Summary of Senate Discussion Draft of H.R. 1628, the Better Care Reconciliation Act
As Modified and Released on June 26, 2017

A draft of legislation called The Better Care Reconciliation Act of 2017 (BCRA) was released on June 22, 2017 by the Senate Budget Committee, and was subsequently modified on June 26, 2017.[1] The draft is of an amendment in the nature of a substitute for H.R. 1628, as passed in the House of Representatives on May 4, 2017.

The June 26th modifications involved the addition of a new section 206 providing for a continuous coverage requirement in the individual market and changes in the section 106 state stability provision with respect to use of funds.

Table of Contents

[1] Available at https://www.budget.senate.gov/imo/media/doc/BetterCareReconcilistionAct.6.26.17.pdf.

Title I

Sec. 101. Elimination of Limit on Recapture of Excess Advance Payments of Premium Tax Credits

Limits on recapture of advance payments of premium tax credits would be repealed. Any advance payments of the current premium tax credits under section 36B of the Internal Revenue Code (IRC) to a household in excess of the final amount determined on the household's tax return would be fully subject to recapture, effective for tax years beginning with 2018. Under current law, the recapture is limited for individuals with income below 400% of the federal poverty level (FPL). Specifically, for the 2017 tax year, the "recapture" of excess advance payments is limited to the following amounts, which would be repealed:

2017 limits on recapture of advanced payments of premium tax credits		
Household income as % of FPL	Tax Filing Status	
	Single	All other
Less than 200%	$300	$600
At least 200% but <300%	$750	$1,500
At least 300% but <400%	$1,275	$2,550

Sec. 102. Restrictions for the Premium Tax Credit

Modifications would be made to the premium tax credit currently available under section 36B of the IRC for tax years beginning in 2020.

Eligibility for the credit. Eligibility for the credit would be limited to individuals with incomes up to 350 percent of the FPL, compared with 400 percent in current law.

The current requirement that limits eligibility for credits to a citizen or national of the United States or an alien "lawfully present" would be modified to apply to a citizen or national or a "qualified alien within the meaning of section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996". Similar amendments to replace "an alien lawfully present" with "a qualified alien" are also made to sections 1411 and 1412 of the Patient Protection and Affordable Care Act (PPACA) relating to eligibility determinations and the advanced payment of premium tax credits.

Amount of the credit. The amounts that individuals would be required to contribute toward the cost of premiums would be modified to vary by age as well as income, as shown in the table below. The age applicable to a taxpayer is the age attained before the close of the tax year by the oldest individual for which the credit is claimed.

The value of the tax credit would be calculated as the difference between the premium for the "median cost benchmark plan" and the required contribution. (Under current law, the value of the tax credit is equal to the difference between the premium for the second lowest cost silver plan available on the Exchange and the required contribution.)

The "median cost benchmark plan" is defined as the median premium of plans in the individual market in the taxpayer's rating area that have an actuarial value of 58 percent as determined under rules "similar to" the rules for calculating actuarial value specified in paragraphs 1302(d)(2) and (d)(3) of PPACA. Current requirements that the plan be offered through the Exchange and provide for self-only and family coverage are retained.[2]

The methodology for indexing the required contribution percentages would be modified. Under current law, the methodology provides for annual adjustments to the required premium contribution percentages to reflect the excess of the growth rate of premiums over the growth rate of income for the previous year. An additional adjustment is made in years after 2018 if the aggregate amount of premium tax credits and cost sharing subsidies exceeds 0.504 percent of the gross domestic product (GDP). (The adjustment reflects the excess of the rate of growth in premiums over the rate of growth in the Consumer Price Index for the previous year.) Under the provision, the additional adjustment would be triggered if the aggregate amount of premium tax credits and cost sharing subsidies exceeds 0.4 percent of GDP instead of 0.504 percent.

[2]There is no requirement that issuers participating in the Exchange offer a plan with an actuarial value (AV) of 58 percent. Bronze plans have an AV of 60 percent, and under current *de minimis* regulations may have an actuarial value as low as 58 percent. Issuers participating in an Exchange are required to offer at least one silver level plan (70 percent AV) and one gold level plan (80 percent AV).

"In the case of household income (expressed as a percent of the poverty line) within the following income tier:	Up to Age 29		Age 30-39		Age 40-49		Age 50-59		Over Age 59	
	Initial %	Final %	Initial %	Final %	Initial %	Final %	Initial %	Final %	Initial %	Final %
Up to 100%	2	2	2	2	2	2	2	2	2	2
100%-133%	2	2.5	2	2.5	2	2.5	2	2.5	2	2.5
133%-150%	2.5	4	2.5	4	2.5	4	2.5	4	2.5	4
150%-200%	4	4.3	4	5.3	4	6.3	4	7.3	4	8.3
200%-250%	4.3	4.3	5.3	5.9	6.3	8.05	7.3	9	8.3	10
250%-300%	4.3	4.3	5.9	5.9	8.05	8.35	9	10.5	10	11.5
300%-350%	4.3	6.4	5.9	8.9	8.35	12.5	10.5	15.8	11.5	16.2",

For purposes of comparison, the 2017 premium tax credit household contribution is determined using the following table. (See IRS Revenue Procedure Publication 2016-24.)

Household income percentage of Federal poverty line:	**Initial percentage**	**Final percentage**
Less than 133%	2.04%	2.04%
At least 133% but less than 150%	3.06%	4.08%
At least 150% but less than 200%	4.08%	6.43%
At least 200% but less than 250%	6.43%	8.21%
At least 250% but less than 300%	8.21%	9.69%
At least 300% but not more than 400%	9.69%	9.69%

Treatment of employer-sponsored coverage. The bill would strike the provision of current law that provides eligibility for the tax credit in the case of individuals who are enrolled in minimum essential coverage through an employer plan that does not meet specified requirements as affordable coverage (i.e., the required employee contribution is in excess of 9.69 percent of household income).

Special rules for small employer health reimbursement arrangements. Current rules regarding the interaction between the premium tax credit and qualified small employer health reimbursement arrangements would be changed. Credit eligibility would be denied for any month in which an individual is enrolled in a qualified small employer health reimbursement arrangement, and the amount of any credit provided for such a month without regard to this restriction would be reduced by 1/12 of the benefit under the arrangement. Under current law, the exclusion applies only when the arrangement constitutes affordable coverage (i.e., when the employee's net cost of coverage for the plan is no more than 9.69 percent of their household income.

Penalties for Erroneous Claims of Credit. In the case of a taxpayer who files a tax return claiming a section 36B credit in excess of the allowed amount, a penalty would be imposed equal to 25 percent of the excess, unless the excess claim is shown to be for a reasonable cause. (In general, under the IRC, the penalty associated with excess claims for a tax credit is 20 percent of the excess.)

Prohibition on Abortion Coverage. For purposes of the tax credit, the definition of qualified health plan is modified to exclude plans that include coverage for abortion other than abortions necessary to save the life of the mother or with respect to a pregnancy that is the result of rape or incest. This prohibition is effective for tax years beginning in 2018.

Sec. 103. Small Business Tax Credit

The small business tax credit provided under section 45R of the IRC would not apply to taxable years beginning after December 31, 2019.

In the interim, for taxable years beginning in 2018 and 2019, the credit would be modified to exclude plans that include coverage for abortions (other than those necessary to save the life of the mother or with respect to a pregnancy that is the result of rape or incest).

Sec. 104. Individual Mandate

The penalty for individuals who fail to maintain minimum essential coverage (the "individual mandate") would be reduced to zero for months beginning after December 31, 2015.

Sec. 105. Employer Mandate

The penalty for employers failing to meet the shared responsibility requirements regarding health coverage under section 4980H of the IRC (the "employer mandate") would be reduced to zero for months beginning after December 31, 2015.

