Overview of the Senate Substitute Better Care Reconciliation Act of 2017 (BCRA)

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Massachusetts Coalition for Coverage and Care

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FOUNDATION MASSACHUSETTS

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Overview of Better Care Reconciliation Act Impacts on Medicaid

Like the House-passed American Health Care Act (AHCA), the Senate-proposed Better Care Reconciliation Act (BCRA) includes major changes to Medicaid:

- Converts Medicaid to a per capita cap with state option for block grant for non-disabled/non-expansion/non-elderly adults
- Phases out, before entirely eliminating, enhanced federal funding for Medicaid expansion beginning in 2021

BCRA makes additional cuts to Medicaid over and above the AHCA, including:

- Reducing the per capita cap trend rate to CPI in 2025
- Maintaining ACA DSH cuts for Medicaid expansion states only, even after enhanced expansion funding is eliminated
- Reducing the allowable provider tax threshold

CBO projects that the BCRA would cut federal Medicaid spending by $772 billion over 10 years (2017-2026) and reduce Medicaid coverage by 15 million in 2026 (and reduce coverage overall by 22 million as compared to coverage under the ACA).

Senate is driving to a vote on the BCRA at the end of this week

Source: Better Care Reconciliation Act of 2017, Discussion Draft as of June 22, 2017, available at: https://www.budget.senate.gov/imo/media/doc/SENATEHEALTHCARE.pdf

Key Medicaid Expansion Provisions

- **Eliminates opportunity for non-expansion states to receive enhanced federal funding for expansion effective March 1, 2017; regular match still available**

- **Maintains enhanced federal Medicaid funding for existing expansion states through 2020, before phasing down, and ultimately eliminating, enhanced federal funding in 2024:**
  - Phases down enhanced funding over three years beginning January 1, 2021:
    - 2021: 85% eFMAP
    - 2022: 80% eFMAP
    - 2023: 75% eFMAP
    - 2024+: State's regular FMAP
  - Reduces enhanced federal Medicaid funding for "leader states" after 2017 through 2023
  - Converts mandatory group of adults with income up to 133% FPL to an optional group beginning January 1, 2020

It is unclear how many states could maintain the expansion under the phase down due to either "poison pill" legislation or a lack of state general funds to replace reduced federal funding

- **Maintains ACA DSH cuts for expansion states <u>only,</u> even after enhanced expansion funding is eliminated**

Treatment of Non-Expansion States

- **Establishes "supplemental payment allotment"**
  - $2 billion annually from FY 2018 through 2022 for states that have not expanded Medicaid to increase payments to Medicaid providers (all types, not only hospitals)
  - Each non-expansion state's share is based on its share of individuals residing in non-expansion states with income below 138% FPL in 2015
  - The federal government will provide an enhanced match rate for payments made out of the allotment at:
    - 100% for FY 2018-2021
    - 95% for FY 2022
- **Exempts non-expansion states from ACA DSH cuts (which cuts become effective in 2018, now just for expansion states)**
- **From FY 2020 to FY 2023, increases DSH allotment for non-expansion states with below average DSH allotments in FY 2016**

Block Grant Option

Calculating the federal block grant allotment

- States may opt to receive a block grant beginning in FY 2020 for "targeted health assistance" to non-elderly/non-expansion/non-disabled adults (i.e., "Medicaid Flexibility Program" for low-income parents and pregnant women)
- Election applies for 5 years, with option to automatically continue for another 5 years
- Initial year of federal block grant funding calculated by multiplying the state's:
  - Average FMAP;
  - Per capita spending target for applicable eligibility group in FY 2019; and
  - Enrollment in applicable eligibility group
- Block grant amount trended forward at CPI
- State would be paid an amount equal to average FMAP of total computable amount expended for Medicaid Flexibility Program on quarterly basis; state responsible for program balance

Block Grant Option, cont.

