Highlights from the Senate's Proposed Health Care Bill

On June 22, 2017, Republican leaders in the U.S. Senate released a draft proposal aimed at repealing and replacing key portions of the Affordable Care Act ("ACA"). In many respects, the Senate proposal, the Better Care Reconciliation Act of 2017 ("BCRA"), is very different from the American Health Care Act ("AHCA") passed by the House of Representatives on May 6, though some of the hallmarks of the AHCA are retained in the Senate bill.

The Senate could vote on the BCRA as early as next week, once the Congressional Budget Office releases its estimate of the bill's financial impact. Senate Majority Leader Mitch McConnell (R-KY) has indicated he intends to bring the bill to a vote before Congress' July 4 recess. Assuming the BCRA will have no support from Senate Democrats, McConnell can only afford to lose two Republican votes and still pass the bill. It is far from clear whether the bill will garner enough support from Senate Republicans to pass in its current form.

Below are highlights of the key provisions in the BCRA that are of particular interest to employers. We will publish a more thorough analysis if and when the bill passes the Senate.

Like the AHCA passed by the House in May, the Senate bill would:

- Not alter the existing tax benefits for employer-sponsored health coverage. As a result, employers could continue to provide health benefits to employees on a tax-free basis.
- Reduce the ACA's individual and employer shared responsibility penalties to $0 retroactively to 2016.
- Delay the so-called "Cadillac tax" on high cost health coverage to 2026.
- Repeal various ACA taxes and fees, including but not limited to the annual provider fee, prescription drug tax, net investment income tax, medical device tax, and additional Medicare tax for high wage earners. However, the repeals

would occur on a different schedule than under the AHCA.

- Eliminate the ACA's prohibition on reimbursement of over-the-counter drug costs from FSAs, HRAs, and HSAs, as well as the $2,500 limit on FSA contributions.
- Liberalize the rules for HSAs, including increasing the annual contribution limit to equal the out-of-pocket maximum for high deductible health plans, allowing both spouses to make catch-up contributions to the same HSA, and reducing the tax penalty non-qualified HSA withdrawals from 20% to 10%.
- Expand the permissible age bands for premium rates in the individual and small group markets to 5:1 (from 3:1 under the ACA) and give states the option to determine their own ratio.
- Impose a one-year prohibition on federal funding for Planned Parenthood.
- Significantly overhaul the existing Medicaid structure, including phasing out ACA Medicaid expansion, allowing states to impose a work requirement on non-disabled, non-elderly, non-pregnant adults, and restructuring the Medicaid financing system to provide for per capita caps (with the option for block grants for certain populations). Some of the specifics in the Medicaid reform provisions of the BCRA differ from those in the ACHA, but the details are beyond the scope of this bulletin.
- Authorize federal funding programs designed to stabilize the individual and small group markets, although the specific funding structure and amounts in the BCRA differ from those in the AHCA.

On the other hand, as previously noted, many of the provisions in the BCRA differ substantively from the House-passed AHCA. Some notable differences include:

- The BCRA would <u>not</u> replace the individual mandate with a penalty on individuals who fail to maintain continuous health coverage.
- Unlike the AHCA, which replaced ACA premium tax credits for individual health plans with a new tax credit based on age and income, the BCRA would largely retain the existing ACA tax credit structure, though it would modify

the various eligibility and income amounts. First, tax credits would only be available to individuals with income up to 350% of the federal poverty level (instead of 400% under the ACA). The amount of an individual's tax credit would be determined by the median cost of a less generous "benchmark" plan (rather than the second lowest cost silver plan under the ACA). Further, while tax credits under the BCRA would not be available to individuals who are eligible for employer-sponsored health coverage (like the ACA), the BCRA would eliminate the ACA requirement that such coverage satisfy affordability and minimum value metrics. Finally, premium tax credits would not be available for plans providing coverage for abortions other than in cases of rape or incest.

- The Senate bill would amend ERISA to allow for new "small business health plans." Eligible trade associations and franchisee-franchisor arrangements would be permitted to sponsor these new large fully-insured group plans for their small employer and individual members/franchisees. State laws attempting to preclude insurance carriers from offering these plans would be preempted.
- The ACA innovation waiver program would be expanded under the BCRA, allowing the Department of Health and Human Services to grant states waivers from various ACA insurance market reforms beginning in 2017. HHS would be required to grant waiver applications unless doing so would increase the federal deficit.
- Beginning in 2019, the BCRA would require states to establish their own medical loss ratio and rebate thresholds.

It is expected that the Senate bill will be hotly debated over the coming week, and the bill could be certainly be amended between now and a Senate vote. We will be watching the bill closely and will bring you significant developments as they occur.