Sec. 106. State Stability and Innovation Program

Title XXI of the Social Security Act (SSA) (the State Children's Health Insurance Program) would be amended to provide funding for short-term and long-term assistance to address stability of insurance markets.

Short-term assistance to address coverage and access disruption and provide support for states. For 2018 through 2021, the BCRA would authorize and appropriate $50 billion in funds for distribution by the Administrator of the Centers for Medicare & Medicaid Services (CMS) to participating issuers. (Funding would be $15 billion each for 2018 and 2019 and $10 billion each for 2020 and 2021.) The funds would be used for arrangements with health insurance issuers to assist in the purchase of health insurance coverage by addressing coverage and access disruption and responding to urgent health care needs within states. The funds appropriated would remain available until expended. No state matching requirements would apply to these funds.

The Administrator would have 30 days to issue guidance to health insurance issuers regarding how to submit a notice of intent to participate in the program. For 2018, the notice would need to be submitted no later than 35 days after the date of enactment, and for 2019 through 2021, by March 31 of the previous year. The Administrator would determine the form and manner by which issuers would submit a notice of intent and the procedure for distributing funds.

The notice of intent would include a certification by the issuer that the funds would be used to help stabilize premiums and promote state health insurance market participation and choice of plans offered in the individual market, and that other specified requirements were met. These include a certification that the funds would not be used by a state for an expenditure attributable to an intergovernmental transfer, certified public expenditure, or other expenditure used to finance the required non-federal share of expenditures for Medicaid or CHIP or any other provision of law. In addition, certain of the restrictions on the use of funds applicable to CHIP and specified at section 2105(c) would not apply to these payments; those that would be retained involve use of funds for abortion, use of federal funds to meet non-federal matching requirements, and citizenship documentation requirements.

Long-term state stability and innovation program. Beginning with 2019, states (defined here as the 50 states and the District of Columbia) could apply for an allotment of funds to do one or more of the following:

> (1) establish or maintain a program to help high-risk individuals without access to employer coverage purchase an individual market plan;
> (2) establish or maintain a program to enter into arrangements with issuers to assist in the purchase of health benefits coverage by stabilizing premiums and promoting state health insurance market participation and choice of plans in the individual market;
> (3) provide payments to providers as specified by the Administrator; and
> (4) provide health insurance coverage by funding assistance to reduce out-of-pocket costs for enrollees of plans offered in the individual market.

States would apply for funding for a year by March 31 of the preceding year in a form and manner determined by the Administrator, and describe how the funds would be used. An application approved for one year would be deemed to be approved for that year and each subsequent year through 2026. In the application, states would certify that matching requirements would be met; that the funds would be used for the activities specified; and that the funds would not be used for an expenditure attributable to an intergovernmental transfer, certified public expenditure, or other expenditure used to finance the required non-federal share of expenditures for Medicaid or CHIP or any other provision of law. Other information may be required by the Administrator.

Funds appropriated for this program total $62 billion for 2019 through 2026 as follows: $8 billion in 2019; $14 billion each for 2020 and 2021; $6 billion each for 2022 and 2023; $5 billion each for 2024 and 2025; and $4 billion for 2026.

The Administrator would make allotments to the states with approved applications and would be directed to ensure that, for 2019, 2020, and 2021 at least $5 billion of the amounts appropriated for each year is used by states for the purpose identified in item (2) above: establish or maintain a

program to enter into arrangements with issuers to help stabilize premiums and promote state health insurance market participation and choice of plans in the individual market.

Beginning in 2022, state matching requirements would be imposed. For that year, states receiving federal funds would contribute 7 percent of the allotted amounts, rising to 14 percent in 2023, 21 percent in 2024, 28 percent in 2025 and 35 percent for 2026 and later years.

Amounts allotted to a state would be available for expenditure by the state through the end of the second succeeding year. Beginning with 2021, amounts unused as of March 31 from the previous year would be redistributed among states with approved applications using a methodology specified by the Administrator. State matching requirements would apply to redistributed funds. Redistributed funds received by a state would be available to the state for expenditure through the end of the second succeeding year.

The Administrator would be authorized to make payments for each year based on estimates submitted by the state and would adjust as necessary to account for overpayment or underpayment in prior years. States could make claims for prior year expenditures. Payments to a state could be withheld, reduced, or recovered, as appropriate, if a state is determined to have used funds in a manner inconsistent with the approved application. Certain of the restrictions on the use of funds applicable to CHIP specified at section 2105(c) would not apply to these payments; those that would be retained involve the use of funds for abortion, the use of federal funds to meet non-federal matching requirements, and citizenship documentation requirements.

Sec. 107. Better Care Reconciliation Implementation Fund

The sum of $500 million would be appropriated to a new fund within the Department of Health and Human Services (HHS) to provide for administrative expenses in implementing the provisions of the Better Care Reconciliation Act.

Sec. 108. Repeal of the Tax on Employee Health Insurance Premiums and Health Plan Benefits

The excise tax on high-cost employer-sponsored coverage (section 4980I of the IRC- also known as the “Cadillac tax”), scheduled under current law to apply for taxable years beginning after December 31, 2019, would be delayed until taxable years beginning after December 31, 2025.

Sec. 109. Repeal of Tax on Over-the-Counter Medications

Section 223(d)(2)(A) of the IRC would be amended to allow reimbursements from Health Flexible Spending Accounts (FSAs) and Health Reimbursement Arrangements (HRAs) and distributions from HSAs or Archer Medical Savings Accounts (MSAs) to be used for over-the-counter medications, and those amounts would be excluded from the taxpayer’s income. In the case of HSAs and MSAs, the provision would be effective for amounts paid with respect to taxable years beginning after December 31, 2016. In the case of health FSAs and HRAs, it would be effective for expenses incurred for taxable years beginning after December 31, 2016.

Sec. 110. Repeal of Increase in Tax on Health Savings Accounts

The tax imposed on distributions from HSAs for nonqualified medical expenses (section 223(f)(4)(A) of the IRC) would be reduced from 20% to 10%. The tax imposed on distributions from Archer MSAs (section 223(f)(4)(A) of the IRC) would be reduced from 20% to 15%. These changes would apply for distributions made after December 31, 2016.

Sec. 111. Repeal of Limitations on Contributions to Flexible Spending Accounts

Section 125 of the IRC would be amended to repeal the dollar limitation on the maximum amount an employee may contribute through salary reduction to a health flexible spending account. (For 2017, that amount is $2,600). This change would apply to taxable years beginning after December 31, 2017.

Sec. 112. Repeal of Tax on Prescription Medications

The annual fee on covered entities engaged in the business of manufacturing or importing branded prescription drugs for sale to any specified government program, or pursuant to coverage under any such program, would be repealed with respect to any calendar year beginning after December 31, 2017.

Sec. 113. Repeal of Medical Device Excise Tax

Section 4191 of the IRC providing for an excise tax on medical devices would be amended so that that the tax would not apply to sales after December 31, 2017.

Sec. 114. Repeal of Health Insurance Tax

The annual fee on entities engaged in the business of providing health insurance in the U.S. would be repealed for any calendar year beginning after December 31, 2016. This tax was in effect for calendar years 2014 through 2016 and suspended for 2017 under the Consolidated Appropriations Act of 2016.

Sec. 115. Repeal of Elimination of Deduction for Expenses Allocable to Medicare Part D Subsidy

Section 139A of the IRC currently provides that a deduction for qualified retiree health prescription drug expenses that would otherwise be allowable to a taxpayer (i.e., an employer) is not available if the taxpayer excludes from income qualified retiree prescription drug plan subsidies received from HHS with respect to those expenses (i.e. the taxpayer cannot deduct prescription drug expenses if the retiree also has prescription drug coverage through an employer that is subsidized by HHS). This section would be amended effective for taxable years beginning after December 31, 2016 to provide that such a taxpayer would be able to claim a deduction for covered retiree prescription drug expenses even though that taxpayer excluded from income qualified retiree prescription plan subsidies received from HHS.

