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The Better Care Reconciliation Act: Overview of CBO Analysis and Healthcare Industry Reactions

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Last week, the United States Senate released a draft of its long awaited version of a healthcare bill designed to respond to criticism of the House of Representative's American Health Care Act (AHCA), passed in May, while still honoring the campaign promise of the GOP to repeal and replace the Affordable Care Act (ACA or Obamacare). Although the Senate initially promised to start from scratch and write its own bill, rather than tinker with the AHCA, in reality the Senate bill - called the Better Care Reconciliation Act of 2017 (BCRA) - is similar to the AHCA in many ways.

However, the Senate's BCRA does have a few critical distinctions. First, the BCRA does, in its current form, incorporate more long term changes to Medicaid. Medicaid as it currently exists is intended to provide coverage for anyone who meets its enrollment requirements – i.e. it is intended as a safety net for those in need. Further, under current Medicaid law, if costs of treatment rise, states receive more federal money to cover healthcare needs. While current law puts the burden of a large portion of the funding for Medicaid programs on the states, the federal government currently matches a percentage of these costs.

Both the AHCA and the BCRA try to address the federal government's share of Medicaid costs by incorporating a *per capita* funding formula. Rather than the federal government providing states with funding based on healthcare costs, states would only be entitled to a fixed amount of money based on enrollment numbers. Funding growth would then be set at a rate adjusted according to inflation and the consumer price index (CPI) of medical care. However, the formula used in the BCRA would lead to far more restriction on growth of Medicaid funding, eventually basing funding growth rates on the CPI of all goods (CPI-U), instead of medical care (CPI-M).

The repeal of the ACA's individual mandate, which is the legal requirement that everyone have at least basic health coverage, is also addressed differently by the BCRA and AHCA. Both bills reduce the penalty for having no coverage to $0. However, whereas the AHCA imposed a "re-entry penalty" for someone who drops healthcare coverage, goes uninsured for more than 63 days, and then tries to re-purchase health insurance, the BCRA initially had no similar penalty to incentivize people to buy health insurance and remain insured on an uninterrupted basis. This week, the Senate added a waiting period provision to its bill, which would "penalize" anyone who did not maintain coverage in the prior year by making them wait six months before being able to access coverage benefits if they signed up the following year. Without the ACA's penalty provisions left intact, there is heightened concern that more Americans will go uninsured until they become ill, leading to increased premiums for those who do purchase private insurance through the exchanges.

The BCRA and AHCA also provide for differential treatment of the subsidies that are designed to assist low and moderate income individuals with the purchase of health insurance through the exchanges. These subsidies are considered critical by many to ensure the affordability of insurance for a portion of the marketplace that historically would otherwise forego insurance coverage. The BCRA, like the AHCA, retains the ACA for low and moderate income individuals. However, the AHCA bases subsidies solely on age categories. The BCRA also takes into account other relevant factors, such as age, income, and geographical location.

Finally, key issues in the "repeal and replace" debate have been requirements that there be minimum coverage in all policies for a package of ten essential benefits, and coverage for pre-existing conditions, which are by far the most popular aspects of the ACA. There has been significant debate over whether everyone should be required to pay for all such benefits or if plans should be more flexible – e.g. should men or older Americans have to pay for maternity coverage. However, there is a compelling argument that

requiring the same coverage for all allows for spreading the cost of such coverage over a broader population - thereby helping to lower premiums across the board. Likewise, coverage for pre-existing conditions is critical for providing coverage for those who have chronic medical conditions - particularly to the extent that someone loses or changes employment. Under the current law, insurance plans are not allowed to discriminate based on pre-existing conditions and, therefore, cannot charge sick people more for their coverage. Again, this concept essentially diffuses the costs of insuring those who are already sick over the total population of both well and sick people.

The AHCA provides that a state can apply for waivers that allow it to remove any of the ten essential benefits or restrictions against charging for pre-existing conditions. However, these waivers are only applicable to people who failed to maintain continuous healthcare coverage. The BCRA, like the AHCA, would allow state waivers for essential benefits, but it does not give states an option to reject or discriminate against pre-existing conditions.

What do the BCRA and/or the AHCA mean for healthcare and healthcare coverage in the United States?

The various components that make up the United States healthcare industry now account for roughly 18% of the nation's GDP. In 1950, by comparison, that figure stood at 4.4%. Some project that by 2040, the figure may rise to between 26% and 30%.

While past U.S. economies were primarily devoted to preserving citizens' lives through defense spending, improving the quality of lives through infrastructure improvements, and the manufacturing of creature comforts, a fundamental shift in the nature of the human condition has, because of advances in medicine, occurred. How government policy – in support of this new aspect of our economy - responds to that shift is critically important, both for the industries involved and the citizens who stand to benefit from the care those industries provide.

