American Hospital Association

Action Alert

Monday, June 26, 2017

New Resources to Assist You as You Urge Your Senators to Oppose BCRA

Talking Points, FAQs, Side-by-Side Comparison Available

The AHA has developed a number of new resources to assist you as you urge your senators to oppose the Better Care Reconciliation Act (BCRA), legislation introduced June 22 to repeal and replace parts of the Affordable Care Act (ACA). The Senate is poised to vote on the bill by the end of this week before it adjourns for the July 4 recess; the first in a series of key votes could come as early as Tuesday, June 27.

To assist you in your conversations with your senators and their staff, we have drafted talking points, answers to a set of Frequently Asked Questions, and a side-by-side comparison of the ACA and House and Senate bills. All of these resources are posted on our special members-only advocacy resource page. Please check back frequently, as they are being updated as new information emerges.

Please also continue to enlist your employees and trustees in our advocacy efforts. You can share the link to this special webpage, where they can send an email to their senators in just a few easy clicks, through a special email or notice in your employee or board newsletter. Every message is critical at this time.

In addition, the Coalition to Protect America's Health Care, of which the AHA is a founding member, continues to run TV, radio and digital advertising reinforcing our message. Watch for more information on a new ad campaign today from the Coalition.

Please contact us at 1-800-424-4301 with any questions.

TALKING POINTS ON THE BETTER CARE RECONCILIATION ACT OF 2017

Deep Cuts to the Medicaid Program Threaten Coverage.

- ✓ Cutting hundreds of billions of dollars and phasing out Medicaid expansion will result in tens of millions of Americans losing health coverage, increased uncompensated care for providers, and reduced benefits and eligibility for patients.
- ✓ The vast majority of people on Medicaid are children, the elderly, and the disabled. It is those populations that will be most harmed by the legislation, particularly vulnerable seniors who rely on the program for nursing home care.
    - o One in three children is covered by Medicaid.
    - o Nearly two-thirds of Medicaid spending goes for nursing home care for the elderly and disabled.
    - o More than one-third of Medicaid spending is for Medicare patients.
- ✓ All states will suffer economically, as their budgets will be dramatically harmed by cutbacks in federal support. Expansion states will lose the enhanced federal match, with a likely result of major losses in coverage.
- ✓ Medicaid already underpays providers, covering less than the cost of care.
- ✓ Loss of Medicaid coverage will threaten access to treatment for behavioral health and those suffering from addiction to opioids.

Subsidies Will Not Provide Adequate Coverage.

- ✓ The subsidies provided to working Americans in the bill are significantly lower than those in current law, leaving patients with gaps in coverage and leading to higher out-of-pocket costs. Some patients will not be able to afford coverage, leading to even more uninsured individuals and families.
    - o The bill will push people into cheaper plans. Premiums for such "bare-bones" health insurance policies may be lower, but individuals will have to make up the difference if they want to maintain the level of coverage they currently have. Again, they will end up paying more out of pocket.
- ✓ The ability to purchase insurance will be most at risk for those between ages 50 and 64, who will face higher premiums than any other age

group. The cost to a 60-year-old will nearly double (from 9 percent to 16 percent of annual income).
- ✓ Individuals between 350 and 400 percent of the federal poverty level will lose access to subsidies.

Premiums Will Rise.

- ✓ This bill will adversely affect everyone with private insurance. Underfunded Medicaid programs will lead to significantly higher health insurance costs and increased premiums for consumers and employers.
- ✓ Medicaid underpayments create a payment gap to providers that privately insured employers and individuals will be forced to close through a "cost shift" or "hidden tax."

Jobs Will Be Lost and Services Reduced.

- ✓ Today hospitals and health systems employ more than 5.7 million people and support 16 million total jobs, or 1 in 9 jobs private-sector jobs.
- ✓ But that number will decrease as hospitals and health systems are forced to make tough choices as their financial health deteriorate due to the loss in Medicaid funding, increased uncompensated care, and unpaid out-of-pocket expenses.
- ✓ The bill would not restore hospital and health system reductions intended to fund coverage. Those resources would be vital to help hospitals care for the increased number of uninsured that would result from the Senate bill.
- ✓ Hospitals and health systems will have no choice but to reduce services, and possibly even close. This will have broad economic effects across communities, not only due to the loss of hospital jobs but the loss of a local hospital often makes a community less attractive to potential companies and manufacturers. This exacerbates the economic impact and employment opportunities in communities.

Frequently Asked Questions Regarding the Better Care Reconciliation Act

1. What parts of the Senate bill are most concerning for patients and hospitals?

Loss of health coverage has been the AHA's most urgent concern. Hospitals and health systems see the effects of lack of insurance in our emergency departments. The two main objectives to the Senate bill are deep cuts to Medicaid and cuts to health insurance subsidies.