Sec. 116. Repeal of Chronic Care Tax (Change in Medical Expense Deduction)

Under current law, taxpayers may deduct unreimbursed qualified medical expenses that exceed 10% of adjusted gross income. The deduction threshold would be changed to 7.5% of adjusted gross income effective for taxable years beginning after December 31, 2016.

Sec. 117. Repeal of Medicare Tax Increase

The increased Medicare hospital insurance (HI) taxes (0.9% FICA tax and self-employment tax) owed by taxpayers whose wages exceed a certain threshold (e.g., $250,000 in the case of a joint return) would be repealed effective with respect to remuneration received after, and taxable years beginning after December 31, 2022.

Sec. 118. Repeal of Tanning Tax

The 10% retail sales tax on indoor tanning services would be repealed for services performed after September 30, 2017.

Sec. 119. Repeal of Net Investment Income Tax

The 3.8% tax on net investment income of certain high-income taxpayers ($250,000 joint return or surviving spouse, $125,000 in the case of a married individual filing a separate return, and $200,000 in any other case) would be repealed effective for tax years beginning after December 31, 2016.

Sec. 120. Remuneration from Certain Insurers

The limitation on deductibility of compensation paid by health insurers would be repealed effective for taxable years beginning after December 31, 2016. (In general, health insurance providers may currently only deduct as a business expense for a year the compensation paid to any officers, employees, directors, and other workers or service providers (such as consultants) performing services for or on behalf of the insurer up to $500,000.)

Sec. 121. Maximum Contribution Limit to Health Savings Accounts

Sections 223(b)(2)(A) and (B) of the IRC (relating to HSAs) would be amended to increase the maximum contribution limit to a qualified HSA (which, for 2017, is $3,400 for self-only coverage and $6,750 for family coverage) to the sum of the annual deductible and out-of-pocket limit permitted under the taxpayer's high deductible health plan. For 2017, those deductible/out-of-pocket limit amounts are $6,650 in the case of self-only coverage and $13,100 in the case of family coverage. As under current law, the basic HSA contribution limits would be increased by $1,000 for an eligible individual who has attained age 55 by the end of the taxable year. The changes would apply for taxable years beginning after December 31, 2017.

Sec. 122. Allow Both Spouses to Make Catch-up Contributions to the Same Health Savings Account

Section 223(b) of the IRC would be amended to provide that, if both spouses are eligible for catch-up contributions to their HSAs and either has family coverage, the annual contribution limit that can be divided between them would include the catch-up contribution amount of both spouses. (Catch-up contributions increase the basic HSA contribution limit by $1,000 for an eligible individual who has attained age 55 by the end of the taxable year.) The provision applies for taxable years beginning after December 31, 2017.

Sec. 123. Special Rule for Certain Medical Expenses Incurred Before Establishment of Health Savings Account

Section 223(d)(2) of the IRC would be amended by adding a new subparagraph (D) providing that if an HSA is established during the 60-day period beginning on the date that coverage of the account beneficiary under a high deductible health plan begins, then solely for purposes of determining whether an amount paid is used for a qualified medical expense, the HSA would be treated as having been established on the date that the coverage began. In other words, if a taxpayer with a high deductible health plan established an HSA within 60 days of the date that the high deductible plan coverage began, any payment made by the taxpayer from the HSA for a qualified medical expense incurred during that 60-day period would be excludable from their gross income. Applies with respect to coverage beginning after December 31, 2017.

Sec. 124. Federal Payments to States

States would be prohibited from using federal funds in making payments to a prohibited entity, which, as specified, describes Planned Parenthood, for the one-year period beginning on the date of enactment of BCRA. Restricted federal funds would be those made as direct spending (i.e., provided by law other than appropriation acts; entitlement authority; and the Supplemental Nutrition Assistance Program) and would include payments made to the states under section 1115 or 1915 waivers of the SSA.

Sec. 125. Medicaid Provisions

Hospital Presumptive Eligibility. A provision requiring states to allow hospitals to make presumptive eligibility determinations for all categories of Medicaid beneficiaries would be repealed beginning January 1, 2020. Any existing elections by hospitals to conduct presumptive eligibility determinations under this provision would cease to be effective beginning on that date. States would continue to have the option under separate authority to authorize "qualified entities" including hospitals to make presumptive eligibility determinations for children, pregnant women, and women qualifying on the basis of having breast or cervical cancer.

Low-Income Children Over Age 6. The requirement that states provide Medicaid to low-income children over age 6 in families with income up to 133% of the FPL would end on December 31, 2019. Beginning January 1, 2020, states would only be required to provide Medicaid to those children over age 6 who are in families with income below 100% of the FPL.

Enhanced Federal Matching Payments for Attendant Care Services. The bill would eliminate the additional 6 percentage point federal match for states that provide community-based attendant services and supports on December 31, 2019. Standard federal matching rates would apply to state spending on these services beginning January 1, 2020.

Sec. 126. Medicaid Expansion

Sunset of Expansion Provisions. The legislation would sunset the Medicaid expansion provisions of the ACA on December 31, 2019 but would establish a new "Expansion Enrollees" optional coverage group that would become available beginning January 1, 2020.

The state option to extend Medicaid coverage to adults with income *above* 133% of the federal poverty level would be eliminated. The option would no longer be available to states after December 31, 2017.

The BCRA would create a new optional eligibility group called "Expansion Enrollees" in new section 1902(nn) of the SSA comprised of individuals under age 65, not pregnant, not entitled to Medicare, not otherwise eligible for Medicaid and whose income is below 133% (138% taking into account the standard income disregard) of the FPL applicable to a family of the size involved.

Phase-down of Enhanced Matching Rate for Childless Adults. The bill would phase down the enhanced federal matching payment percentage (EFMAP) for expansion enrollees in states that expanded coverage before March 1, 2017. Under current law, the federal share of program costs for this population is equal to 95% for calendar quarters in 2017 descending to 90% for calendar quarters in 2020 and each year thereafter. This provision would reduce the federal share for years after 2020. The federal share would become the higher of the state's usual federal matching percentage or 85% for calendar quarters in 2021; 80% for calendar quarters in 2022; and 75% for calendar quarters in 2023. After 2023, the state would receive their usual federal matching percentage for expansion enrollees.

In states expanding coverage to expansion enrollees after March 1, 2017, the state's usual federal matching percentage would apply beginning with calendar quarters (or any portion of a calendar quarter) after February 28, 2017.

Phase-down Enhanced Match for Early Adopter States. The BCRA would also amend the formula for enhanced federal matching payment percentages for "early adopter states," or those states that expanded Medicaid for non-pregnant childless adults before March 23, 2010. Under current law, for those states, the federal match for childless adults will phase up from the state's regular FMAP for medical assistance services to the EFMAP for new ACA expansion enrollees so that for calendar year (CY) 2017, a state will receive 80% of the difference between those two percentages; in CY 2018 they will receive 90% of that difference; and beginning in CY 2019 a state will reach the full EFMAP for ACA expansion enrollees. Under the BCRA, an early adopter state would stop phasing up at the 2017 percentage – or 80% of the difference between

the state's regular FMAP and the EFMAP. They would receive 80% for CY 2017 through CY 2023, after which the state's regular FMAP would apply.

Sunset of Essential Health Benefits Requirement. The BCRA would eliminate the requirement that alternative benefit plans under Medicaid include the coverage of essential health benefits after December 31, 2019.

