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The Senate Takes a Crack at a Healthcare Reform Replacement Bill

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On June 22, 2017, Senator Mitch McConnell released a draft of the Better Care Reconciliation Act ("BCRA"), which is the Senate's version of a replacement bill of the Patient Protection and Affordable Care Act ("ACA"). An amended version of the BCRA was released on June 26, 2017.

Process

A Senate vote is expected on the BCRA sometime this summer. It is not expected that the House will approve the BCRA in its current form — which is very different from the American Health Care Act ("AHCA") that was passed by the House in May. Because of these differences, the House and Senate will likely need to negotiate a compromise bill in conference, to be approved by a majority of the House and the Senate. Therefore, it is likely that there will be substantial changes to the BCRA before it is approved by both chambers of Congress and then presented to President Trump for his signature.

Provisions that Affect Employer-Sponsored Group Health Plans ("GHPs")

Below is a summary of the BCRA provisions that would affect GHPs.

Employer Mandate — Reduce the Pay or Play Penalties to $0

The BCRA reduces the penalties under Internal Revenue Code Sections 4980H(a) and (b) to $0 effective January 1, 2016. This change means that if the employer failed to offer at least 95% of its full-time employees the ability to elect coverage for themselves and their dependents, the penalty to the employer would be $0. In addition, if a full-time employee obtains coverage on the ACA health insurance marketplaces (the "Exchanges") and receives a premium tax credit for that coverage, the penalty to the employer would be $0.

> **Likely Effect.** Employers will likely change the eligibility rules in their GHPs, such as their processes for determining who is an eligible full-time employee (*e.g.*, not use the

look-back measurement method, but instead rely on regularly scheduled hours). The Congressional Budget Office report predicts that this change will cause some employers to cease to offer GHPs.

Difference from AHCA. The AHCA includes the same provision.

Individual Mandate

The BCRA reduces the individual mandate to $0, effective January 1, 2016.

Likely Effect. While this change does not directly affect GHPs, it may cause some employees (such as younger, healthy employees) not to elect GHP coverage. (The Congressional Budget Office report estimates that in 2018, 15 million more people will not have health coverage, primarily due to the elimination of the individual mandate.) If enough younger, healthy employees do not elect coverage, it could cause adverse selection for GHPs and drive up the costs of those plans.

Difference from AHCA. The AHCA includes the same provision.

Premium Tax Credits

The BCRA keeps the ACA advanced premium tax credits ("PTC"), but changes the credits' eligibility requirements and the amounts. This change to the PTC would be effective January 1, 2020.

The ACA provides PTCs to individuals who: (1) have household income between 100% and 400% of the federal poverty level and (2) do not have access to affordable, minimum value GHP coverage. (An individual is also barred from the PTC if he is enrolled in a GHP, even if it is not affordable.) Under the ACA, the PTC amount is based on a benchmark plan — the second lowest silver-level plan on the Exchange — and the amount effectively caps how much an individual or family must pay for monthly premiums if they enroll in a benchmark plan. A person eligible for the PTC would never pay more than a certain percentage of his household income to purchase coverage — essentially providing a cap. This cap depends on the family's income, with lower-income families required to pay less for coverage and higher income families required to pay more for coverage. The required payment percentage ranges from 2% to 9.5% of household income. (These numbers are adjusted each year.)

The BCRA makes the PTC available to individuals with incomes not above 350% of the federal poverty level (a reduction from the ACA's 400%). In addition, the amount of household income that an individual must spend on coverage before becoming eligible for the PTC would be higher for older people and lower for younger people. For example, a 63-year-old with income of 300% of the federal poverty level would have to spend 16.2% of his income on premiums (*i.e.*, the cap is 16.2%), while a 25-year-old with the same income would have to pay 4.3% of his income on premiums. The PTC would be based on a bronze-level type plan (rather than the silver-level under the ACA). However, in all cases, if the individual was eligible for a GHP, he would be ineligible for the PTC, *even if that GHP coverage was unaffordable and did not provide minimum value*.

