnell has more flexibility to cut deals with individual Senators to pick off opposition.

## Comparison Chart

Issue	ACA	AHCA	BCRA 1.0/2.0
<b>Plan Design, Cost and Coverage Items</b>			
Employer Mandate	Large employers must offer minimum value, affordable coverage to full-time employees, or pay a penalty	No penalty for failure to comply with the employer mandate	No penalty for failure to comply with the employer mandate
Encouraging Individuals to Purchase Health Coverage	Individual Mandate	Individual Mandate Penalty reduced to \$0 <i>Continuous Coverage Penalty:</i> Individuals with a break in coverage in excess of 63 days within the last 12 months OR those who aged out of parents plan and did not enroll in own coverage at next open enrollment period, must pay a 30% premium surcharge to the insurance carrier to re-enroll in coverage. For up to 12 months.	Individual Mandate Penalty reduced to \$0 <i>Continuous Coverage Penalty:</i> Individuals with a break in coverage in excess of 63 days within the last 12 months OR those who aged out of parents plan and did not enroll in own coverage at next open enrollment period, can be excluded from purchasing coverage for six months.
Affordability of Coverage	Cost-sharing subsidies for lower-income individuals for Exchange Plans  Income-based premium tax credits to assist lower-income individuals (between 100% and 400% of FPL) purchasing health insurance on the Exchanges with plan AV of 70%	Age-based credits only: \$2,000 < 30 \$2,500 between 30 and 40 \$3,000 between 40 and 50 \$3,500 between 50 and 60 \$4,000 > 60  Phased out for persons earning in excess of \$75,000 (\$150,000 for joint filers)	Cost-sharing subsidies for lower-income individuals for Exchange Plans. Funded through 2019.  Tax credits available for those making up to 350% of FPL (including those below 100% of FPL); based on a plan with AV of 58%  <b>BCRA 2.0:</b> Two-Track System -- May use tax credits to pay for catastrophic insurance coverage (not meeting minimum coverage standards)
Premium Rating	May not charge more for health status (i.e., pre-existing conditions)	May charge 30% more than standard rate where lapse in coverage within the last 12 months.  Allows states to waive community rating standards. Instead of surcharge for lapse of coverage, states may apply for a waiver to allow health status rating for a 12-month period.	May not charge more for health status (i.e., pre-existing conditions);  Surcharge may be added in an amendment;  No state waiver provision  <b>BCRA 2.0:</b> Two-Track System -- Insurers could offer plans that charge more (or deny coverage) based on health status if they offer Exchange plans as well.
	Older enrollees may not be required to pay more than 3x the rate of younger enrollees	Older enrollees may not be required to pay more than 5x the rate of younger enrollees;  States may apply for a waiver to allow for an even greater age weighting	Older enrollees may not be required to pay more than 5x the rate of younger enrollees;  States may apply for a waiver to allow for an even greater age weighting

Essential Health Benefits	<p>Requires coverage by plans on Exchange of 10 categories of EHBs:</p> <ul style="list-style-type: none"> <li>- Ambulatory patient services (outpatient care);</li> <li>- Emergency services;</li> <li>- Hospitalization;</li> <li>- Maternity and newborn care;</li> <li>- Mental health services and addiction treatment;</li> <li>- Prescription drugs;</li> <li>- Rehabilitative services and devices;</li> <li>- Laboratory services;</li> <li>- Preventive services, wellness services and chronic disease treatment;</li> <li>- Pediatric services.</li> </ul>	Allows states to waive the requirement of EHBs for plans on their exchange	<p>Allows states to waive the requirement of EHBs for plans on their exchange</p> <p><b>BCRA 2.0:</b> Two-Track System -- Insurers could offer plans that do not satisfy EHBs if they offer Exchange plans as well.</p>
Generosity of Plan Coverage	Plans on individual and small group markets must offer 10 EHBs listed above, comply with cost-sharing limitations, and meet certain actuarial value levels	The provisions on actuarial "metal" levels have been repealed	<p>ACA actuarial Metal levels remain</p> <p>States may waive the ACA actuarial value level.</p> <p>States may waive definition of a "quality health plan"</p>
Medicaid	<p>State expansion funded by Federal Government:</p> <p>133% of FPL was minimum income-eligibility level; State option to extend coverage for those with income above this minimum</p>	<p>Gradual phase out of expansion beginning 12/31/19; shift Medicaid funding to per capita or block grants (i.e., federal contribution is set subject to income inflation), meaning states carry the primary risk of increasing costs</p> <p>Five eligible categories of elderly, blind and disabled, children, expansion enrollees, and others.</p> <p>\$880 billion of cuts to program</p> <p>Will no longer have to cover 10 EHBs in 2020</p> <p>Option to extend to those above 133% of FPL is repealed after 3/1/2017</p>	<p>Gradual phase out of expansion beginning 12/31/20 through 12/31/23;</p> <p>Shift Medicaid funding to per capita or block grants (i.e., federal contribution is set subject to CPI-M inflation until 2025 when CPI inflation), meaning states carry the primary risk of increasing costs</p> <p>Five eligible categories of elderly, blind and disabled, children, expansion enrollees, and others. Carves out medically complex children from cap.</p> <p>Deeper cuts than AHCA (&gt;\$880 B)</p> <p>Will no longer have to cover 10 EHBs in 2020</p> <p>Option to extend to those above 133% of FPL is repealed after 12/31/2017</p> <p><b>BCRA 2.0:</b> In event of a <i>public health emergency</i>, state spending will not count against spending caps.</p>