State requirements for receiving federal block grant funding

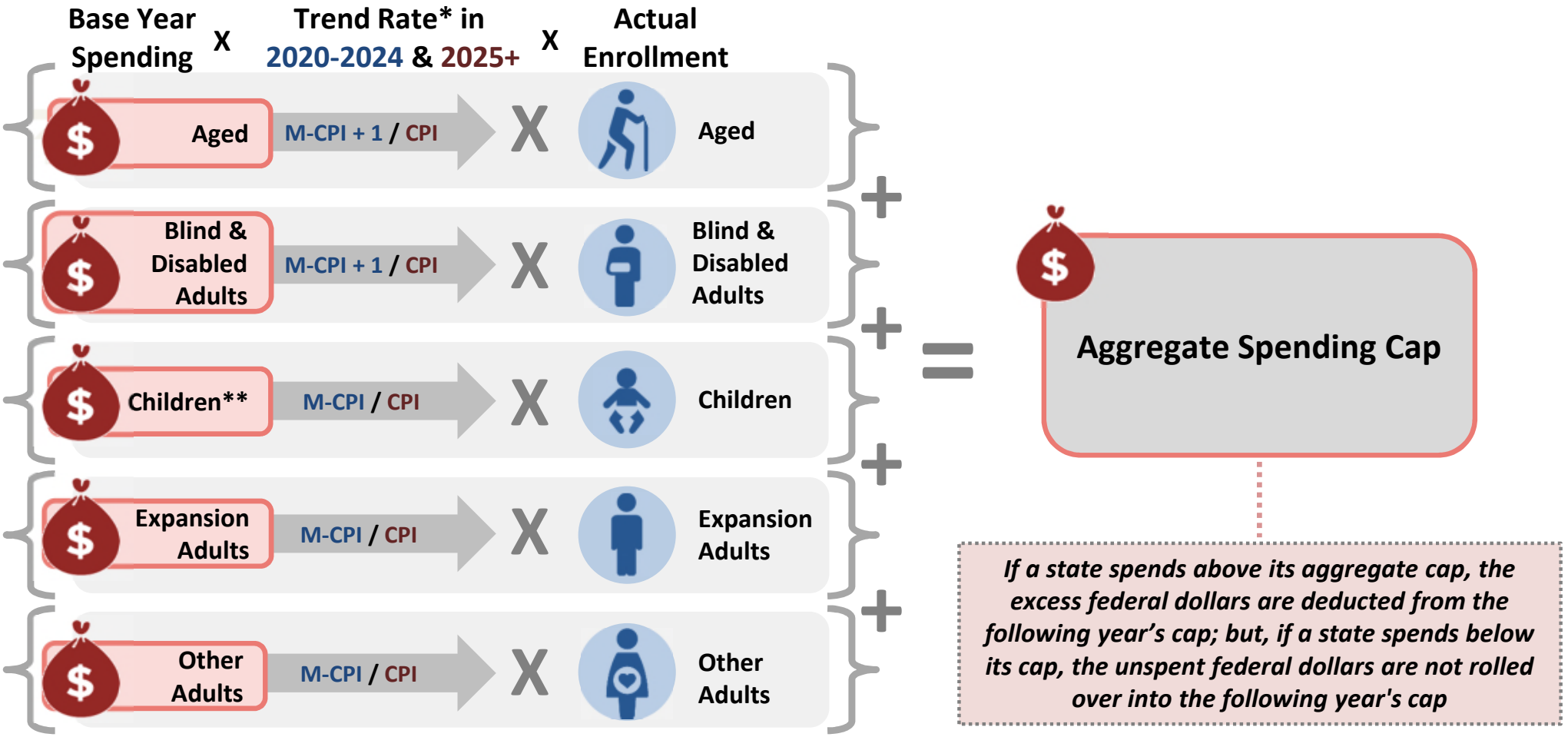
- State subject to MOE requiring state's annual targeted health assistance expenditures be equal to the product of its annual block grant amount and enhanced CHIP FMAP
- States failing to meet MOE in a given fiscal year would receive a reduced block grant allotment the following fiscal year
- Unspent block grant funding would rollover from year to year as long as state meets certain conditions; states are not required to spend rollover funds on health care-related costs
- State's benefit package is more prescribed than under the AHCA; must meet 95% AV; and must provide mental health and substance use disorder coverage that complies with federal mental health parity requirements.
  - If state opts to provide prescription drug coverage, it would be subject to both coverage and rebate requirements
- States generally would have significant latitude regarding eligibility, benefits, delivery system, and cost-sharing (as long as premiums, deductibles and cost-sharing does not exceed 5% of family's annual income)

Required Benefits for Block Grant Option

1. Inpatient/outpatient hospital services
2. Lab and x-ray services
3. Nursing facility services for 21+
4. Physician services
5. Home health care services
6. Rural health clinic services
7. FQHC services
8. Family planning services & supplies
9. Nurse midwife services
10. Certified pediatric and family NP services
11. Freestanding birth center services
12. Emergency medical transportation
13. Non-cosmetic dental services
14. Pregnancy-related services

Medicaid Per Capita Cap

Like the AHCA, ***aggregate cap*** on Medicaid funding is built up from ***per capita caps*** for five different eligibility groups



*To calculate states' starting caps in FY 2020, base year spending is trended by M-CPI; starting in 2020, M-CPI+1 is used to trend and calculate the aged and disabled spending caps, while M-CPI continues to apply to children, expansion adults, and other adults; beginning in FY 2025, CPI is used for all eligibility groups.
** BCRA per capita cap carves out children enrolled based on a disability determination.