Under current law, states that expand Medicaid to the ACA adult expansion group are required to provide "benchmark benefits" or "benchmark equivalent" coverage to those individuals (also known as Alternate Benefit Plans (ABPs)). States can provide ABP coverage to certain other groups of Medicaid enrollees but some populations, such as people who are blind and disabled, cannot be required to enroll in such plans. ABPs are based on one of the three commercial insurance products, or the "Secretary approved" coverage option. The ACA modified the definition of ABPs to include coverage of the essential health benefits as described in section 1302(b) of the ACA, requiring that the following ten benefit categories be part of any ABP: (1) ambulatory patient services, (2) emergency services, (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance use disorder services, including behavioral health treatment, (6) prescription drugs, (7) rehabilitative and habilitative services and devices, (8) laboratory services, (9) preventive and wellness services and chronic disease management, and (10) pediatric services, including oral and vision care.

Sec. 127. Restoring Fairness to DSH Allotments

Non-Expansion States. The cuts in disproportionate share hospital (DSH) allotments specified in current law for fiscal years 2018 through 2025 would be eliminated for any fiscal year in which a state is a non-expansion state. In addition, certain non-expansion states would, for fiscal year 2020, be eligible for an increase in their DSH allotment. Non-expansion states that have a ratio of their 2016 DSH allotment to their 2016 Medicaid enrollment that is below the national average of such ratio would qualify for a boost in their DSH allotment, such that the ratio would no longer be below the national average for all states. Such an increase would be disregarded when CMS calculates the state's DSH allotment for the second, third, and fourth quarters of fiscal year 2024 and thereafter (which has the effect of boosting allotments for those states for the periods between fiscal year 2020 and the second quarter of fiscal year 2024).

Expansion States. For expansion states, for a fiscal year, the share of the DSH reduction for that year would be calculated as if all states continued to be subject to those reductions as under current law.

Sec. 128. Reducing State Medicaid Costs

The period of retroactive eligibility for Medicaid beneficiaries would be shortened. Under current law, Medicaid eligibility begins at the start of the third month before the month in which the person made their application. Under the legislation, effective on October 1, 2017, eligibility would begin at the start of the month in which the individual made their application.

Sec. 129. Providing Safety Net Funding for Non-Expansion States

A total of $2 billion in new "safety net" funding would be made available for non-expansion states for each of FYs 2018 – 2022. During those years, states that, as of July 1 of the preceding fiscal year, did not expand coverage for ACA childless adults would qualify for a portion of those funds. The funds would be made available to states to allow for payments to health care providers that provide Medicaid services.

The funds would be available to non-expanding states at a 100% federal matching rate for calendar quarters in FY 2018 through FY 2021 and 95% for calendar quarters in FY 2022. Each state would be eligible to receive an amount in each of those years that is equal to $2 billion multiplied by a ratio based on the state's share of individuals under 138% of poverty in 2015 in non-expansion states. The data used for the calculation would come from using the table entitled "Health Insurance Coverage Status and Type by Ratio of Income to Poverty Level in the Past 12 Months by Age" for the civilian non-institutionalized population based on the 2015 American Community Survey 1 Year Estimates. Each hospital would be limited to receiving an amount that does not exceed its costs in furnishing health care services to either Medicaid individuals or those who have no health insurance or coverage for such services.

Sec. 130. Eligibility Redeterminations

Beginning on October 1, 2017, states would have the option, when determining eligibility for childless adults and those with income above 133% of the FPL whose financial eligibility is based on modified adjusted gross income, to re-determine Medicaid eligibility as often as every 6 months or more frequently.

Federal matching payments for state spending attributable to increasing the frequency of re-determining eligibility would be increased by 5 percentage points for states for calendar quarters beginning on October 1, 2017 and ending on December 31, 2019.

Sec. 131. Optional Work Requirement for Nondisabled, Non-elderly, Non-pregnant Individuals

States would be permitted to elect, beginning October 1, 2017, to condition medical assistance for adult beneficiaries who are non-disabled, non-elderly, and not pregnant, on their satisfaction of a work requirement.

Work requirements under this section are those defined in section 407(d) of the SSA (pertaining to federal requirements for the Temporary Assistance for Needy Families program) and include unsubsidized employment, subsidized private or public sector employment, on-the-job or vocational training, job search and job readiness assistance, community services programs, vocational education, job skills training, education related to employment and secondary school attendance.

A state could not apply work requirements to pregnant women for 60 days post-partum; children under age 19; individuals who are the only parent or caretaker of a child under the age of 6 or the

only parent or caretaker of a child with a disability; or to individuals under age 20 who are married or the head of the household and who maintain satisfactory attendance at school or participate in education directly related to employment.

The administrative matching rate would be increased by 5 percentage points for the costs of carrying out work requirements.

Sec. 132. Provider Taxes

Under current Medicaid law, states are prohibited from enacting provider taxes that hold the providers harmless by guaranteeing, directly or indirectly, that the providers will be repaid for the amount of taxes they pay. The test for such a guarantee, however, does not apply to those taxes for which the tax rate falls below 6% of the provider's net patient revenue. This provision is commonly referred to as the "safe harbor." The BCRA would gradually reduce the safe harbor to 5%. Under the bill, the safe harbor would be reduced to:

- 5.8% for FY 2021;
- 5.6% for FY 2022;
- 5.4% for FY 2023;
- 5.2% for FY 2024; and
- 5% for FY 2025 and thereafter.

Sec. 133. Per Capita Allotment for Medical Assistance

Federal financing of the Medicaid program would be reformed by instituting a cap on federal payments for most program spending as described in new section 1903A of the SSA.

Section 1903A of the SSA Per Capita-Based Cap on Payment for Medical Assistance

(a) Application of Per Capita Cap on Payment for Medical Assistance Expenditures
An aggregate cap would be applied to most federal payments for state Medicaid programs beginning with fiscal year 2020. To the extent that a state Medicaid program makes payments in excess of its aggregate cap for the portion of the program subject to the cap, federal payments to that state in the following fiscal year would be reduced by the federal share of the amount by which state program spending exceeded the aggregate cap.

The BCRA defines excess aggregate medical assistance expenditures, excess aggregate medical assistance payments, federal average medical assistance matching percentage, and per capita base period. Under this legislation, the base period for the application of the caps would be a period of 8 consecutive fiscal quarters that are selected by each state. Those quarters must begin no earlier than the 1st quarter of FY 2014 and must end no later than the 3rd quarter of FY 2017.

(b) Adjusted Total Medical Assistance (MA) Expenditures
Several definitions necessary for calculating caps and spending subject to caps are provided in 1903A(b).

- Would define "Adjusted Total MA Expenditures" for a state as follows:
  - For a state's base period, adjusted total MA expenditures are MA expenditures (defined below) excluding DSH payments, Medicare cost sharing payments and safety net provider payment adjustments described under new section 129 (see above) multiplied by the 1903A base period population percentage[3]; and
  - For 2019 or a subsequent fiscal year, adjusted total MA expenditures are MA expenditures excluding DSH payments, Medicare cost sharing payments, and safety net provider payment adjustments under new section 129. They specifically *exclude* payments for pediatric vaccines and specifically *include* non-DSH supplemental payments and other supplemental payments such as delivery system reform incentive payments and uncompensated care fund payments (referred to as "pool payments"). With respect to non-DSH supplemental and pool payments (defined in (d) below), the bill would treat all of those payments as being attributable to 1903A enrollees.
- MA Expenditures would be defined as those payments reported by medical service category on Form CMS-64.
- 1903A Base Period Population Percentage would be defined as the percentage of MA spending reported on Form CMS-64 for calendar quarters in the state's per capita base period that are attributable to 1903A enrollees (defined in (e) below to be Medicaid beneficiaries who fall into 5 groups: Elderly, Blind or Disabled (excluding children who are blind and disabled), Children, Expansion Adults, Other Adults.