Risk Pools/ Stability Funds	Funding for temporary high risk pools between 2010 and 2014 Marketplaces with shared risk pooling effective 2014, with high cost claims offset by new taxes (such as the Transitional Reinsurance Program fee)	\$100B over 10 years into funding state efforts; up to states as to how to apply: - \$15B for each of 2018-19 - \$10B for each of 2020-26 \$8B for states with waivers to help on premiums and OOP in 2018-2023 \$15B from 2018-2026 to pay insurers for help with high claims for certain individuals	Four year reinsurance program; Short-term: \$50B to CMS to help insurers: - \$15B for each of 2018-19 - \$10B for each of 2021-22 Long-Term: \$62B from 2019-26 into funding state efforts, being front-loaded. States required to match an increasing % beginning in 2022. State Performance Bonuses: \$8B distributed by HHS to state Medicaid and CHIP programs (2023-2026)
Public Health Funds	\$1B for Prevention and Public Health Fund	\$15B for maternity and mental health in 2020	\$2 billion in 2018 for states substance-use-disorder treatment and recovery support services (opioid funding) Medicaid coverage of inpatient psychiatric care ages 21-65 up to 30 days/mth or 90 days/yr. <b>BCRA 2.0:</b> Additional \$70B to states to reduce premiums and hold down OOP costs. <b>BCRA 2.0:</b> Additional \$45B for opioid crisis.
<b>Tax-Advantaged Accounts</b>			
Health Savings Accounts	Increases the excise tax on non-medical withdrawals from 10% to 20%	Reduces the excise tax on non-medical withdrawals back to 10%	Reduces the excise tax on non-medical withdrawals back to 10%
		Permits deposit of age-based tax credits into an HSA	
		Significantly increases HSA contribution limits to the inflation-adjusted deductible/out-of-pocket maximum limits for HDHPs	Significantly increases HSA contribution limits to the inflation-adjusted deductible/out-of-pocket maximum limits for HDHPs
		Permits reimbursement of expenses incurred pre-HSA establishment, if HSA is established within 60 days of the date qualifying HDHP coverage commences	Permits reimbursement of expenses incurred pre-HSA establishment, if HSA is established within 60 days of the date qualifying HDHP coverage commences
		Permit both spouses to make catch-up contributions to an HSA	Permit both spouses to make catch-up contributions to an HSA
			<b>BCRA 2.0:</b> Allows HSA balances to be used to pay premiums

Over-the-Counter Drugs	Prohibits tax-free reimbursement for over-the-counter drugs (e.g., through HSAs, FSAs, etc.)	Removes prohibition on reimbursement for tax-free over the counter drugs	Removes prohibition on reimbursement for tax-free over the counter drugs
Health Flexible Spending Cap	Capped health FSA contributions at \$2,500 (adjusted for inflation)	Removes health FSA cap for 2017	Removes health FSA cap for 2018
<b>Tax Provisions</b>			
Additional Medicare Tax for High Wage Earners	Imposed an additional 0.9% Medicare HI tax for high wage earners	Removes additional Medicare HI tax 2023	Repeals tax increase effective 2023 <b>BCRA 2.0:</b> Keeps tax in place
Net Investment Income	3.8% tax on certain passive income	Removes tax 2017	<b>BCRA 2.0:</b> Keeps tax in place
Wages Paid by Insurers	Wages paid in excess of \$500,000 to officer, director or employee of insurer is not deductible	Repealed 2017	Repealed 2017 <b>BCRA 2.0:</b> Keeps limit in place
Tanning Tax	10% tax on indoor tanning services	Repealed	Repealed
Rx Tax	Annual tax on manufacturers or importers of certain branded drugs	Repealed 2017	Repealed 2018
Health Insurance Tax	Annual fee on health insurers	Repealed 2017	Repealed 2017
Excise Tax on High Cost Health Plan	40% Cadillac Tax effective 2020	40% Cadillac Tax delayed to 2026	40% Cadillac Tax delayed to 2026
Medical Device Tax	2.3% excise tax on sale of certain medical devices (was in a moratorium 20-16-2017)	Repealed 2017	Repealed 2018
Rx Retiree Coverage Deduction	Eliminated deduction for employers who receive a Medicare Part D prescription drug subsidy	Reinstates deduction for employers receiving Medicare Part D prescription drug subsidy in 2017	Reinstates deduction for employers receiving Medicare Part D prescription drug subsidy in 2018
Itemized Medical Care Deductions	Threshold increased from 7.5% to 10% of AGI	Reduced threshold to 5.8% of AGI in 2017	Reduced threshold to 5.8% of AGI in 2017
Small Businesses	Small Business Health Insurance Tax Credit	Will be sunset	Amends ERISA to set up insured small business health plans

Medicaid Provider Tax	6% tax		Reduced by .2% a year beginning in 2021 until hits 5%
<b>Material ACA Provisions Left in Place</b>			
Adult child coverage	Coverage mandated for children through age 26	Same	
Preventive Services	First dollar coverage mandated	Same (except for regulatory push to narrow scope of contraceptive mandate)	
Lifetime and annual limits	Prohibited on Essential Health Benefits	Same	
Out-of-Pocket maximums	Limit of \$7,150 self-only; \$14,300 family (Indexed)	Same	
Non-Discrimination requirements	Providers acting within scope of license  Section 1557	Same	
Medical Loss Ratios	Insurers must spend at least 80-85% of premiums on care, or refund to customers	Same	Beginning in 2019, states may determine the MLR.
Medicare	Cuts to reimbursement rates (based on increased insured pool)	Same cuts (predicted smaller insurance pool)	

Seyfarth Shaw will continue to monitor Congressional and regulatory efforts and will alert clients as new developments occur.

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