BCRA vs. AHCA: Changes to Base Year and Trend

Base year differences

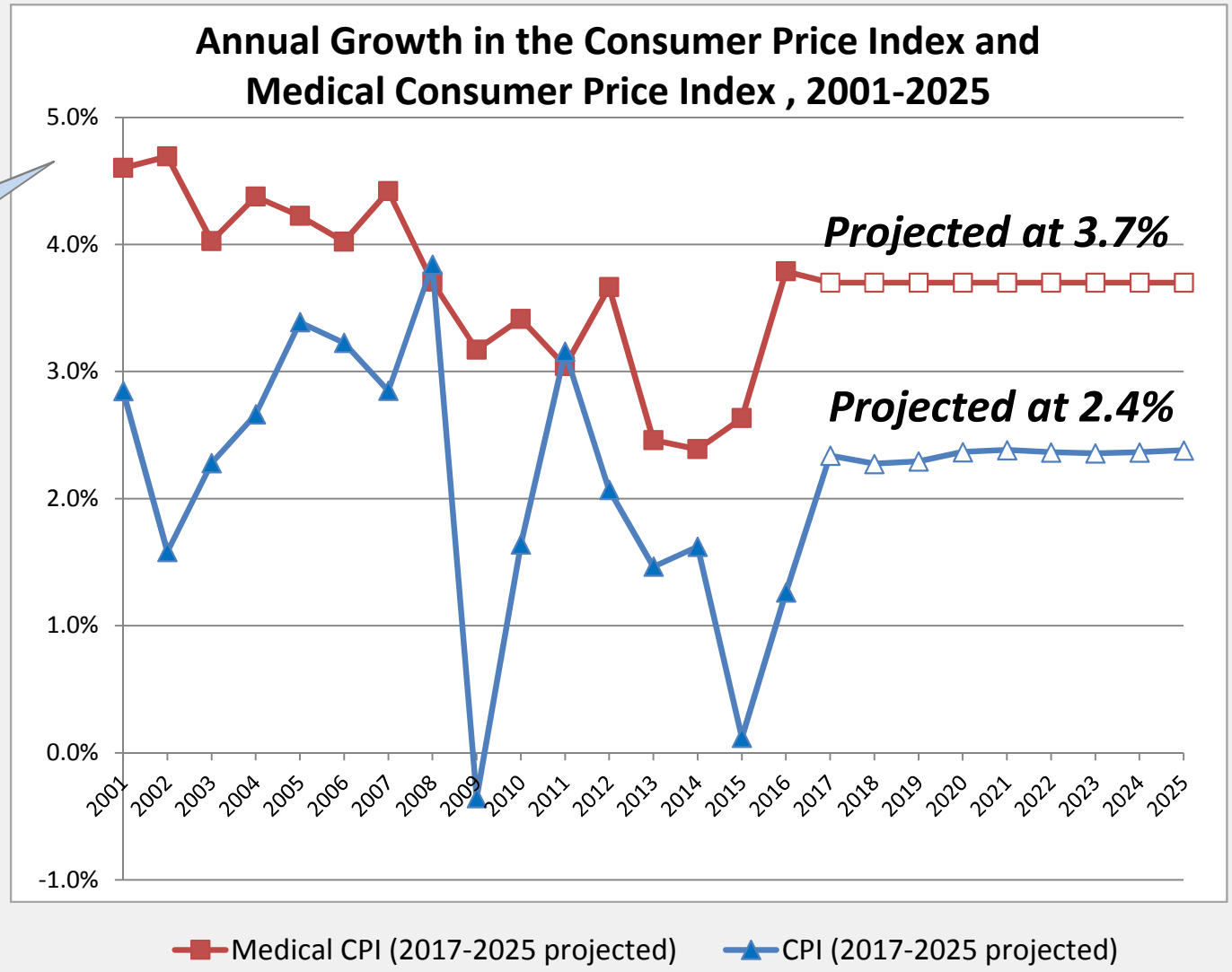
- States will select their base year period from eight consecutive fiscal quarters of spending between first quarter of FY 2014 and end of third quarter of FY 2017 (October 1, 2013 through June 30, 2017)
- Base year period spending will be divided in half to calculate an annualized spending amount
- Children enrolled in Medicaid based on a disability determination are carved out from the cap

Trend rate differences

- Trend rate is reduced; beginning in 2025, aggregate cap will be trended forward by CPI for all eligibility groups (instead of M-CPI + 1 for elderly and disabled adults, and M-CPI for children, expansion adults, and other adults)

Trend Rates Matter

CPI has historically trended well below Medical-CPI, meaning that states are likely to face a dramatic impact to the per capita cap allotment in 2025 and beyond



Source: Manatt analysis of Bureau of Labor Statistics, CPI Databases, https://www.bls.gov/cpi/data.htm; Congressional Budget Office, https://www.cbo.gov/publication/52486; https://www.cbo.gov/sites/default/files/recurringdata/51135-2017-01-economicprojections.xlsx.

