

# Health Care in Motion

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## Fundamental Meanness: Senate Unveils Health Care Proposal That Would Drastically Reduce Access to Care for Millions of Americans

On June 22, 2017, after weeks of secretive closed-door drafting, Republican leadership in the Senate released a [discussion draft](#) of their bill aimed at repealing and replacing key portions of the Affordable Care Act (ACA). The Senate's bill, titled the Better Care Reconciliation Act of 2017 (BCRA), largely cribs from the structure of the House bill, the American Health Care Act<sup>1</sup> (AHCA), but includes some notable changes. While Senate Republican leaders claim that these changes would soften the negative impact the AHCA has on vulnerable and lower-income consumers, many critics have noted that the Senate bill would actually include deeper Medicaid cuts and a significant rollback of key consumer protections of the ACA. Particularly concerning, the BCRA would dramatically modify Medicaid by shifting it from an entitlement program to per capita caps that put far more of the financial burden on states. This change, along with other elements of the BCRA, demonstrates that Senate Republicans are committed to pursuing legislation that will make health care less affordable and less accessible for millions of Americans.

Despite the strong outcry against the secretive process in which the BCRA was drafted, Republican leadership continues to operate far outside regular order for considering legislation. Senate leadership largely drafted their bill in [closed sessions](#) with no public input, hearings, or debate. The bill will not be sent through any Senate committee for consideration or amendment, and no hearings or other opportunities for debate are planned. These procedural deficiencies are particularly startling for a major legislative proposal that will impact millions of Americans' access to health care. Rather, the Congressional Budget Office (CBO) is expected to release its evaluation of the bill's cost and coverage impacts early next week, and leadership plans to hold a [vote](#) very shortly thereafter. This accelerated timeline affords limited opportunities for stakeholders to weigh in and raises significant transparency concerns. Due to this short timeframe and the major impacts the BCRA could have on the American health care system, advocates should move quickly to respond.

### Advocates should:

- 1. Understand the potential impact the BCRA would have on the private insurance market, including limiting subsidies received by lower-income individuals and weakening consumer protections for people living with pre-existing conditions.**

<sup>1</sup> For an in-depth discussion of the AHCA as passed by the House, please see our previous *Health Care in Motion* piece [here](#).

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2. Understand the ramifications the BCRA would have on ending Medicaid expansion and limiting federal financial support of Medicaid. Advocates should recognize how these financial changes will impact eligibility and benefits for their state's Medicaid program.
3. Move quickly to educate their [Senators](#) on the negative impact the BCRA would have on access to care for vulnerable and low-income individuals in their state.

## The Senate's Proposal Will Make it Harder for All Consumers, Particularly Vulnerable Populations, to Access Meaningful Coverage on the Private Market

While the BCRA does not directly dismantle the private insurance state Marketplaces, it does remove measures meant to ensure that the insurance products offered in those Marketplaces would be affordable and provide meaningful coverage. The BCRA reduces the subsidies designed to make insurance affordable for lower-income consumers. It also directly removes many consumer protections and allows states to easily secure waivers from still more.

### Affordability

Under the ACA, premium subsidies are scaled based on income and the local cost of coverage, and are designed such that lower- and moderate-income consumers' contributions towards premiums are capped at a reasonable percentage of their income. Enrollees with incomes from 100-400% of the Federal Poverty Level (FPL) qualify for these subsidies. The ACA also placed guardrails limiting how much more insurers could charge older consumers for premiums.

The BCRA, however, modifies the ACA's subsidies to limit them to those with incomes up to 350% of FPL and reduce the overall amount of financial support offered. The BCRA's subsidies also decrease based on age, with older individuals receiving far less financial support than under the ACA. For example, an individual over the age of 59 with an income that is 300% FPL is expected to contribute 11.5% of their income towards premiums, whereas this individual would pay no more than 9.5% of their income under the ACA.