Because of technological advances in medicine, revolutionary treatment of and even thinking about disease that have come online in the last two decades, the delivery of medicine to the citizens of the United States can - really for the first time in human history – effectively preserve life and promote the ability to pursue happiness.

Given all of the above, there is tremendous concern in the healthcare industry about what effect the BCRA and/or the AHCA would have on the healthcare industry – and that concern is coming from a host of different voices. Hospital and health systems, physicians, and some insurers have all weighed in with their views, many of them negative, about the current "repeal and replace" efforts.

The reasons for concern are stark. According to the neutral Congressional Budget Office (CBO) – headed by a director appointed by current Secretary of Health and Human Services Tom Price – within 10 years, under the House of Representatives' "repeal and replace" bill (the ACHA), 23 million more people will be uninsured than if the ACA is maintained and, under the Senate's bill (the BCRA), 22 million people more people will be uninsured.

The problem isn't just mid-term. It is acute, as well. Under the BCRA, the CBO has found that 15 million less people will be covered *next year* – four million because of Medicaid cuts, four million because of employers dropping coverage for their employees, and seven million through dropouts from the individual exchanges. The CBO describes the BCRA as promoting "high premiums," "high deductibles," and the reality that "few low-income people would purchase any plan."

Further, cuts to Medicaid spending under the BCRA will have dramatic effects. According to the CBO, there will be 15 million less enrollees in Medicaid by 2026. For Medicaid enrollees under the age of 65 – i.e. children, pregnant women, and those with disabilities – the CBO estimates a 16% reduction in enrollment by 2026. Beyond 2026, the CBO – while limited in its prognostication ability – foresees even more drastic consequences. This reduction in Medicaid participation is directly tied to funding cuts in the BCRA that the

CBO estimates as being in the range of $772 billion over the next ten years. These funding cuts correspond with approximately $541 billion in tax cuts – mostly for the wealthiest Americans - generated by the BCRA. It has been reported that the top 400 wealthiest families would receive an average of $7 million in tax savings per year as a result of the tax cuts proposed by the BCRA.

Regarding premiums, the CBO foresees that, under the BCRA, premiums would increase in 2018 and 2019 – by 20% more than under current law in 2018, and 10% more in 2019. The CBO believes that premiums would begin to come down beginning in 2020 - but this is driven by a change in the risk pool which will lead to many older and poorer Americans being priced out of the system.

Further, according to the CBO, deductibles and out-of-pocket costs would increase substantially. "Under current law for a single policyholder in 2017, the average deductible (for medical and drug expenses combined) is about $6,000 for a bronze plan and $3,600 for a silver plan," the CBO reported, adding that it and the Joint Committee on Taxation "expect that the benchmark plans under BCRA would have high deductibles similar to those for the bronze plans offered under current law."

The CBO did say that the newly added waiting-period "penalty" provision added to the BCRA on Monday, June 26 would slightly increase the number of people with insurance throughout the 2018 - 2026 period — but not in 2019, "when the incentives to obtain coverage would be weak because premiums would be relatively high."

Some of the opinions about the reality of what the BCRA "is" and "is not"

According to the Hospital and Healthsystem Association of Pennsylvania (HAP) – the leading voice for hospitals and health systems in Pennsylvania, with more than 240 members, and a partner with the American Hospital Association - the CBO analysis of the BCRA "paints a stark picture of the future of healthcare under this legislation. Its affirmation of deep cuts to access, spikes in premiums, and inadequate coverage options stand to hurt Pennsylvanians across the commonwealth." HAP is warning the community that healthcare for Pennsylvanians, including the more than 1.1 million who have gained access to care under the ACA "could be negatively impacted by or lost as a result of" the BCRA.

The Healthcare Association of New York State (HANYS), the New Jersey Hospital Association (NJHA), and the Massachusetts Health and Hospital Association (MHHA) take a similar position against the ACA reforms that are percolating in Washington. The NJHA reminds its members that the American Cancer Society, AARP, the National Disability Rights Network, the Children's Defense Fund, and America's Health Insurance Plans (the national organization that represents insurance companies) all oppose the reform bills being considered.

Particularly hard hit by the BCRA would be rural hospitals. The ACA provides vital benefits to these important but financially challenged medical centers. Many believe that a full repeal of the ACA – including its Medicaid expansion - would force many rural hospitals to close altogether. Pennsylvania – with the third largest rural population in the country, and with many counties having only one hospital that, if closed, would require residents to travel 25 miles or more to get to an emergency department – could be particularly hard hit.

The American Medical Association (AMA) – the nation's largest doctors' group – opposes the BCRA as well. In a letter to Senate Majority Leader Mitch McConnell and Senate Minority Leader Chuck Schumer, the AMA warned, "it seems highly likely that a combination of smaller subsidies resulting from lower benchmarks and the increased likelihood of waivers of important protections such as required benefits, actuarial value standards, and out-of-pocket spending limits will expose low and middle income patients to higher costs and greater difficulty in affording care."