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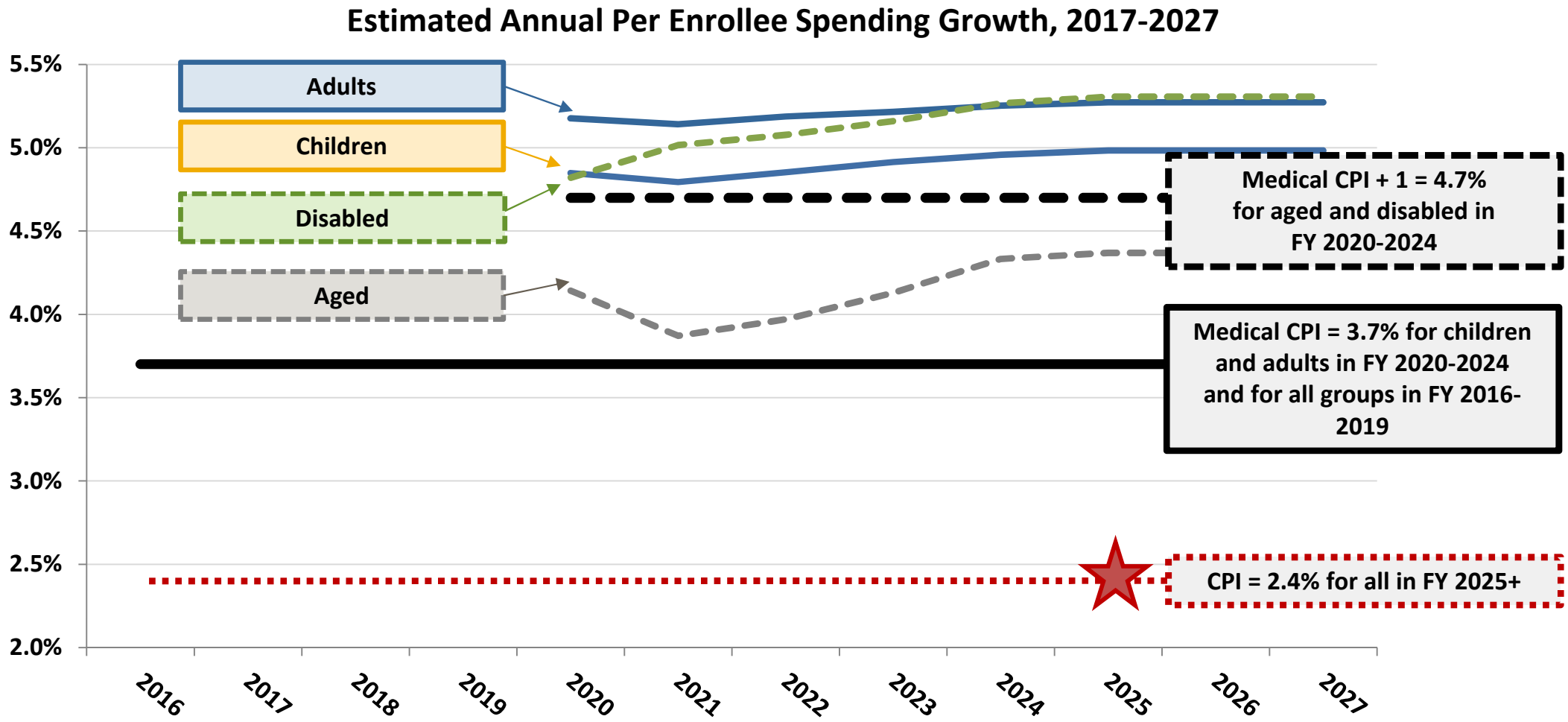
Projected Spending Growth Relative to BCRA Caps

- Per enrollee spending is projected to grow more quickly than the trend rates established in the BCRA for all eligibility groups except aged through 2024
- Starting in 2025, all groups are projected to substantially exceed the trend rate



Source : Manatt Medicaid financing model. Note: Per enrollee growth rates projected by CMS Office of the Actuary; medical CPI projected by CBO. Spending growth for the aged and disabled groups is capped at medical CPI plus one percentage point starting in 2020-2024; the 2019 baseline amount from which 2020 caps are calculated is trended forward from 2016 by medical CPI.