Additionally, the BCRA would further decrease the financial support provided to lower-income enrollees by modifying the "benchmark" plan used to calculate the amount of the subsidy provided. Under the ACA, premium subsidies are calculated with reference to a benchmark plan, the second-lowest cost [silver level](#) health plan available to consumers. The difference between an enrollee's premium contribution cap and the benchmark premium determines the amount of the subsidy. This was designed to ensure that lower-income individuals could purchase a health plan that covers a sizable percentage of expenses, as silver health plans are required to cover 70% of an enrollee's health care expenditures.

The BCRA would determine the subsidy amount with reference to a benchmark plan that only covers 58% of an individual's health care needs. This would reduce the size of the subsidies further, as the benchmark plan's premium would likely be lower. As a result, low-income individuals may only be able to afford health plans that push more out-of-pocket costs onto consumers and are only meant to provide catastrophic coverage. This is especially concerning for people living with chronic illnesses and disabilities, as these individuals rely on affordable access to regular medical care and other services.

Furthermore, the BCRA would eliminate the ACA's [cost-sharing reductions](#), which help lower the costs of deductibles,

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copayments, and coinsurance for low-income individuals. The cost-sharing subsidies have been a source of constant anxiety for insurers in recent months, as the Trump Administration has consistently refused to commit to funding this program. In response, many insurers have either [increased premiums](#) or exited the ACA's Marketplace altogether. While the BCRA would formally appropriate funds for the cost-sharing reductions for 2018 and 2019, it would eliminate them beginning in 2020. More than [5.6 million](#) individuals, accounting for 59% of all Marketplace enrollees, received these cost-sharing reductions in 2016. Eliminating these important subsidies, along with scaling back the premium tax credits, will place increased financial burdens onto those with lower incomes, forcing these individuals to potentially forego needed services and treatment.

## Insurance Market Changes and Rollback of Key Consumer Protections

The BCRA does retain some of the consumer protections that its House counterpart, the AHCA, would repeal, although it will allow states the flexibility to secure waivers of many of the consumer protections it appears to spare. The ACA's prohibition on denying coverage to those living with pre-existing conditions or charging these individuals higher premiums based on their health status would remain in the BCRA. The BCRA would also retain the ACA's Essential Health Benefits (EHBs) and actuarial value<sup>2</sup> requirements for qualified health plans sold on the Marketplace. As discussed below, however, states could individually request waivers of many of these requirements for insurance plans sold in their states.

The BCRA would also eliminate the individual mandate to obtain health insurance, which is a key cornerstone of the ACA's insurance reforms. By requiring most individuals to enroll in health insurance coverage, the individual mandate increases the number of healthy individuals in insurance pools, ensuring that insurers collect enough premiums to pay for the cost of providing care to sicker individuals who incur higher health care expenses. Insurance experts have [recognized](#) that requiring insurers to accept all patients at the same premium rates without an incentive to buy coverage runs the risk of destabilizing insurance markets. Removing the individual mandate will likely cause healthier enrollees to "opt out" of purchasing coverage, while those who need health coverage, such as individuals living with chronic illnesses and disabilities, will continue to need access to coverage. The resulting imbalance in insurance enrollment could potentially increase premiums by up to [20%](#).

In an effort to mitigate this impact, the BCRA provides states with funds through a State Stability and Innovation Program to create reinsurance programs, high-risk pools, or other Marketplace stabilization efforts. The fund will provide a total of \$112 billion for state use between 2018 and 2026, an average of \$11.2 billion per year with each year's allotment fluctuating. However, these funds would likely be [inadequate](#) to fund robust enough high-risk pools to compensate for other changes to the Marketplace, and, in any case, [past experience](#) with high-risk pools has shown that [they do not work](#). While a reinsurance program or other efforts might help stabilize the problems associated with removing the individual mandate, adequate funding is key, and the small amount provided to states by the BCRA is likely insufficient.

Perhaps most concerning, the Senate's bill would allow states to undermine key consumer protections for vulnerable populations. The BCRA would give states far greater flexibility to design their individual insurance Marketplaces, even at the cost of access to care. States would be allowed to increase the age rating band above the 3 to 1 ratio currently permitted, which would cause premiums to skyrocket for older Americans seeking coverage in the Marketplaces.

