Washington State Hospital Association

Discussion Draft: Senate's Better Care Reconciliation Act of 2017
June 22, 2017

The following is a WSHA analysis of the Senate Republican's discussion draft, the Better Care Reconciliation Act of 2017. This is the Senate's version of the American Health Care Act. The bill has yet to be scored by the Congressional Budget Office, which will release the estimate of the impact on health coverage. We know millions of Americans will lose health coverage as a result of the deep cuts proposed. Our initial reaction is that this bill is worse for our state's Medicaid program and hospitals than the House's version of the bill. This draft will also likely be changing in the coming days.

WSHA has significant concerns about the Senate version and the reductions of health care coverage that would result. Here are the highlights of the bill:

Changes to Medicaid

Expansion population. The Senate bill phases down significant federal support for Medicaid expansion between 2021 and 2023 – from 90% to 75%. In 2024, the federal government would provide only 50% of the matching rate — instead of the 90% contained in the Affordable Care Act (ACA). By 2024, Washington State will need more than $1.2 billion per year in the state budget to sustain coverage at this decreased rate. This change will result in the legislature reducing coverage or significantly cutting Medicaid rates to providers. WSHA is concerned about the impact to 600,000 Medicaid expansion enrollees and other Medicaid populations.

In contrast, the House bill allows existing enrollees to draw down federal matching funds at 90% as long as they have no change in enrollment status. New enrollees would receive only 50% of the match in 2021.

Block grants or per capita payments. The bill allows states to choose between block grant or per-capita support for their Medicaid population beginning in 2020. Unlike the House version, the caps on Medicaid are stricter and would cut the program deeper over time. This is concerning because Medicaid already pays significantly below the cost of delivering care.

Beginning in 2025, the payments for per-capita caps to states will be tied to a slower growth rate, the Consumer Price Index (CPI) Urban, instead of Medical CPI. Under this formula, federal funding would fall further and further behind anticipated expenses, causing cuts to providers or limits in eligibility. The House bill does not tie Medicaid to CPI Urban.

Hospital Cuts Not Restored

The bill maintains the cuts to hospitals contained in the ACA that were meant to pay for the coverage expansions. Hospitals will continue to be cut nearly $4.2 billion over 10 years in Washington State. This means we are effectively being cut twice – once through the phasing out of Medicaid expansion, and the second time by keeping the cuts intended to pay for it in

place. The House version of the bill restored the Medicaid Disproportionate Share Hospital cuts to hospitals that were about $400 million over 10 years.

Requirements for Coverage and Insurance Changes

Similar to the House bill, the Senate repeals both the individual and employer mandates for health coverage. This creates increased uncertainty for the insurance markets, in particular the individual market. In the individual market, insurers would be able to charge older customers up to five times more than they charge younger customers.

Subsidies to Purchase Insurance

The Senate bill would provide tax credits for the purchase of insurance for individuals with incomes between 0% and 350% of the federal poverty level (FPL). The House bill's tax credits are between 138% and 400% of FPL, and change based on age. Individuals are excluded if they are on Medicaid. We think these subsidies will be less than what are offered today under the ACA.

According to the American Hospital Association, the bill would adjust the dollar value of the tax credit to account for the cost of coverage in a region, something the House bill did not do. The tax credits would be pegged to the ''applicable median cost benchmark plan'' in the region with an actuarial value of 58% (meaning that the insurer is responsible for 58% of expected costs through the premium payments with the consumer responsible for the remaining 42% through co-pays, deductibles and other out-of-pocket cost sharing). Such a plan would qualify today as a bronze plan. This has the impact of reducing the value of the tax credit because the tax credits today are pegged to silver plans, through which insurers are responsible for 70% of costs. Finally, the tax credits are also adjusted by age, with younger individuals responsible for a smaller proportion of the cost of coverage than older individuals.

Incentives for Health Savings Accounts (HSAs)

The bill would incentivize the use of HSAs by increasing the maximum amount an individual could contribute to his or her HSA, among other provisions.

Opioid Funding

The Senate bill would remove the Medicaid restriction for treatment of opioid addiction for stays up to 30 days, not to exceed 90 days in a calendar year. This should result in more dollars being available for Medicaid programs when people need treatment. The bill also includes $2 billion in 2018 for states battling the opioid crisis.

Repealing of Taxes

The bill repeals many of the taxes that were contained in the ACA that were designed to pay for coverage expansions, including the payroll tax on high-income earners in 2023, as well as taxes on medical devices and tanning salons.

State Stability and Innovation Fund

According to the American Hospital Association's analysis, the Senate bill would establish pools of funds for both insurers and states to help ensure access to coverage and improve the affordability of coverage. The fund is split into "short-term" and "long-term" components. The short-term fund makes $50 billion available to the Centers for Medicare & Medicaid Services between 2018 and 2022 to provide resources to insurers to help "address coverage and access disruption and respond to urgent health care needs." There are no state matching requirements for this portion of the funding. The long-term fund would provide states with access to $62 billion from 2019 to 2026 to implement high-risk pools, establish premium stabilization programs, make payments to providers, and assist individuals with premiums and cost sharing, among other potential uses. States would be required to contribute toward program costs, starting with a 7% contribution beginning in 2022, increasing to 35% in 2026.

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