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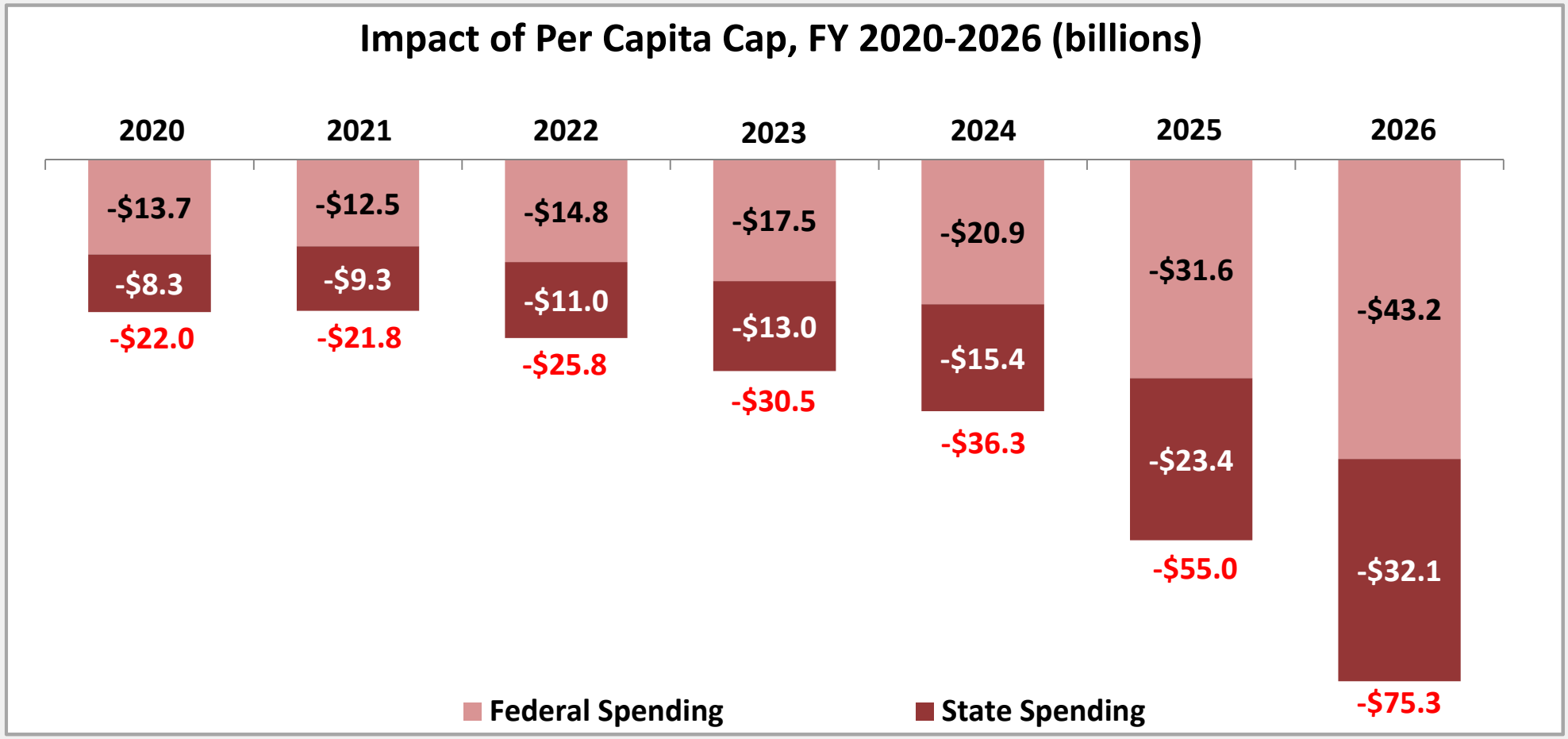
Estimated Impact of Per Capita Cap across All States

Impact of the per capita cap is projected to result in total cuts of more than $266 billion between FY 2020-2026



Source: Manatt Medicaid Finance Model.
Note: Impact of per capita cap if states maintain expansion only through 2020 and reduce their state spending to remain below per capita cap allotment. If it were instead assumed that states maintain expansion indefinitely, the estimated size of the cut is $322.8 billion between FY 2020-2026 ($189.2 billion in federal reductions and $133.5 billion in state reductions).

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Redistribution among "High" and "Low" Spend States

- **An additional adjustment is made to state's aggregate cap if per capita spending is significantly above or below the mean for all states**
  - States ***above*** mean by 25% or more: Cap will be decreased the following year by .5% to 2%
  - States ***below*** mean by 25% or more: Cap will be increased the following year by .5% to 2%
- **Redistribution excludes states with low population density (i.e., AK, MT, ND, SD, and WY)**
- **In FY 2020 and FY 2021, adjustment will be based on state's average per capita spending across all eligibility groups**
- **In FY 2022+, the adjustments will be made for each eligibility group; as a result, some states may receive a downward adjustment for one eligibility group and an upward adjustment for another**
- **This dramatic restructuring of Medicaid's federal funding mechanism shifts risks to states and sets up a "race to the bottom"—all states will be worse off**

HHS Secretary determines adjustment level between .5% and 2%; overall impact must be budget neutral

"High" and "Low" Spend States Potentially Affected by BCRA Redistribution: FY 2020 and FY 2021

Difference in State's Average Per Member Per Year (PMPY) Spending *across All Eligibility Groups* from U.S. Average

Under the redistribution model, 3 states are projected to receive an increase in their per capita cap ("reward"), while 9 may be subject to a downward adjustment ("penalty") for FY 2020 and FY 2021

Key

- Below national mean by 25% or more = Subject to cap "reward"
- Above national mean by 25% or more = Subject to cap "penalty"
- State within 25% of national mean = No impact on cap as a result of redistribution (*includes states exempted from model due to low population density)

Note: Per member per year (PMPY) spending amounts in FY 2019 for full-benefit enrollees as estimated in Manatt's Medicaid Financing Model.