Likely Effect. Beginning in 2020, an employer's reporting of health coverage would be significantly simplified. The employer will need to report to the government if the individual was eligible for its GHP each month (this includes if the employee was eligible for

its GHP and if the employee's spouse and dependents were eligible for its GHP), and it would not be required to report if that coverage was affordable or provided minimum value — data that is irrelevant because there is no employer mandate and the availability of PTCs is not tied to the cost and value of GHP coverage.

Difference from AHCA. The AHCA eliminates the PTC and replaces it with a flat dollar amount that would be provided to individuals to use to purchase insurance. The amount was based on age and family size, with a phase-out based on income. In many cases, the AHCA also provides less federal assistance for the purchase of healthcare because it provides a flat dollar amount that could be used to purchase coverage rather than ensuring that the individual would only have to pay a certain amount of his income to purchase coverage.

Cadillac Tax Delayed

Under the ACA, the value of GHP coverage that exceeds specified thresholds is subject to a 40% excise tax starting in 2020 — the Cadillac tax. Under the BCRA, the Cadillac tax is delayed until 2026.

Likely Effect. In anticipation of the Cadillac tax, employers are planning to reduce health coverage in order to stay under the threshold for that tax. With the delay of the Cadillac tax, employers will continue to look at ways to reduce the cost of health coverage, but not as dramatically as would be required to stay under the threshold for the Cadillac tax.

Difference from AHCA. The AHCA includes the same provision.

Pre-Existing Condition Exclusion

Neither the ACA, the AHCA, nor the original draft of the BCRA allows for pre-existing condition exclusions. However, the amended BCRA version includes a six-month waiting period in the individual insurance market for any person who has a break in coverage of 63 days or longer. This provision does not apply to a newborn child who is covered within 30 days of birth or an adopted child (under age 18) who is covered within 30 days of the adoption. This is effective January 1, 2019. (The exceptions for children mean that even if the parent failed to meet the continuous-coverage requirement, the child could not be subject to that 6-month exclusion period. Child-only coverage is required for certain plans offered on the Exchanges, but not for all coverage offered outside of the Exchanges.)

Likely Effect. This provision does not directly affect GHPs. However, it may put more pressure on employers to grant "exceptions" for employees who miss midyear enrollment events, such as marriage or the birth of a child. If an employee misses this midyear enrollment event for a child, the employee may have a hard time obtaining individual coverage for that child — and may have to wait for the next annual open enrollment. In addition, employers will be required to provide certificates of coverage to participants (which had become obsolete under the ACA).

Difference from AHCA. The AHCA allows insurance carriers to increase premiums by 30% for up to 12 months for a person who has at least a 63-day break in coverage. Under the state waiver program, a state could allow insurance carriers to engage in health status

underwriting for an enrollee who had a break in coverage for at least 63 days. Both of these provisions apply to the individual market.

Essential Health Benefits — State Waiver Program

The BCRA allows states to seek waivers of certain ACA insurer mandates, including the requirement for insurers in the individual and small group markets to cover all benefits that are considered essential health benefits ("EHBs"). This BCRA provision would allow a state to define EHBs in a manner that is different from what is required by the ACA — and could even allow that state to permit insurance carriers to eliminate coverage for EHBs entirely in the individual and small group markets.

It is unclear how this type of waiver would affect self-funded GHPs. Under the ACA, there are provisions that prohibit annual and lifetime limits on EHBs. In addition, in-network out-of-pocket-maximum requirements apply only to the EHBs. Currently, a self-funded GHP can select a state "benchmark plan" to determine what benefits are considered EHBs, regardless of whether the employer or plan has any connection to that state. However, if a state received a waiver so that some of the insured plans did not cover all EHBs, could a self-funded GHP use that state plan for determining what is considered EHBs? This potential GHP impact is not clear under the BCRA.