Since the base period is comprised of 8 quarters, amounts above which use base period MA and base period non-DSH supplemental and pool payments would be divided by two to adjust to a 4 quarter average.

(c) Target Total MA Expenditures
Describes each state's cap, or target total MA expenditures for 2020, as equal to the sum of 5 amounts – each the product of a provisional target per capita amount for 2019 for each enrollee category increased by the applicable annual inflation factor for 2020 multiplied by the number of 1903A enrollees in each group. For years after 2020, each state's cap, or target total MA expenditures, would be equal to the target per capita MA expenditures for the prior year increased by the applicable annual inflation factor.

For FY 2020 – 2024, the applicable annual inflation factor would be equal to the medical component of the consumer price index (medical-CPI) for three of the groups: children, expansion adults, and other adults. For the other two groups, the elderly and those who are blind or disabled excluding children, the index would be equal to the medical-CPI plus 1 percentage point.

[3] It is unclear if amounts for the base period are intended to include or exclude non-DSH and pool supplemental payments and payments for the Vaccines for Children's program.

For FY 2025 and thereafter, the applicable annual inflation factor for all groups would be the CPI for all urban consumers (CPI-U).

Exception for Certain Political Subdivisions. The legislation provides that the target total MA spending for a state that had a 2016 DSH allotment in excess of 6 times the national average and which requires political subdivisions within the state to contribute a share of the costs of Medicaid be reduced by the amount that those political subdivisions are required to contribute.[4] In calculating this reduction, payments under Medicaid as well as under Medicaid waivers will be taken into account. Funds not taken into account would include:

- Contributions required by the state from a political subdivision that, as of the calendar year in which the fiscal year involved begins, has more than 5 million people in it and imposes a local income tax on its residents; and
- Contributions required by the state from a political subdivision for administrative expenses if the state required such contributions without repayment as of January 1, 2017.

Adjustments to State Expenditures to Promote Equity. Beginning in FY2020, target total MA expenditures for certain states would be adjusted upward or downward depending on each state's spending in the prior year. For FY 2020 and 2021, this adjustment would be made by comparing a state's per capita MA spending for all of the individuals subject to the per capita caps together rather than in 5 separate categories. For all other years, the adjustments would be made based on per capita spending for each category of enrollees. The Secretary would be required to make the following adjustments in a way that would not result in a net increase in federal payments and would not apply these adjustments to any state with a population density of fewer than 15 people per square mile.

- A state with per capita MA spending for the prior year for a category of enrollees that is higher than the mean per capita spending for all states for that group of enrollees and for that year by 25% or greater would be subject to a reduction in its target per capita MA expenditures for that category for the fiscal year. The reduction would be by a percentage between 0.5% and 2%. (The precise percentage reduction is left to the discretion of the Secretary.)
- Likewise, a state with per capita MA spending for the prior year for a category of enrollees that is lower than the mean per capita spending for that group of enrollees for that year by 25% or more would be subject to an increase in its target per capita MA expenditures. The increase would be by a percentage between 0.5% and 2%. (Again, the precise percentage reduction is left to the discretion of the Secretary.)

The adjustment made to per capita MA spending amounts under this section would be disregarded when determining a state's target MA spending amounts for the next year.

(d) Calculation of FY 2019 Provisional Target Amount for Each 1903A Enrollee Category
This section describes how provisional target per capita amounts for 2019 would be calculated. It also provides definitions for several other factors used for adjusting the per capita amounts.

[4] This provision is understood to apply only to New York.

- *Provisional per capita target amount for each 1903A enrollee category*. For each of the five 1903A enrollee groups, the average MA spending per capita for the state for FY 2019 would be calculated by dividing FY 2019 MA payments (minus non-DSH supplemental and pool payments) for 1903A enrollees by the number of 1903A enrollees and increasing those amounts by the non-DSH supplemental and pool payment percentage.
    - Non-DSH supplemental payments are payments to providers that are not DSH payments; are not made with respect to a specific item or service; are in addition to payments for specific items or services; and are compliant with requirements related to upper payment limits (defined in 1903(d)(4)(A)(ii)). Pool payments are those that are not DSH payments; not made with respect to a specific item or service; are in addition to payments for specific items or services; and are authorized under a waiver that funds delivery system reform, uncompensated care pools, certain designated health programs or a similar expenditure (defined in 1903(d)(4)(A)(iii)).
    - The state's non-DSH supplemental and pool payment percentage would be defined as the state's spending for non-DSH supplemental and pool payments in the base period divided by the state's total adjusted medical assistance spending in the base period as described in new 1903A(b)(1)(A)[5]. These amounts would be divided by 2 to adjust to 4 quarters.

  Those amounts are then adjusted up or down by the following ratio to match reported overall spending for 2019:

$$\frac{(\textit{Overall average per capita for } 2019 \textbf{ X } \textit{The number of } 1903A \textit{ enrollees in } 2019)}{\textit{Adjusted total medical assistance in } 2019}$$

    - A base year *overall average per capita amount* would be calculated for each state based on adjusted total MA spending for the base year for the state divided by the number of 1903A enrollees on the state's program in that year. That amount for each state would be inflated to 2019 using the CPI-U (from the last month of the state's base period to September of FY 2019) to produce a FY 2019 *overall average per capita* amount for each state.
- *Notice*. The Secretary would provide notice to each state no later than January 1, 2020 of the amount of the adjusted total MA expenditures for the base year, the number of 1903A enrollees for the base period, the average per capita MA spending for the base period, the provisional FY 2019 per capita target amount as well as the non-DSH supplemental and pool payment percentage.

(e) 1903A Enrollee; 1903A Enrollee Category

The 5 enrollee groups that would be subject to per capita caps are defined in this section to be:

- Enrollees who are 65 years of age or older;

[5] As noted above, it is unclear if amounts for the base period are intended to include all non-DSH and pool supplemental payments and payments for the Vaccines for Children program raising concerns that the authority to make some non-DSH supplemental and pool payments will be lost.

- Enrollees who are blind or disabled (those eligible for medical assistance on the basis of being blind or disabled who are not 65 years and not under age 19);
- Children under 19 years of age;
- Expansion enrollees; and
- Other non-elderly, non-disabled, non-expansion adults.

The following categories of enrollees would not be considered 1903A enrollees: children under age 19 who are eligible for medical assistance on the basis of being blind or disabled; individuals covered under a CHIP Medicaid expansion program; individuals who receive medical assistance through an Indian Health Service facility; women receiving Medicaid coverage due to screening under the Breast and Cervical Cancer Early Detection Program; and partial benefit enrollees. Partial benefit enrollees are those receiving only family planning services; tuberculosis related services for those infected with TB; those unauthorized aliens receiving coverage for Medicaid emergency medical care; individuals who are dually eligible for Medicaid and Medicare and for whom Medicaid pays only Medicare premiums and cost-sharing; and individuals receiving premium assistance.

(f) Special Payment Rules
Medical assistance spending under waivers approved under SSA section 1115, SSA section 1915, or any other provision of Medicaid would be subject to the per capita caps in the same manner as if such payments had been made under a state plan under title XIX and the per capita caps described in this section would supersede any other payment limitations otherwise applicable under those waivers.

In the case of states that expand coverage after FY 2016 to include the ACA childless adults, the provisional FY 2019 per capita target amount for that enrollee category would be equal to the provisional FY 2019 per capita target amount for non-disabled adults.

If a state fails to satisfactorily submit data on spending and enrollees as required in subsection (h) (described below) the Secretary would calculate and apply the caps as if all 1903A enrollee categories for which the spending and enrollee data were not satisfactorily submitted were a single 1903A enrollee category, and the growth factor otherwise applied would be reduced by one percentage point.