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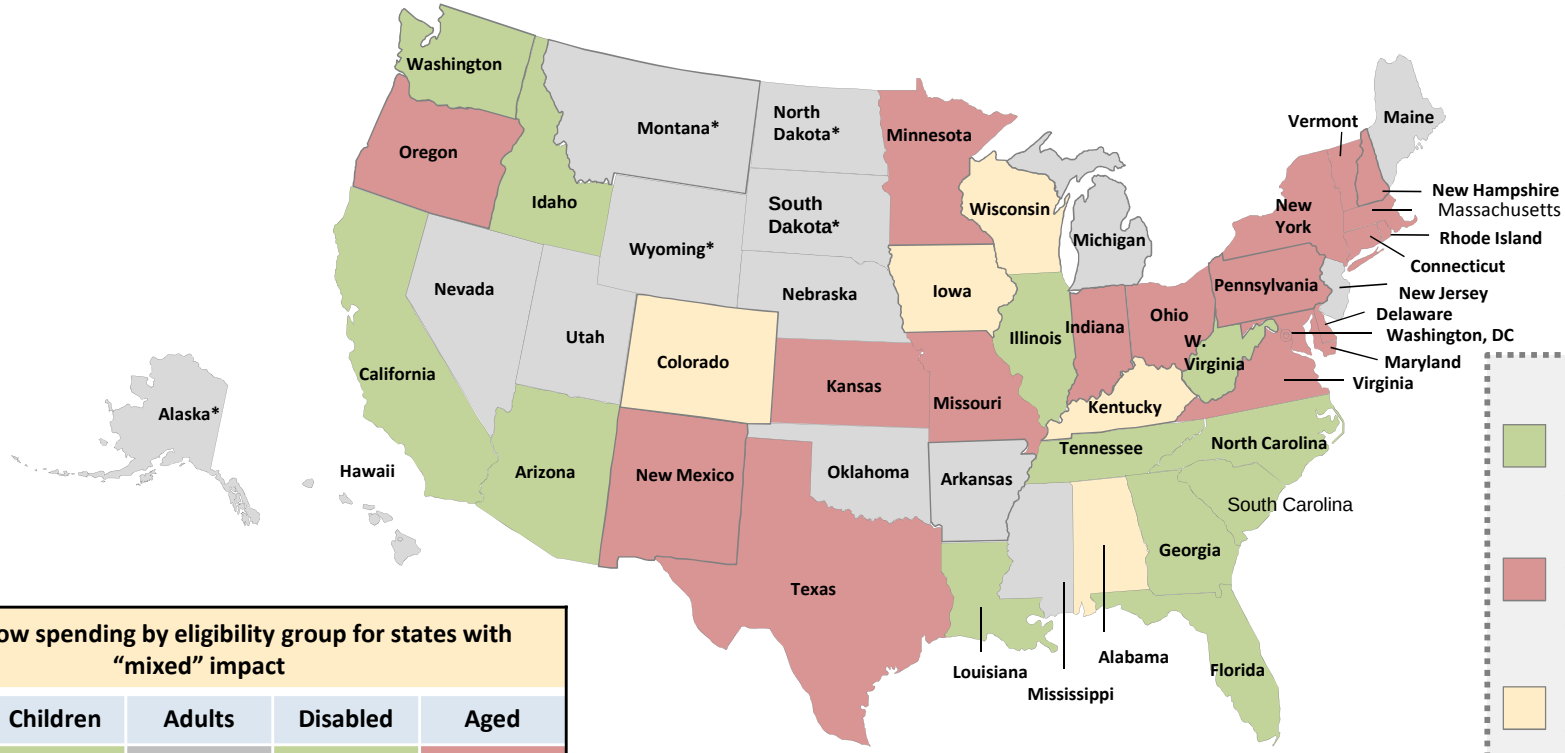
"High" and "Low" Spend States Potentially Affected by BCRA Redistribution: FY 2022 and Beyond

Difference in State's Average Per Member Per Year (PMPY) Spending *for Each Eligibility Group* from U.S. Average for Each Group



Key

- Below national mean by 25% or more in 1 or more eligibility groups= Subject to cap "reward" *(12 states)*
- Above national mean by 25% or more in 1 or more eligibility groups= Subject to cap "penalty" *(19 states)*
- Mixed: 1 or more eligibility groups below national mean and 1 or more eligibility groups above national mean = Unclear whether they will reap "reward" or face "penalty" *(5 states)*
- All eligibility groups within 25% of national mean = No impact on cap as a result of redistribution (*includes states exempted from model due to low population density) *(15 states)*

High and low spending by eligibility group for states with "mixed" impact

State	Children	Adults	Disabled	Aged
AL	-30%	-8%	-52%	42%
CO	-15%	-26%	25%	17%
IA	8%	-39%	33%	57%
KY	16%	35%	-26%	-2%
WI	-40%	-30%	-24%	33%

Note: Per member per year (PMPY) spending amounts in FY 2019 for full-benefit enrollees as estimated in Manatt's Medicaid Financing Model.

