Better Care Reconciliation Act of 2017

AUCD Summary

June 22 marked the 18th anniversary of the U.S. Supreme Court's *Olmstead v. LC* decision, which declared that people with disabilities have a civil right under the Americans with Disabilities Act to live and participate in their communities. June 22, 2017, now also marks the day the Senate released its bill, the Better Care Reconciliation Act, to repeal parts of the Affordable Care Act. Like the House version, the Senate bill has a disproportionately negative effect on people with disabilities, and will limit – or eliminate – access to needed medical and community-based services that facilitate the health and inclusion of Americans with disabilities. The proposal is an aggressive retreat from the current federal commitment to this community, abandoning a decades-long, bipartisan tradition of crafting policy with the input of people living with disabilities. The Congressional Budget Office estimates that 22 million people (15 million Medicaid recipients; 7 million in the private market) will lose health insurance coverage as a result of this proposal, and $321 billion in savings will be generated – savings that would otherwise pay for needed health-related services.

Medicaid cuts and program financing

People with disabilities, especially those with severe disabilities, often rely on a complex array of supports across many areas of public policy to lead successful and productive lives in the community. They often rely on the Medicaid program to address these needs. Under the Senate proposal, funding cuts would, over time, exceed the $800 billion (over 10 years) approved by the House, and overall spending would be capped. Specifically, it proposes:

- **Per capita caps:** Under current law, anyone meeting the eligibility criteria for the Medicaid program is entitled to enroll. In the future, states will only have to pay for those they can afford to enroll. Instead of the current practice of paying states based on their annual Medicaid spending, federal supports would be limited or 'capped' as a fixed annual amount, beginning in fiscal year 2020. States could also choose a block grant option. (The proposal also creates incentive payments for states to spend less than their allotted amount.) This effectively reduces spending on an annual basis, and will require states to fund the gap between the needs of Medicaid enrollees and the amount of the federal payment. Since most states currently face budget deficits, the more likely response will be to limit eligibility for access to the Medicaid program, cut services, cut reimbursements to providers, or increase co-payments for Medicaid recipients.
- **Retroactive coverage:** Current law allows for three months of eligibility prior to enrollment in the program, which protects individuals from being financially responsible for a costly hospital

or nursing home stay resulting from accident or injury. The Senate proposal eliminates this protection beginning October 1, 2017.

- **Roll back enrollment in expansion states:** Federal reimbursement for states who chose to provide coverage to the uninsured through Medicaid – including people with disabilities who would otherwise not qualify for the program – would phase out beginning in 2020. After December 31, 2017, adults above 133 percent of the federal poverty level would be prohibited in enrolling in Medicaid.
- **Eliminate financial incentive to improve home care services:** Additional matching funds have been available to states (6 percent) under the Community First Choice Option, which provides community based services for people with disabilities in the state plan without waivers. This would be eliminated in 2020.

Changes in subsidy availability to purchase insurance (down to 350% of FPG vs 400%)

The Affordable Care Act provides tax credits to individuals with incomes between 100 and 400% ($48,000) of the federal poverty level (FPL) to purchase insurance through the exchanges. Starting in 2020, the Senate bill reduces those tax credits to 350% FPL ($42,000). Additionally, individuals who are offered any employer-based coverage, whether affordable or not, would not be eligible for tax credits. As a result, many people will no longer have access to subsidies to help pay for their insurance, making care significantly less affordable. For people with disabilities, this may well mean forcing more individuals onto Medicaid (and its barriers to employment) to access needed health services.

Higher Health Insurance Premium Rates

According to the CBO, the legislation would *increase* average premiums in the nongroup market prior to 2020. Health insurance plans would also be allowed to charge seniors five times the premium rate of a 21-year-old, under the proposal, beginning in 2019.