Regarding proposed Medicaid spending cuts, the AMA reminded Senator McConnell that "[t]he Senate proposal to artificially limit the growth of Medicaid expenditures below even the rate of medical inflation threatens to limit states' ability to address the health care needs of their most vulnerable citizens." The AMA criticizes the BCRA for undoing the ACA's Medicaid expansion, and for ending the current open-ended federal commitment to pay more than half the expense of covering any eligible Medicaid enrollee. Under the BCRA, federal Medicaid funding would be capped at a flat amount per person, or a flat amount per state – based upon a state's preference.

Regarding insurance market rules, the AMA notes that the BCRA would permit states to make sweeping changes – allowing insurers to offer bare-bones plans that do not contain even basic guaranteed benefits, and that could exclude treatments and medicines for high-cost conditions. Relaxing benefits rules, and requiring patients to pay more out-of-pocket, the AMA warned, would "make the coverage less valuable, especially for patients with pre-existing conditions."

Other organizations that have come out against the BCRA in the last week include, the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the Federation of American Hospitals (FAH), the Children's Hospital Association (CHA), America's Essential Hospitals (AEH), the Catholic Health Association of the United States (CHAUS), and the American Lung Association (ALA).

Among insurers, a more measured approach was expressed by the Blue Cross Blue Shield Association (BCBSA) - a national federation of 36 independent, community-based and locally operated Blue Cross and Blue Shield companies that collectively provide healthcare coverage for one in three Americans. BCBSA expressed encouragement that the BCRA includes "several urgently needed and important steps to help make the individual market for insurance more stable and affordable in 2018 and 2019". BCBSA does caveat that "[a]s a nation, we also have an obligation to protect low-income people and the most vulnerable among us," that "coverage must be more affordable for patients, families and taxpayers," and "key consumer protections should remain in place."

Anthem (known as Wellpoint prior to 2014), the largest for-profit managed health company in the BCBSA - and which has announced plans to pull out of the ACA Exchanges in Ohio, Wisconsin and Indiana next year - offered support for the BCRA (and the ACHA) – focusing on the fact that "stability of the individual market" is imperative, and that the current ACA repeal/replacement bills would contribute to stability.

On the other hand, Blue Cross Blue Shield of Massachusetts and Blue Shield of California have expressed opposition to the BCRA. Likewise, Kaiser Permanente has indicated that it "cannot support the current draft" of the BCRA – because "changes to Medicaid and the reductions in subsidies for low-income people enrolled in the exchanges will lead to reduced coverage in our country."

On June 26, 2017, a group of three dozen world-renowned economists, including six Nobel Laureates, wrote to Senators McConnell and Schumer to object to the BCRA – indicating that their analysis of the bill concludes that the BCRA would "narrow coverage, and by driving relatively healthy people from the market, raise premiums for those who remain." These economists' predictions about the numbers that would lose coverage under the BCRA square with the CBO analysis.

Joining the chorus of those voicing opposition to the Medicaid component of the BCRA is the National Association of Medicaid Directors (NAMD) – representing the state officials who oversee the program. The NAMD criticizes the greatly reduced funding amounts in the BCRA. The NAMD notes that the BCRA would merely be a "transfer of risk, responsibility and cost to the states" – who cannot afford it – "of historic proportions." The NAMD joined with the National Governors Associations (NGA) in urging the Senate to "slow down" so as to "give states sufficient time to review the legislation before proceeding, so that the full impact of the legislation may be understood and explained to the American people."

This call seems like it may have been heeded. On June 27, 2017, Senator McConnell announced that he was cancelling a vote on the BCRA that he had hoped to have by June 30, 2017. The vote will not take place until after the July 4th recess. Senator McConnell has indicated that he would like to see a revised BCRA, that addresses the concerns that have been expressed, released by this Friday, June 30, 2017 – with the July 4th recess being used to obtain a new CBO score, and for Senators to hear feedback from their constituents.

Conclusion

It remains to be seen what the next steps will be in the ongoing battle over repeal and replace of the ACA. While the GOP continues to insist that they need to carry through on campaign promises to overhaul the system, and there is general agreement that the ACA needs, at least, to be repaired, as healthcare costs continue to soar, a hyper-partisan Congress finds itself stuck within a very complicated healthcare system that is hard to navigate, and even more difficult to change. Adopting the ACA was not a process that happened overnight, but was something in the offing for many decades. Gaining a consensus and obtaining the necessary votes to address problems with the ACA will require careful consideration and, as many inside and outside of Congress have noted, is not a move that should be rushed - but rather one that requires adequate time to debate and address issues in a manner that is fair.