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Additional Medicaid Provisions New to BCRA

- Reduces allowable provider tax threshold from 6% to 5% in FY 2025 and beyond; phase down begins in FY 2021
- Offers states the option of covering mental health and substance use disorder services provided to Medicaid beneficiaries ages 21 to 65 in Institutes of Mental Disease (IMDs) under certain conditions; match rate will be 50%
- Establishes new bonus pool to reward states that spend below their aggregate caps and meet quality metrics in a given FY (available from FY 2023-FY 2026)
- Permits 6-month redetermination of expansion adults at state option
- Permits states to continue “grandfathered managed care waivers” in perpetuity through state plan authority, subject to meeting certain conditions
- Requires HHS Secretary to solicit advice from state Medicaid agencies and Medicaid Directors before promulgating proposed rules with impacts to Medicaid program operations and financing

Additional Medicaid Provisions in Both BCRA and AHCA

- Ends the requirement for states to provide beneficiaries with retroactive coverage effective October 1, 2017
- Lowers minimum income eligibility for children ages 6+ from 133% FPL to 100% FPL effective January 1, 2020
- Eliminates option for states to expand Medicaid to adults with income > 133% FPL after December 31, 2017
- Permits state option to condition Medicaid eligibility on work requirements for certain adults ages 19 to 64 beginning after October 1, 2017
- Prohibits states from using Medicaid funds to pay for services provided by Planned Parenthood clinics for a period of one year from enactment of the bill
- Ends the requirement that alternative benefit designs for Medicaid meet the EHB standard as of January 1, 2020
- Ends two provisions that provide people with temporary coverage pending a full review of their application, effective January 1, 2020
- Eliminates the six percentage point increase in the federal match rate for home and community-based services for community integration, effective January 1, 2020

Key Takeaways

- **Both the BCRA and AHCA fundamentally alter federal financing of Medicaid, shifting financial risk to states**
- **Like the AHCA, BCRA reduces federal Medicaid funding for states and Medicaid coverage for low-income population**
- **Per capita caps lock in current state spending; new BCRA provisions add new risks**
- **Per capita caps put coverage and care at risk for children, seniors, people with disabilities and low-income Medicare beneficiaries, low-income adults and pregnant women in all states**
- **Like the House, the Senate eliminates enhanced federal funding for expansion; while the Senate bill phases out the enhanced funding over three years, many states will have no choice but to eliminate coverage immediately and few are expected to maintain expansion coverage beyond 2023 when the federal match drops to regular levels**
- **Capped funding shifts states' focus: Patient-centered → Cap-centric**

Thank You

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Key AHCA/BCRA Proposals (1 of 3)

	House-Passed AHCA	BCRA (Senate Proposed Substitute)
Tax Credits & HSAs	• Provides advanceable premium tax credits adjusted for age, ranging from $2000 to $4000 per individual up to $14,000 family cap for individuals making less than $115,000. (Gradual reduction after incomes of $75,000.) • Enrollee bears risk of premium increases (defined contribution) • Enhances value of HSAs	• Advanceable and refundable tax credits based on ACA structure, but adjusted for age and benchmarked to a 58% AV qualified health plan (equivalent to a plan with coverage b/w catastrophic and Bronze in the ACA) • Federal govt bears risk of premium increases (defined benefit) • Tax credits available for individuals between 0-350% FPL • Tax credits only available for plan purchased on the Marketplace • Waivers could be used to allow tax credits to be used outside of the Marketplace
Market-places	• Plan years 2018-2019: premium tax credits available for plans purchased on and off Marketplaces; tax credits for plans purchased off Marketplaces are not advanceable	• Plan years 2018-2019: Current law premium tax credits and CSR payments appropriated • CSRs eliminated after 2020
Mandates	• Eliminates individual and employer mandate tax penalties, effective 1/1/2016	• *Same as House bill*
Insurance Reforms	• Guaranteed issue at standard rates only for individuals who maintain continuous coverage, defined as no gap in coverage greater than 63 days in past 12 months • Individuals with coverage gaps pay penalty in individual market (30% of premium) for 12 months starting in plan year 2018 for special enrollments and plan year 2019 for open enrollment • Allows 5:1 age rating beginning in plan year 2020 and provides states with the option to adjust as early as plan year 2018 • Repeals ACA metal-level requirements	• Guaranteed issue at standard rates only for individuals who maintain continuous coverage, defined as no gap in coverage greater than 63 days in past 12 months • Individuals with coverage gaps face six-month or longer waiting period for coverage effective on or after January 1, 2019 • Allows 5:1 age rating beginning in plan year 2020 *(same as House bill)*