Repeal of the individual coverage mandate (making the risk pools sicker and older)

The Affordable Care Act required all U.S. citizens and legal residents to have health coverage or pay a tax penalty. This was necessary to sustain the health care system. The tax penalty is eliminated as of January 1, 2016, under the Senate bill, thus repealing the "individual mandate". This allows healthy people to drop their coverage, leaving insurance companies with sicker, more costly plan members in their risk pool. This is likely to cause insurers to raise premiums on those that remain in the pool. Additionally, those who lose their insurance or for whom insurance lapses for more than two months (beginning in 2019) will be locked out of the system for six months, unable to obtain coverage. People with disabilities need the services covered by insurance to remain healthy and in their communities. For people with disabilities, there remains a tension between trying to pay for insurance, that doesn't cover what you need and is not affordable, but may allow you to remain employed, and opting into Medicaid with its current barriers to employment. For people with disabilities who cannot risk being without insurance, the lock-out provision may well be another barrier to employment as the risk of being uninsured becomes too great.

Repeal of the employer mandate

Similar to the repeal of the individual coverage mandate, businesses would no longer be required to provide health insurance to their employees. This provision would be retroactive to January 1, 2016.

Pre-existing conditions

While the Senate bill does not allow insurers to deny coverage to those with pre-existing conditions, it does allow states to waive portions of the essential health benefit requirements, thus potentially creating the same effect. The Affordable Care Act requires that certain benefits – outpatient services, emergency room care, hospitalization, maternity, mental health and substance abuse, prescription drugs, rehab services, lab tests, preventative care, and pediatric care – be included in any insurance plan offered on the exchanges. Under the Senate bill, states could apply to waive these essential health benefits, allowing insurers to deny the very services that people with disabilities, and others with pre-existing conditions, need to remain healthy and independent in the community. (These include habilitative and rehabilitative services and behavioral health services, including services for people with autism). It would also mean that individuals living in one state may be able to access the services they need, while those in another state may not. People with pre-existing conditions may be able to purchase insurance, just not the insurance that includes the services they need at a cost they can afford.

Out-of-pocket-limits on annual costs; lifetime caps

Current law provides an annual cap on the amount that insurers can charge individuals and families for out-of-pocket payments. The Senate proposal would make it easier for states to apply to the federal government to waive these limits. Similarly, while there is language in the bill that continues the prohibition on lifetime coverage caps, these only apply to limits on essential health benefits. If a state changes the benefit options, caps could effectively be implemented. This would have a disproportionate impact on individuals with disabilities.

Elimination of the Prevention and Public Health Fund

Effective October 1, 2017, $1 billion annually in funding for core public health programs that make up about 12 percent of the budget for the Centers for Disease Control and Prevention (CDC) would end. A majority of the funds go to states to address many issues that people with disabilities experience as secondary conditions, such as obesity, diabetes, hypertension, and tobacco use. In its place would be a one-time appropriation of $2 billion for substance abuse and mental health treatment.

Health plan dollars spent on care

Current law has strict requirements regarding how much of every health care premium dollar spent must go to delivering services (either 80 or 85 percent, depending on a number of factors). The bill would eliminate this requirement, effective in 2019, and allow states to set their own limits on administrative expenses and profits, otherwise known as the “medical loss ratio.

In Sum

In summary, states will decide whether people with disabilities have affordable private health insurance that include benefits to meet their needs or not. Under the auspices of "lowering premiums," this proposal gives states the option to trim benefit packages, which opens the door to significant increases in out-of-pocket costs (and premium hikes of up to five times what their non-disabled peers will pay) for less coverage than they have today. Alternatively, people with disabilities can impoverish themselves to join a Medicaid program that has strict income limitations, and in the future will have fewer benefits under a capped system that will see a cut in federal funding by 26 percent. Prior to the expansion of Medicaid, two-thirds of all spending in the program was for people with disabilities and those over age 65. Despite assurances that these populations would be protected, the Senate proposal provides no safe harbor for the most vulnerable Americans in need of health care and community supports.