Summary of Key Provisions of Better Care Reconciliation Act (BCRA)

Premium Tax Credits

The Senate changes the ACA premium tax credit structure starting in 2020. Particular changes include:

- Premium tax credits based on a percentage of income and also adjusted by age (this will result in shifts among individuals in terms of tax credit amounts compared to the ACA)
- An upper income tax credit limit of 350% of FPL (400% under the ACA)
- Availability of the premium tax credits for those under 100% of FPL
- The tax credit is now also pegged to a median 58% AV plan rather than a second-lowest cost silver plan

CSRs

CSRs are funded for 2018 and 2019 and repealed after 2020.

Other market provisions

- The age rating is changed to 5:1 starting in 2019 (states can opt for another rating level).
- The states would take responsibility for MLR starting in 2019.

Mandates

The individual and employer mandates are repealed back to 2016 (same as House bill).

Stability Fund

The Senate version of the Stability Fund is broken into two programs:

- Short-Term Assistance: Funds insurers directly to address coverage and access disruption, and to respond to urgent care needs within states. Distribution of funds will be specified by the Administrator. A total of $50 billion over four years (without a match from states) would be made available starting in 2018
- Long-Term State Stability and Innovation: Requires states to submit an application that certifies that the State will provide matching funds starting in 2022. For those states certified, a total of $62 billion would be made available for this program starting in 2019 through 2026. The funds can be used for one of the four purposes below:
  1. Program for high-risk individuals (which combines purposes (1) and (3) of the AHCA Stability Fund)
  2. Program to enter into arrangements with issuers to stabilize premiums and promote market participation (which combines purposes (2) and (4) of the AHCA Stability Fund)
  3. Provide payments to providers (similar to AHCA (8))
  4. Provide assistance to reduce out-of-pocket costs (similar to AHCA (9))

  For 2019, 2020, and 2021, $5 billion of the states' long-term stability fund year's allotted must be used for number 2 purpose (above). States appear to have three years to spend their money.

Taxes

The repeal of tax provisions largely parallels the House AHCA except for slightly later start dates on some of the taxes.

- The HIT is repealed going forward (same as the House).
- The medical deduction threshold is changed to 7.5% (5.8%).

State Waivers

The Senate bill amends the ACA's Section 1332 to make it easier for states to obtain a waiver of ACA provisions, including requirements around QHPs, EHBs, Exchanges, APTC and CSR payments. These are the same parts of the ACA that could be waived under current law, but the Senate's language would not require states' waivers to maintain comprehensive coverage levels and cost sharing levels. The 1332 waiver under the Senate bill would require that the waiver increase access to coverage, reduce average premiums and increase enrollment, while not increasing the Federal deficit. The process for obtaining a waiver is also streamlined under the Senate bill.

Medicaid

Expansion Population and Associated FMAP

- In a departure from the House bill, states can continue to expand Medicaid through the end of 2019 but enhanced federal funding appears to end in 2023. There isn't "roll-off" approach after a month in loss of eligibility as there was in the House bill.
- For states that expanded Medicaid under the ACA (including those states that expand Medicaid through 2019), the enhanced match rate would decrease as follows:
    - 90% in 2020
    - 85% in 2021
    - 80% in 2022
    - 75% in 2023
- For those that expanded Medicaid prior to the ACA, the enhanced FMAP transition percentage is capped at 80% beginning in 2017-2023.
- The EHB requirement is repealed, as it was in the House bill, for the expansion population beginning in 2020.

Per Capita Caps

The structure of the per capita caps is largely the same. Below is a list of key differences.

- **Base rate:** Under the Senate version, states can select eight consecutive fiscal quarters between 2014 through the third quarter of 2017 to establish their base rate—the House bill base rate was set based on states' 2016 experience.
- **Inflation factor:** The inflation rate in the Senate bill is not as generous as the House version. The House bill pegged the inflation factors to medical CPI-U through (ABD population got a +1%). The Senate bill would also use medical CPI-U as the inflation factor through 2024, but after that point in time the inflation factor would decrease to CPI-U.
- **"Adjustment to State Expenditures Targets to Promote Program Equity Across States":** this new section (not in the House bill) creates a corridor-like check on the per capita caps. If a state per capita medical assistance expenditures in the preceding year exceed the mean per capita medical assistance expenditures for all states by more than 25% the state's target per capita medical assistance expenditures for the category would be reduced using an approach established by the Secretary, but that cannot be less than .5% or more than 2%. If vice versa, the state is less than 25% of the mean, the state

would see an increase in funding no less than .5% or more than 2%. There are certain exception to this process, including for states that have low population densities. The transfers in totality cannot increase federal payments for a fiscal year.

Non-expansion State Olive Branches

- DSH allotments are increased for non-expansion states only (similar to House bill but Senate bill uses a different formula).
- Non-expansion states could provide enhanced payment rates to providers that serve the Medicaid population and/or the uninsured from FY 2018-2022. The FMAP for the associated increases will be covered at as much as 100% from FY 2018-2021 and 95% in 2022.

Block Grant Option

Beginning in 2020, states can apply for the "Flexible Block Grant Option". The Senate version is more prescriptive than the House version in how states must implement the program in terms of the benefits that must be provided, the level of cost sharing that can be imposed, how States may use the funds, among other features.

Medicaid CHIP and Quality Performance Bonus Payments

From 2023 through 2026, the Secretary may award a total of $8 billion to states (and the District of Columbia) who meet performance standards on a series of quality measures, to be determined by the Secretary. In addition to meeting the quality standards, a state's adjusted total medical assistance expenditures must be less than its target total medical assistance expenditures, to be eligible for the funds.

Waivers

The bill allows for managed care waivers under Sections 1115 or 1915 to be grandfathered if they have been renewed at least once and no changes are made to the waiver. In addition, the bill directs the Secretary to promote the use of state waivers expanding access to home- and community-based services (HCBS).

Coordinating with States

The bill requires the Secretary to coordinate with state agencies involved with carrying out the provisions in Title 1 of the bill, including state Medicaid programs and their directors, before finalizing any proposed rule implementing Title 1 of the bill.