1. *Added to the AHCA by a House Rules Committee amendment on 4/6/17*

Key AHCA/BCRA Proposals (2 of 3)

	House-Passed AHCA	BCRA (Senate Proposed Substitute)
 ***Waivers***	• Permits states to apply for limited waivers of EHB and community rating provisions	• Loosens 1332 waiver requirements to make it easier for states to make changes
 ***Medicaid Expansion***	• Maintains Medicaid expansion for states that have already expanded but eliminates enhanced federal funding effective CY 2020 for all but grandfathered enrollees (if they maintain continuous coverage after December 31, 2019) • Terminates EHB requirement for expansion adult coverage • Reduces mandatory coverage for children age 6-19 from 138% to 100% of FPL • Sunsets enhanced federal match for new expansions effective March 1, 2017	• Maintains Medicaid expansion for states that have already expanded but eliminates enhanced federal funding effective CY 2021 • Enhanced funding is phased-out over three years (2021-2023), reverting to standard matching rate in 2024 • *Other provisions same as House bill.*
 ***Medicaid Financing***	• Aggregate cap on state Medicaid spending starting in FY 2020 • Per capita caps on spending across five categories are trended forward by either medical CPI (children, expansion adults, and other non-elderly/non-disabled/non-expansion adults) or by medical CPI plus one percentage point (elderly and blind/disabled groups) • Uses FY 2016 as base year to establish a target spending amount for FY 2019; DSH payments excluded under cap; UPL payments included under cap; treatment of waiver payments unclear • State option of block grants for children and non-disabled adults trended forward by CPI-U	• Aggregate cap on state Medicaid spending starting in FY 2020 • Uses state-chosen 8 consecutive quarters between 1st quarter FY 2014 and 3rd quarter of FY 2017 as the base • House growth rate maintained through 2024; beginning in 2025 the trend factor is reduced to the growth of CPI for all eligibility groups. • States are subject to a further adjustment if their spending is above or below average, by eligibility group, compared to other states. • Blind and disabled children under 19 • are excluded from the cap • Creates a quality bonus pool to promote “programmatic efficiency” (+/- 2%)

Key AHCA/BCRA Proposals (3 of 3)

	House-Passed AHCA	BCRA (Senate Proposed Substitute)
DSH	• ACA DSH cuts repealed beginning in FY 2020 • Non-expansion states exempt from cuts beginning in FY 2018	• Does not repeal DSH cuts for expansion states • Non-expansion states exempt from DSH cuts beginning in FY 2018 • Additional DSH funding for non-expansion states
Revenue Raising Taxes	• Eliminates most revenue raisers in 2017, including prescription drug tax • Repeals additional Medicare Tax in 2023 • Cadillac tax delayed until CY 2026	• *Similar to House bill except for effective dates and eliminated AHCA deduction change*
Abortion Coverage	• Prohibits using tax credits to purchase plans that cover abortion • Prohibits for one year any Medicaid, CHIP, Maternal and Child Health Services Block Grant, and Social Services Block Grant funding for Planned Parenthood	• Prohibits using tax credits to purchase plans that cover abortion • Prohibits for one year any Medicaid, CHIP, Maternal and Child Health Services Block Grant, and Social Services Block Grant funding for Planned Parenthood

CBO Score: Net Change to Federal Deficit

	2026 Baseline (current law)	CBO Score: AHCA vs. BCRA *Expected Coverage Changes in 2026*	
		House Bill (AHCA)	Senate Bill (BCRA)
Total Uninsured	**28M Uninsured**	**51M Uninsured (+23M)**	**49M Uninsured* (+22M)**
Moving from Medicaid Coverage to Uninsured	*Not included in score*	+14M Uninsured	+15M Uninsured
Moving from Nongroup, ESI, Other Coverage to Uninsured		+9M Uninsured	+7M Uninsured

*Note: Numbers do not add up due to rounding.

CBO Score: Net Change to Coverage

CBO Score: AHCA and BCRA *Changes to the Baseline (in billions)*		
	House Bill (AHCA)	**Senate Bill (BCRA)**
Spending Reductions	***-$1,111***	***-$1,022***
Revenue Reductions	***+$992***	***+701***
Medicaid	-$834	-$772
Tax Credits and Selected Coverage Provisions	-$276	-$408
Patient and State Stability Fund Grants	+$117	+$107
Penalty Payments	+$210	+$210
Non-Coverage Provisions (e.g., Taxes)	+$664	+$541
Total Deficit Reduction	***-$119***	***-$321***