Furthermore, the BCRA would give states far greater leeway to obtain waivers from key ACA requirements through Section 1332.<sup>3</sup> Currently, states may apply to the Centers for Medicare and Medicaid Services under Section 1332 of the ACA for a

<sup>2</sup> This refers to the percentage of annual health care costs covered by the insurer rather than covered out of pocket by the enrollee.

<sup>3</sup> For an in-depth discussion of Section 1332 waiver requirements, please see our previous *Health Care in Motion* piece [here](#).

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waiver of the ACA's key consumer protections, including the EHB package, actuarial value requirements, and [out-of-pocket limits](#). Under the ACA, 1332 waivers can only be granted where a state can demonstrate that their proposal will cover at least as many individuals with similarly affordable and comprehensive coverage absent a waiver, without increasing the federal deficit. Under the BCRA, Section 1332 waivers would be much easier to acquire, as a state would only need to demonstrate that their waiver would not increase the federal deficit.

In states that obtained such waivers, insurers would be allowed to offer plans that do not cover items and services that are critical for people living with chronic illnesses and disabilities, such as prescription drug coverage and substance use and mental health services, and offer plans that are less generous overall. Further, because the ACA's ban on annual and lifetime limits and the cap on annual out-of-pocket costs only apply with respect to EHBs, states seeking to modify the EHB package will likely be able to define these protections as well.

## A Call to Action

This is a critical moment for advocates to weigh in to support vulnerable populations' access to care. As the Senate is likely to amend their bill before it reaches the floor for a vote, advocates should educate their [Senators](#) about the importance of providing subsidies robust enough to allow Americans, especially lower-income individuals, the ability to purchase quality coverage. Advocates should also highlight the importance of maintaining strong consumer protections for people living with chronic illnesses and disabilities, such as the EHB package and actuarial value requirements, as well as the inadequacy of high-risk pools to address these individuals' health care needs.

## A Truly Stunning Blow to Medicaid

The Senate's bill is a full frontal assault on Medicaid and the vulnerable and low-income populations that rely on the program. Much like the AHCA, the BCRA would significantly change the Medicaid program, both by phasing out the ACA's Medicaid expansion and limiting federal financial support of the entire Medicaid program. While it would implement its changes over a phased in time, the BCRA's cuts to Medicaid would be even deeper over time than the [\\$834 billion](#) cut the program would see under the AHCA. In 2015, 97 million Americans relied on Medicaid, including at least [10 million individuals](#) living with chronic illnesses and disabilities. The BCRA would result in many individuals losing access to Medicaid, while other enrollees would likely experience greatly reduced benefits.

## Elimination of Medicaid Expansion

Many people who became newly insured under the ACA are beneficiaries of the Medicaid expansion. Under the ACA, in states that opted to expand their Medicaid program, the federal government covers 90% of the cost to state government of that expansion population. Today, about [11 million Americans](#) receive access to health care through Medicaid expansion. Beginning in 2021, the BCRA would gradually eliminate the special financial support for the Medicaid expansion population by 2024, with the cuts phased in over each year. Most expansion states will not be able to continue providing coverage to the expansion population absent this enhanced financial support. Individuals who were previously covered by Medicaid expansion will most likely not be able to afford individual Marketplace premiums, even after taking the BCRA's tax credits into account, leaving these individuals with no options to access comprehensive health care.

While states could opt to continue to provide Medicaid to the expanded eligibility groups after the phase-out, they would bear much more of the financial burden as they would no longer receive enhanced federal reimbursement for this population. This will force states to make difficult decisions about whether they can afford to continue covering the expansion population. While the phase-down of the Medicaid expansion is meant to take place over the course of four years,

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some expansion states would feel the effects more quickly. Eight states, Arkansas, Illinois, Indiana, Michigan, Montana, New Hampshire, New Mexico, and Washington, have laws that would automatically end their expansion as a result of reduced financial funding.