The Senate bill inflicts devastating cuts to Medicaid, resulting in the loss of coverage for tens of millions of our most vulnerable, particularly children, the elderly and disabled. The Senate bill does provide a few extra years in the Medicaid repeal transition, but it arrives at an even worse place in the later years.

- Not only do millions of people covered under Medicaid expansion lose health coverage, but the bill further cuts the program through the use of a new formula that does not reflect the true cost of care. By the end of 2026 and beyond, the cuts will substantially harm state budgets and the Medicaid program.

On insurance subsidies, the Senate bill results in products covering less of the costs of insurance, making it more expensive for patients.

- Current law sets the actuarial value of insurance – a measure of the total average costs a plan will cover – on the exchange at 70 percent of such costs. The Senate bill reduces it to 58 percent.
- This shifts significant out-of-pocket costs to the patient. This is a low-income population; many will be unable to afford copays and deductibles under the Senate bill.

The Senate bill makes age a factor in health insurance subsidy amounts for premium costs.

- It nearly doubles the amount 60-64 year olds must pay in premiums after getting a subsidy (from 9.69 percent of income under current law, to 16.2 percent of income).
- Also, their insurance can now cost 5 times more than what younger individuals pay (Senate retains this from House bill; current law is 3 times).
- Premiums alone will cost 16.2 percent of their income, and copays and deductibles are far higher (as actuarial value cut from 70 to 58 percent).

2. What is Medicaid and who will be affected by the cuts?

Medicaid is a public health insurance program for low-income people, the disabled and the elderly. About 74 million people are covered by the Medicaid program nationwide.

This federal-state program provides health coverage to one in three children and covers half of all births in the nation. It also covers two-thirds of nursing home care for the elderly – many of whom are in the middle class – and the disabled.

3. **What changes would be made to Medicaid under the health bills in Congress?**

Under the Affordable Care Act (ACA), states could expand the populations covered under Medicaid. The Senate and House bills would change the way the federal government pays its share of Medicaid costs, setting a per-person limit on spending that would adjust annually for inflation. The bills would end the ACA's Medicaid expansion and would make deep cuts to program funding by setting this annual inflation rate for Medicaid far below actual costs to providers.

4. **What are the key changes needed to the Senate bill?**

- Eliminate the reductions to Medicaid funding and maintain the full federal match for the Medicaid expansion population.
- Allow non-expansion states to come to parity with states that expanded.
- Use waivers with safeguards for coverage and payment as the preferred method to provide flexibility to states rather than per-capita caps or block grants with government set pricing below the actual cost of providing care.
- Increase the available tax credits and better target assistance to those who need it.
- Maintain the federal essential health benefit standards.
- Restore the hospital payment reductions so hospitals have the resources they need to care for the newly uninsured.

5. **What is the AHA's position on the Senate bill?**

We cannot support a bill that would take away health coverage from millions of Americans. We urge Senators to vote NO on the Senate bill.

6. **What are the next steps with the House?**

If the bill passes the Senate, it will be a delicate balance. The Senate will likely ask the House to take an up-or-down vote on its bill. We don't anticipate a traditional legislative conference between the Senate and House.

7. **Is there still time to affect change**?

Yes. This week is critical. The Senate intends to vote before the July 4 recess. It is vital that everyone – including your employees, trustees and communities – make their voices heard as soon as possible. Our patients are depending on us.

(As of 6/26/17)

A Comparison of the Affordable Care Act, American Health Care Act and Better Care Reconciliation Act

Senate Republican leaders June 22 unveiled draft legislation, the **Better Care Reconciliation Act** (BCRA), to repeal and replace parts of the **Affordable Care Act** (ACA). Below is a summary of how the major provisions in BCRA compare to the ACA and the House-passed **American Health Care Act** (AHCA).