Likely Effect. If self-funded GHPs can select any state waiver plan to determine EHBs, it is possible that some GHPs could go back to adding dollar limits on certain benefits.

Difference from AHCA. The AHCA includes a similar state waiver provision.

Age Ratio

Under the ACA, in the individual and small group market, an insurance carrier can charge older individuals at rates that are 3 times higher than rates charged to younger individuals. The BCRA would change this to a 5:1 ratio (with flexibility to the states to use other ratios), effective January 1, 2019.

Likely Effect. This provision does not affect GHPs for large employers. For employers who purchase insurance coverage on the small group market, the cost of coverage for older workers would increase.

Difference from AHCA. This change to a 5:1 ratio is also permitted under the AHCA.

Over-the-Counter ("OTC") Medicine

Under the ACA, an OTC medicine can only be reimbursed on a non-taxable basis from a health flexible spending account, HRA or HSA if it is prescribed by a doctor (with an exception for insulin). The BCRA eliminates the requirement of a doctor's prescription for OTC medicines, effective January 1, 2017.

Likely Effect. Employers will likely return their plan design to allow for OTC medicines to be a reimbursable expense without a doctor's prescription.

Difference from AHCA. This is similar to the AHCA.

Dollar Limit for Health Flexible Spending Accounts ("Health FSAs")

The ACA limits employee salary contributions to Health FSAs to $2,600 (and is indexed for cost-of-living adjustments each year). The BCRA would eliminate the cap as of January 1, 2018.

Likely Effect. Employers will likely change their plans to allow for a higher salary contribution amount.

Difference from AHCA. The AHCA includes the same provision, but effective one year earlier (January 1, 2017).

Changes to Health Savings Accounts ("HSAs")

The BCRA proposed to increase contribution limits for HSAs to match the out-of-pocket limits for HSA-eligible high-deductible health plans, effective January 1, 2018. Under this change, the maximum contribution for individual coverage would increase from $3,450 to $6,650; from $6,900 to $13,300 for family coverage. The BCRA would also decrease the additional tax on non-qualified HSA distributions (*i.e.*, for non-medical expenses) from 20% (the current ACA amount) back down to 10% (the pre-ACA amount), effective January 1, 2017. Lastly, the BCRA would permit spouses to make catch-up contributions to the same HSA, which is not allowed under the ACA, effective January 1, 2018.

Likely Effect. Many employers have adopted HSA compatible plans. These changes would encourage more employers to do so.

Difference from AHCA. The AHCA makes similar changes, with slightly different effective dates.

Retiree Drug Subsidy ("RDS") Program

The BCRA proposes to repeal the limit on employer deductions for the RDS program effective January 1, 2017. Under the ACA, the employer deduction is essentially reduced by the amount of RDS payments received by the plan.

Likely Effect. This change would potentially allow employers whose retiree health plans receive RDS payments to again take advantage of the larger pre-ACA tax deduction available.

Difference from AHCA. The AHCA includes a very similar provision.

Association Plans

The BCRA would allow small businesses to group together and purchase large group insurance through associations, mostly free from state insurance regulations. The association would need to meet certain requirements (such as bonding and have a purpose other than providing health coverage) and be certified by the Department of Labor. The association plans could avoid the age-rating that applies to small insured GHPs. Currently, small employers can create a fully-insured multiple employer welfare arrangement (MEWA), but the age-rating will, in most cases, still apply to the small employers.

Likely Effect. Small employers may join together to form these association plans to avoid the generally higher age-rating premiums.

Difference from AHCA. This is not included in the AHCA. It is unclear if such a provision can be added through the reconciliation process.

Next Steps

Although Congressional Republicans have completed major steps in the ACA-replacement process, it remains unclear which — if any — changes to the current ACA rules will become law. This continued uncertainty has left employers and other GHP stakeholders in limbo: it is almost impossible to plan in advance for legal changes that may never materialize. Over the next few months, however, it is likely to become more apparent whether an ACA-replacement bill will reach President Trump's desk for signature.

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