(g) Recalculation of Certain Amounts for Data Errors
The Secretary would be permitted to adjust several amounts used to calculate caps based on an appeal by a state filed in such form, manner, time, and containing such information as specified by the Secretary. Any adjustment that the Secretary were to determine to be valid may be made except that the adjustment could not result in an increase of the target total medical assistance expenditures in excess of 2%. Amounts that would be permitted to be adjusted would be: excess spending amounts, federal average medical assistance percentages, non-DSH supplemental and pool payment percentages, adjusted total MA payments under (b) and the number of Medicaid enrollees and 1903A enrollees for 2016, 2019 and subsequent fiscal years.

(h) Required Reporting and Auditing of CMS-64 Data; Transitional Increase in Federal Matching Percentage for Certain Administrative Expenses

Reporting. For each quarter beginning on or after October 1, 2018, states would be required to include data on medical assistance spending within such categories of services and categories of enrollees as the Secretary determines are necessary (including timely guidance published as soon as possible after the date of the enactment of the AHCA) in order to implement this section and to enable States to comply with the requirement of this provision on a timely basis.

The legislation also requires the Secretary to modify CMS-64 forms and requires states to begin submitting data on qualified inpatient psychiatric hospital services and on the number of children enrolled in Medicaid who are under age 21 and have a complex medical condition or serious injury. A complex medical condition or serious injury would be defined as one that affects two or more body systems; affects cognitive or physical functioning (such as reducing the ability to perform the activities of daily living); and either requires intensive healthcare interventions and intensive care coordination or meets the criteria for medical complexity under existing risk adjustment methodologies.

The Secretary would be required to audit each state's reporting of the number of individuals and spending reported through the CMS–64 report for a state's base period, FY 2019, and each subsequent fiscal year. The Secretary could use a representative sample for such audits. The IG would also be required to conduct an audit of each state's spending no less frequently than once every 3 years.

Temporary Increase in Federal Matching Percentage to Support Improved Data Reporting Systems**.** The BCRA would provide for the following increases in the federal matching percentages for calendar quarters beginning on or after October 1, 2017 and before October 1, 2019:

- 10 percentage points (to 100%) for the design, development, and installation of mechanized claims processing and information retrieval systems;
- 25 percentage points (to 100%) for the operation of such systems; and
- 10 percentage points (to 60%) for general administration to the extent that such administrative spending is attributable to implementing the data requirements of this subsection.

Finally, HHS would be required to submit a report to Congress by January 1, 2025 making recommendations as to whether data from the CMS-64 or the Transformed Medicaid Statistical Information System (T-MSIS) would be preferable for the activities required in the section.

Sec. 134. Flexible Block Grant Options for States

The bill would establish new SSA section 1903B providing states with an option, beginning no earlier than FY 2020, to conduct a Medicaid Flexibility Program (MFP).

State Application. A state's application would need to describe the program; how it would satisfy federal requirements (described below); the conditions of eligibility for program enrollees; the types, amount, duration, and scope of services offered; and how current enrollees would be notified of their transition to the new program. The description would also need to include statements certifying that the state agrees to submit regular enrollment data and timely and accurate data to the T-MSIS system; annual evaluations and reports on quality; and additional information as required by the Secretary. It would also need to describe the information technology systems plan indicating the capability of the state to support the program and the goals of the program. Goals must include those related to quality, access, rate of growth targets, consumer satisfaction, and outcomes. The application must include a monitoring and evaluation plan and a process for the state to take actions on unmet goals.

Before an application can be submitted, it must be made publicly available for a 30-day period of public notice and comment including public hearings. The Secretary would be required to specify a deadline for states to submit an application that would begin in the next fiscal year, but that deadline could be no earlier than 60 days after the Secretary publishes state block grant amounts. The Secretary of HHS would also be required to make the application publicly available for a 30-day notice and comment period.

Financing. For the initial year of a state's block grant, the state would be subject to a cap on federal Medicaid spending for the block grant enrollees equal to the usual Medicaid federal matching percentage of the product of:

- the target per capita MA expenditures for the state for the year for people in the category of non-elderly, non-disabled, non-expansion adults, and
- the number of 1903A enrollees in that category two years before increased by the percentage increase in the state's overall population in the preceding fiscal year (except that this number could not exceed the number of such enrollees in the state's per capita base period).

For any subsequent year, the block grant amount would be equal to the amount for the previous fiscal year increased by the percentage increase in the CPI-U.

Unused block grant amounts could be rolled over to a succeeding year as long as a state meets a maintenance of effort requirement and is conducting an MFP program in the succeeding year. Those funds could be used for health or any other purpose as long as it is "consistent with the quality standards established by the Secretary." By January 1, 2020, the Secretary would be required to establish quality standards that would allow for the use of rollover funds for non-health purposes.

Federal Payment and State Maintenance of Effort. Under the block grant alternative, for each calendar quarter, a state would receive federal matching funds for spending on block grant enrollees up to the block grant cap. The federal share of that spending would be equal to the state's standard federal matching percentage applicable under the Medicaid program.

Program Requirements. A state would be required to specify the types of items and services, the amount, duration and scope of such services, the cost-sharing with respect to such services, and the method for delivery of block grant health care assistance. In making these specifications the state would need to provide assistance for individuals who would otherwise be eligible for Medicaid that is at least 95% of the aggregate actuarial value of benchmark coverage or benchmark-equivalent coverage under existing Medicaid and must cover at least --

- Inpatient and outpatient hospital services;
- Laboratory and X-ray services;
- Nursing facility services for those over age 21;
- Physician services;
- Home health services;
- Rural health clinic and Federally-qualified health center services;
- Family planning services and supplies;
- Nurse-midwife services;
- Certified pediatric and family nurse practitioner services;
- Freestanding birth center services;
- Emergency medical transportation;
- Non-cosmetic dental services;
- Pregnancy-related services including post-partum for a 12-week period beginning on the last day of the pregnancy; and
- Mental health and substance use disorder coverage that complies with parity requirements under the Public Health Services Act as applicable to group health plans.

The state may provide other additional optional services. If a state chooses to cover prescription drugs, Medicaid rebates would apply. Cost-sharing may apply so long as in aggregate it does not exceed 5% of a family's income.

An MFP approved by the Secretary must be conducted for no less than one program period (which is defined as 5 consecutive fiscal years) and may be continued by the state without resubmitting an application so long as the state provides notice to the Secretary and does not make significant program changes. Only the state can terminate the program but must have a transition plan approved by the Secretary to do so. If terminated, the per capita caps as described above would apply.

A state conducting an MFP would need to provide coverage to individuals who would otherwise be eligible for Medicaid and must use modified adjusted gross income in accordance with existing Medicaid requirements for income determinations.

Under an MFP, a state would be required to provide for simplified enrollment processes, coordinate with Exchanges, and provide a fair process for appealing eligibility determinations.

MFPs would not be required to meet Medicaid state-wideness, comparability of benefits, and freedom-of-choice requirements.

The draft provides definitions of terms applicable to the MFP including for MFP, program enrollee, program period, state, and targeted health assistance.

Sec. 135. Medicaid and CHIP Quality Performance Bonus Payments

The BCRA would provide $8 billion in funding for Medicaid and CHIP quality performance bonus payments to be made available to states for FY 2023 through FY 2026. States and the District of Columbia would qualify for quality performance bonus payments if (i) the Secretary determines that the state's adjusted total MA spending for the fiscal year is lower than the target total MA level for that fiscal year and (ii) if the state provides information on applicable quality measures and a plan for spending the bonus payments on quality improvement activities. The Secretary would determine a formula for computing the allotments for qualifying states based on the state meeting performance (including improvement) goals on quality measures for the performance period, as determined by the Secretary. The Secretary would be required to identify and publish peer-reviewed quality measures including health care and long-term care outcome measures that are quantifiable, objective, and take into account clinically appropriate measures of quality for the different types of patient populations receiving benefits under Medicaid or CHIP. The measures would be made available pursuant to rulemaking after consultation with state Medicaid agencies.