ACA	AHCA	BCRA
Medicaid		
Expanded Medicaid eligibility to 133% of poverty, with enhanced federal match for newly eligible populations. Enhanced match started at 100% in 2014 and phases down to 90% for FY 2020 and thereafter.	Ends enhanced federal match for expansion population in FY 2020 except for "grandfathered" individuals who have not experienced any disruption in Medicaid coverage.	Phases down enhanced federal funding by reducing the match rate 5% each year over a three-year period (FYs 2021-2023), reverts to the state's regular federal match for FY 2024 and beyond.
Cuts **Medicaid disproportionate share hospital (DSH)** payments through FY 2025.	Repeals Medicaid DSH cuts beginning in FY 2018 for non-expansion states, and beginning in FY 2020 for expansion states.	Retains Medicaid DSH cuts for expansion states through FY 2025. Repeals DSH cuts for non-expansion states beginning FY 2018 and provides a bump in the DSH allotment for certain non-expansion states with DSH allotments lower than national average from FY 2020 through the first quarter of FY 2024.
Not addressed in the ACA.	Converts Medicaid financing to a **per capita cap funding model** beginning in 2020; allotments are assessed by eligibility group and are updated each year by the medical component of the Consumer Price Index (CPI-Medical). States get CPI-Medical plus one percentage point for the elderly and disabled.	Converts Medicaid to a per capita cap funding model; the trend rate is CPI-Medical (CPI-Medical plus one percentage point for the aged and disabled population) through 2024, and changes to CPI-Urban for all populations in 2025, which is substantially lower than CPI-Medical.
Not addressed in the ACA.	Provides states with the option to receive a **block grant** with increased flexibility instead of the per capita cap funding model.	Allows states the option of a block grant with additional flexibilities for the healthy adult population only. Maintenance of effort and additional requirements apply.
Not addressed in the ACA.	Allows states to implement a **work requirement**, with some exceptions.	Same as AHCA.
Not addressed in the ACA.	Repeals requirement for expansion population to receive **essential health benefits.**	Same as AHCA.

ACA	AHCA	BCRA
Not addressed in the ACA.	Provides $10 billion **safety-net fund** for non-expansion states	Same as AHCA.
Not addressed in the ACA.	Not addressed in the AHCA	Provide states the choice to cover **institute for mental disease (IMD)** services for adults ages 21-65.
Not addressed in the ACA.	Not addressed in the AHCA.	Decreases the amount of allowable **provider taxes** from 6% to 5% over a three-year period
Insurance Market Reforms & Health Insurance Marketplaces		
Individual mandate plus penalty for lack of coverage.	No penalty for lack of coverage; 30% premium penalty (or medical underwriting based on state waiver) for individuals with a gap in coverage.	No penalty for lack of coverage.
Employer mandate to provide coverage plus financial penalty for noncompliance.	No penalty for not providing coverage.	No penalty for not providing coverage.
Coverage of **adult children under age 26** through parents' insurance.	Same as ACA.	Same as ACA.
Cost-sharing reductions for individuals between 100-250% of poverty.	Repeals cost-sharing reductions.	Temporarily funds cost-sharing reductions, then terminates them in 2020.
Implements **community rating** with variation in plan pricing only allowed based on geography, age (3:1 ratio limit), level of coverage, and tobacco use.	Allows states to waive age rating rules and health status component of community rating for certain individuals.	Allows age variation up to a 5:1 ratio at state discretion.
Coverage of 10 "**essential health benefits**" (EHBs).	Allows state waivers of EHB standards; repeals requirements on how much of the cost for health benefits is the responsibility of the insurer (actuarial value).	Allows states to use 1332 waivers to modify or eliminate EHB standards.
Prohibition on **annual and lifetime limits** for EHB services.	Same as ACA, unless a state modifies the EHB standards via a waiver.	Same as AHCA.
Cost-sharing limits for EHB services.	Same as ACA, unless a state modifies the EHB standards via a waiver.	Same as AHCA.
Creates minimum **medical loss ratios (**MLR) for individual and group market plans.	Same as ACA.	States set MLR standards as of 2020.
State flexibility via 1332 waivers to provide alternative approach to coverage; requires	Creates new waivers to enable states to modify age rating bands, waive EHB requirements, and allow	Removes coverage and cost comparability requirements from 1332 authority; includes streamlined/fast-track review and approval process.

ACA	AHCA	BCRA
comparability in coverage and cost-sharing protections, among other requirements.	plans to modify pricing based on an individual's health (medical underwriting).	
Not addressed in the ACA	Incentivizes use of **health savings accounts**.	Same as AHCA.
Not addressed in the ACA	$138 billion **Patient & State Stability Fund** to stabilize insurance markets; improve access to coverage and make coverage more affordable.	Short- and long-term "**State Stability and Innovation Fund**" with $50 billion directed toward insurers and $62 billion directed at states to achieve similar goals to AHCA's fund. Also provides $2 billion to help states with **opioid crisis**.
Financing		
Combination of **taxes** on high-income individuals, insurers, pharmaceutical and device manufacturers, tanning salons, and high-value health plans (the "Cadillac Tax"), as well as **provider fee cuts** under the Medicare and Medicaid programs.	Repeals most of the ACA taxes, delays the Cadillac Tax through 2025; retains provider fee cuts, except the Medicaid DSH cuts.	Repeals most of the ACA taxes, delays the Cadillac Tax through 2025; retains provider fee cuts, except the Medicaid DSH cuts for non-expansion states.