## Historic Change to Core Structure of Medicaid – From Entitlement to Per Capita Caps

The BCRA, like the AHCA, would significantly restrict all federal Medicaid spending by replacing the entitlement structure with per capita caps beginning in FY2020. The BCRA would shift Medicaid away from an open ended federal entitlement program, in which the federal government's contribution reflects a percentage of a state's actual health spending, to a program with a pre-set financial limit, here a per capita cap.<sup>4</sup> The BCRA would require states to choose two consecutive fiscal years by which to set targeted spending. The BCRA ties the annual increase in the per capita rates initially to the medical care component of the Consumer Price Index (CPI) for most enrollees. However, starting in FY2025, this increase would be tied only to general inflation or the CPI, and not to medical inflation which is typically higher. This would amount to even deeper cuts over time than under the AHCA: per-enrollee spending on Medicaid is expected to grow 4.4% per year, whereas the medical component of CPI is expected to grow 3.7% and CPI is expected to increase by 2.4%.

A change to per capita caps is alarming for proponents of access to care. Per capita caps can be especially problematic for patients with higher costs, such as those living with chronic illnesses and disabilities, because it puts a ceiling on the federal contribution towards each individual's health care costs. As a result, states would be responsible for all costs above the per-beneficiary cap, which may be challenging for states with tight budgets. This will likely result in heavy pressure on the states to cut eligibility and/or benefits in their programs. This is especially concerning for older individuals and those living with disabilities, who account for [nearly half](#) of Medicaid spending.

The BCRA would also give states the option to implement policies in their Medicaid programs that impose greater burdens for individuals to become and remain eligible for medical assistance. Under current law, Medicaid enrollees' eligibility based on income is determined every 12 months and may not be redetermined more frequently. Beginning October 1, 2017, the BCRA would give states the option to require certain Medicaid enrollees to redetermine their eligibility based on income every 6 months, or potentially even more frequently. Additionally, the BCRA allows states to impose work requirements on expansion population enrollees as a condition of eligibility. This is particularly [concerning](#) for people living with chronic and disabling conditions who are not eligible based on a disability category, but may still be living with conditions that preclude them from attaining employment. A work requirement would likely bar those who need care the most from obtaining it, forcing them to seek costlier late-stage interventions like emergency room visits.

### A Call to Action

Advocates should make their position on Medicaid known to their [Senators](#). In particular, advocates should highlight the success of the Medicaid expansion in reducing the number of uninsured individuals and improving health in states that have expanded Medicaid. Advocates should also highlight the importance of maintaining strong federal funding for Medicaid, and the impact that spending caps could have on coverage and benefits for Medicaid enrollees. Advocates could highlight the importance of Medicaid in financing services, such as [long-term services and supports](#), for individuals living with chronic illnesses and disabilities.

<sup>4</sup> States would be given an alternative option to take a block grant instead of a per capita cap. The results under either scenario are similar: federal spending will not keep pace with expected spending on Medicaid enrollees.

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## Republican Leaders Planning For a Swift Vote – This is a Critical Time for Advocates

With the Fourth of July holiday and August recess looming, Republican leaders are looking to force a quick vote in the Senate. The CBO score is expected early next week and a vote could come as soon as Wednesday the 28<sup>th</sup>. The margin for error here is very thin, and Congressional leadership will need at least fifty of the fifty-two Republican senators to vote in favor of the BCRA. The bill was released as a “discussion draft” and Senator McConnell has indicated he is willing to make changes if needed to secure the votes for passage. Advocates of the BCRA must somehow simultaneously appease virtually every Senator in their party. This will be particularly challenging as both conservative and moderate senators have expressed reservations about the bill, but any change made to appease one group is more likely to alienate the other.

Because of the importance of each Senator’s vote, advocates should act quickly to have their voices heard. Advocates who oppose the bill should particularly focus on contacting the Senate moderates who have expressed reservations about the BCRA, including Senators [Cassidy](#) (R-LA), [Collins](#) (R-ME), [Murkowski](#) (R-AK), [Capito](#) (R-WV), [Portman](#) (R-OH), and [Heller](#) (R-NV). Advocates should also consider educating their [Senators](#) on the importance of robust subsidies, strong consumer protections, and continued federal financial support for Medicaid on access to care for people living with chronic illnesses and disabilities.

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