Sec. 136. Grandfathering Certain Medicaid Waivers; Prioritization of HCBS Waivers

States with existing managed care waivers that have been renewed at least one time already would be provided with an option to submit a state plan amendment to continue the managed care delivery system under the waiver in perpetuity. The budget neutrality requirement under any such waiver would continue to apply, however. If a state wanted to modify terms or conditions of a grandfathered waiver, the state would be required to submit an application for approval of a new waiver which would be deemed approved no later than 90 days after submission unless the Secretary issues a denial or requests more information in that period. If the Secretary requests additional information, he would be required to respond within 30 days of the state's submission, either denying the application or requesting more information.

The Secretary would also be required, under the BCRA, to implement procedures to encourage states to adopt or extend waivers related to home and community-based services if the state determines that such waivers would improve access to services.

Sec. 137. Coordination with States

Beginning on January 1, 2018, the BCRA would prohibit the Secretary from finalizing any proposed rule implementing or interpreting any Medicaid provision without soliciting advice from each state agency responsible for administering Medicaid and the state Medicaid director on a regular ongoing basis. The new SSA section 1904A would also require the Secretary to accept and consider written and oral comments from "a bipartisan, nonprofit, professional

organization that represents State Medicaid Directors" and from any state agency administering a Medicaid plan, and to incorporate a summary of those comments and the Secretary's response to each in the preamble to the proposed rule.

Sec. 138. Optional Assistance for Certain Inpatient Psychiatric Services

The bill would provide states with the option to cover inpatient psychiatric hospital services for individuals between 21 and 65 years of age under their Medicaid programs. Under existing law, states already have the option to cover those services for children. Under the proposed state option, the services could be provided in psychiatric hospitals for an individual for a period not to exceed 30 days in a month and 90 days in any calendar year. The bill would provide for a 50% federal matching percentage for those services if a state should take up the option.

Sec. 139. Small Business Health Plans

Section 139 establishes that small business health plans as defined in a new section 801(a) of the Employee Retirement Income Security Act of 1974 (ERISA) offered to employees would be treated as group health plans for the purposes of applying the insurance market rules laid out in subchapter B of chapter 100 of the Internal Revenue Code of 1986, in Title XXVII of the Public Health Service Act, and in Part 7 of Title I of ERISA. Those statutes provide for many of the ACA's market requirements including rating rules, non-discrimination requirements, guaranteed availability, coverage of certain preventive services, and other rules applicable to the individual and small group markets for insurance. This provision would effectively allow for individuals to purchase health insurance coverage under newly defined 'small business health plans' that are exempt from the premium rating and other protections of those federal laws.

New Part 8 of ERISA. The BCRA would establish a new Part 8 at the end of Subtitle B of Title I of ERISA. Under this part, a new type of health insurance plan called a 'small business health plan' (SBHP) would be defined. Under such a plan, employer groups as well as individuals could be covered under plans that would be exempt from otherwise applicable state law affecting the individual insurance market "insofar as they may now or hereafter preclude a health issuer from offering health insurance coverage."

The SBHP provision would take effect one year after the date of enactment. The Secretary would be required to issue necessary regulations within 6 months. Under new Part 8, a SBHP would be defined as a fully insured group health plan, offered by a health insurance issuer in the large group market, whose sponsor:

- receives certification by the Secretary;
- is organized and maintained in good faith and has a constitution and bylaws specifically stating its purpose and providing for periodic meetings on at least annually;
- is established as a permanent entity for a purpose other than providing health benefits to its members such as an organization established as a bona fide trade association; and
- does not condition membership on the basis of a minimum group size.

Certification of SBHP. To qualify as a SBHP, the plan would need to file an application for certification by the Secretary of Labor (hereinafter referred to as "the Secretary") and pay a filing

fee of $5,000. No later than 6 months after the date of enactment, the Secretary would be required to issue interim final rules describing its procedures for certifying a sponsor of a SBHP and for revoking a certification if the SBHP fails to comply with the requirements. The Secretary may also provide for continued certification procedures.

An application would have to include at least the following: identifying information, the states in which the plan intends to do business, bonding requirements, and plan documents and agreements with service providers. A certification would not become effective until a written notice of such certification is filed with the applicable State authority for each State in which the SBHP operates.

Voluntary Termination. The legislation provides that a certified SBHP may terminate its operation only if the board of trustees provides written notice to the participants and beneficiaries; develops a plan for winding up the affairs of the plan in a manner which would result in timely payment of all benefits for which the plan is obligated; and submits that plan in writing to the applicable authority. These steps must be taken no less than 60 days before the termination date.

Oversight. The Secretary would have the discretion to determine if a person has violated or is about to violate any provision of new Part 8, and could conduct periodic review of SBHP sponsors, consistent with existing rules that prohibit certain people from holding office in a labor organization, and apply the requirements of sections 518[6], 519[7], and 520[8] of ERISA.

Expedited and Deemed Certification. If the Secretary fails to act on a complete application for certification under this new Part 8 within 90 days of receipt, the applying SBHP would be deemed certified. The Secretary would be permitted to assess a penalty of up to $500,000 against the board of trustees and plan sponsor of a SBHP sponsor that is deemed certified if the Secretary determines that the application for certification was willfully or with gross negligence incomplete or inaccurate.

Modifications. The Secretary would be required to issue any regulations deemed necessary to implement SBHPs in consultation with effected entities and persons and with minimum disruption to federal and state laws.

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[6] ERISA section 518 and IRC Code section 7508A permits the Secretaries of Labor and the Treasury to postpone for up to one year the deadline for any action required of (or permitted) with respect to an employee benefit plan, sponsor, administrator, participant, beneficiary, or other person with respect to such a plan in the case of a Presidentially declared disaster.

[7] ERISA section 519 prohibits false statements or representations in the sale or marketing of employee benefits by multi-employer welfare arrangements (MEWAs), including statements/representations on (i) the financial condition or solvency of the arrangement, (ii) the benefits under arrangement, (iii) the regulatory status of the arrangement under any federal or state law governing collective bargaining, labor management relations, or intern union affairs, or (iv) any exemption from state regulatory authority.

[8] ERISA section 520 permits the Secretary of Labor to adopt regulations and/or issue orders to prevent MEWAs from avoiding state law jurisdiction for fraudulent activities. The regulations / orders indicate when MWEAs are subject to state insurance law in the states where they operate notwithstanding ERISA rules.

Board of Trustees. The Secretary would be required to ensure that the Board of Trustees of a certified SBHP complies with the rules of operation and financial controls.

Participation and Coverage Requirements. Generally each participating employer must be a member or an affiliated member of the sponsor. However, in the case of a professional or individual-based association, if at least one of the officers, directors, or employees, or at least one of the individuals who are partners in an employer and who actively participates in the business, is a member or such an affiliated member of the sponsor, participating employers may also include such employer. All individuals beginning coverage after certification as an SBHP must be active or retired owners, officers, directors, or employees of, or partners in, participating employers or their dependents.

No participating employer could provide health insurance coverage in the individual market for any employee not covered under the plan if the exclusion of the employee is based on a health status-related factor. All coverage options available under the plan would have to be made available to any employer eligible to participate.

Franchises. A plan established and maintained by a franchisor for itself or for its franchisees is deemed to meet the sponsorship, participation and coverage, and Board of Trustees requirements.

Definitions. The bill includes definitions for the following terms: "Affiliated member," "franchisor" and "franchisee," "individual market," and "participating employer." It would define "applicable state authority" as the state insurance commissioner or official designated by the state to enforce the requirements of Title XXVII of the Public Health Service Act.

Preemption Rules. The bill would establish that the provisions of new Part 8 would supersede any and all State laws that "preclude a health insurance issuer from offering health insurance coverage" in connection with a certified SBHP.

The draft would require the Secretary to consult with the state in which an SBHP is domiciled regarding the Secretary's authority to enforce the requirements for certification and to certify SBHPs under new Part 8.

TITLE II

Sec. 201. The Prevention and Public Health Fund

Funding for the Prevention and Public Health Fund (provided in section 4002(b) of PPACA, as amended by section 5009 of the 21st Century Cures Act), would be eliminated after 2017. Current law authorizes and appropriates (by fiscal year) the following: $900 million each for 2018 and 2019; $1 billion each for 2020 and 2021; $1.5 billion for 2022; $1 billion for 2023; $1.7 billion for 2024; and $2 billion for 2025 and each year thereafter. For the ten fiscal years from 2018 through 2027, the total is $14 billion.

Sec. 202. Support for State Response to Opioid Crisis

The BCRA would authorize and appropriate $2 billion to HHS for providing grants to states to support substance use disorder treatment and recovery support services for individuals with mental or substance use disorders. Funds would be available until expended.

Sec. 203. Community Health Center Program

An additional $422 million for the CHC Program would be appropriated for fiscal year 2017. (The provision would be effective as if included in section 221(a) of the Medicare Access and CHIP Reauthorization Act of 2015.)

Sec. 204. Change in Permissible Age Variation in Health Insurance Premium Rates

The age rating factors for insurance in the individual and small group markets would be changed. For plan years beginning on or after January 1, 2019, the age rating would be changed from 3 to 1 to 5 to 1, or such other ratio as the state involved may determine.

Sec. 205. Medical Loss Ratio Determined by the State

The current federal limits on medical loss ratios for insurance sold in the individual and group markets would be sunset after 2018. Beginning in 2019, states would determine medical loss ratios for individual and group coverage and determine the amount of any rebates owed to enrollees by issuers that exceed the state limit.

Sec. 206. **Stabilizing the Individual Insurance Markets**

Current law requirements for guaranteed availability of coverage would be modified beginning January 1, 2019, to require insurers in the individual market to impose a 6-month waiting period on individuals who cannot demonstrate 12 months of continuous creditable coverage without a significant break in coverage (63 days). The definitions of waiting period, creditable coverage, and significant break in coverage would be those provided in section 2704 of the Public Health Service Act pertaining to pre-existing condition protections, which were in effect under the Health Insurance Portability and Accountability Act of 1996. PPACA prohibited the application of pre-existing condition exclusions for individual and group insurance.

Under the waiting period, coverage would begin 6 months after the date of application for individuals who apply for coverage during an open enrollment period or during a special enrollment period for which they qualify. For individuals who apply outside the open enrollment period and who do not qualify for a special enrollment period, coverage would begin the later of 6 months after the date of application or the first day of the next plan year.

The requirement on issuers to impose a 6-month waiting period would not apply to an individual who is enrolled in individual market coverage on the day before the effective date of the coverage for which the individual is newly enrolling. Exceptions would also be provided for

newborns who are enrolled within 30 days of birth and children under age 18 who are enrolled in within 30 days of adoption.

Issuers may be required to provide written certification of periods of creditable coverage and waiting periods, as prescribed by the Secretary of HHS, for purposes of verifying that continuous coverage requirements are met.

Sec. 207. Waivers for State Innovation

This provision would make a number of changes to the current waiver authority for state innovation under section 1332 of ACA.

Current Law. A state may apply to HHS to waive any or all of a number of specified ACA requirements with respect to health insurance coverage offered in the state for plan years beginning on or after 1/1/2017, including those relating to essential benefits, affordable choices of plans and consumer choice, cost-sharing, refundable credits for premiums, and employer and individual responsibility. A waiver application must include a comprehensive description of the state legislation and program to implement a plan that meets waiver requirements and a 10-year budget that is budget neutral for the federal government. HHS may only grant a waiver if it determines that the state plan will do all of the following:

- Provide coverage at least as comprehensive as the essential benefits coverage offered through Exchanges (as certified by the CMS Actuary).
- Provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable as under ACA title I provisions.
- Provide coverage to at least a comparable number of its residents as under ACA title I provisions.
- Will not increase the federal deficit.

Under a section 1332 waiver, funding for premium tax credits, cost-sharing reductions, or small business credits may be paid to the state for individuals and small employers in the state who would not qualify for them under the waiver plan. HHS will annually determine the amount of that funding taking into account the experience of other states with respect to participation in an Exchange and credits and reductions provided under such provisions to residents of the other states.

A state must pass a law to carry out the waiver and all its requirements. Waivers are for periods of up to 5 years; a state request to HHS to extend the waiver must be granted unless HHS either denies the request or asks for more information within 90 days.

Proposed Changes. The proposed changes to section 1332 would make it easier for states to qualify for a waiver in part because of lower standards for granting the waiver as well as fewer requirements on states with respect to the waiver.

While the provisions of the ACA that may be waived under current law (e.g., essential health benefits, actuarial value, out-of-pocket limits, etc.) would not be changed under the bill, section 206 eliminates requirements that the state plan approved under the waiver provide for (i)

coverage of EHBs at least as comprehensive as provided for under the ACA, (ii) cost-sharing protections at least as affordable as under the ACA, and (iii) for coverage of at least a comparable number of its residents as under the ACA. Instead, HHS would be required to grant a state waiver request unless it determines that the plan under the waiver will increase the Federal deficit. HHS would also have the authority to grant waiver requests on an expedited basis if it was determined necessary to address an urgent or emergency situation with respect to health insurance coverage in the state.

Corresponding changes would be made to requirements for a state waiver application. For example, the application would have to include a description of how the plan would provide "an alternative means of, and requirements for, increasing access to comprehensive coverage, reducing average premiums, and increasing enrollment." The application would also have to demonstrate that the plan would not increase the federal deficit as opposed to the current requirement that the plan be budget neutral to the federal government presumably allowing for waivers that reduce federal spending.

As noted earlier, a section 1332 waiver requires a state law before approval by HHS. The legislation would permit the state to indicate it has the authority to carry out the plan under the waiver through a certification signed by both by the governor and the state insurance commissioner, bypassing the state legislature.

The period of a waiver would be eight years (in lieu of a maximum of 5 years under current law) and could be renewed for as many additional 8-year periods as the state would like, subject to application requirements. A waiver, including a renewed waiver, could not be cancelled by HHS before the end of its 8-year term.

The BCRA would appropriate $2 billion in additional funding for FY 2017 to assist states in submitting applications for, and implementing state plans under, waivers approved by HHS; the funding would be available through FY 2019. Insofar as a state has applied for an allotment under the long-term state innovation and stability program under proposed new SSA section 2105(i) (see the description in section 106 of the bill above), the state could use funds from that allotment to carry out the state plan under a waiver approved under revised section 1332.

The proposal takes into account that some states may have submitted applications pursuant to section 1332 under current law. For states with a 1332 waiver application approved before the date of enactment, the waiver would be conducted subject to the current law requirements. For states that submitted applications under section 1332 under current law that are not approved before the enactment date, the state could elect to have section 1332 as in effect under current law or as amended by the BCRA apply to its application and plan. Section 1332 as amended would apply to waiver applications submitted on or after the enactment date.

Sec. 208. Funding for Cost-Sharing Payments

The BCRA would appropriate such funds as are necessary to provide for cost-sharing reductions authorized by PPACA, including any adjustments to any prior obligations for such payments, through December 31, 2019. Payments and any other actions for adjustments to any obligations incurred for plan years 2018 and 2019 could be made through December 31, 2020.

Sec. 209. Repeal of Cost-Sharing Subsidy Program

The cost-sharing subsidy program under section 1402 of PPACA would be repealed effective for plan years beginning on or after December 31, 2019.