INSIGHT

Comparing the Market Reforms of the BCRA and AHCA

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On June 22, the Senate released a discussion draft of the "Better Care Reconciliation Act" (BCRA), their revision of the House's American Health Care Act (AHCA).[1,2] There are many similarities between the two bills, but there are also distinct differences that have implications for the for the future sustainability of the marketplace. Below is a summary of each of the major market reforms of the BCRA, how those compare with the reforms of the AHCA, and what it means for the individual marketplace.

5:1 Age-Based Community Rating

Adjusting age-rating restrictions in the individual health insurance marketplace is one of the easiest ways to affect premiums. As insurers' gain freedom to adjust premiums for age to more accurately reflect spending by age, there is a correlating downward pressure on premiums. Currently, premiums can only vary based on age by a ratio of 3:1—even though health costs vary on average by 4.8:1.[3] Like the AHCA, the BCRA changes the national default age-rating to a 5:1 ratio, while still giving the states the opportunity to tailor the age bands to fit their own marketplace conditions. Previous research by AAF has shown that an adjustment like this can lead to 5 to 10 percent decreases in premiums.[4]

Tax Credit Structure and Cost Sharing Reductions

Like the AHCA, the BCRA offers advanced premium tax credits. However, instead of the primarily age-based credit structure of the AHCA, the BCRA would offer tax credits similar to the AHCA's near-term transition structure. The BCRA's tax credits are primarily income-based with a significant age adjustment. Similar to current law, the BCRA places a maximum income contribution on certain ages and income levels. The percentages are outlined in Table 1 below.

Table 1. Maximum Income Contribution Levels under BCRA

FPL Level	Under 30		30-39		40-49		50-59		60 or higher	
	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	8.3	10
250-300%	4.3	4.3	5.9	5.9	8.05	8.35	9.8	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

The BCRA tax credits would be offered to the roughly 2.6 million people whose income is below the tax credit threshold, but have fallen into the Affordable Care Act's Medicaid coverage gap, and everyone else under 350 percent of the Federal Poverty Level (FPL).[5] For those people under 350 percent of the FPL, the tax credits under the BCRA have the potential to be far more generous—especially for younger consumers—than under the AHCA since they are more closely tied to income. However, the availability of these tax credits would be narrower as the AHCA tax credit would reach those with incomes of $75,000 ($150,000 for those filing jointly) and upwards of 800 percent FPL in a reduced form. One significant positive of the BCRA's proposed credits is that they would be more enticing to eligible younger consumers than both current law and the AHCA's proposed credits.

State Stability and Innovation Program

Both the House and Senate bills include a stability program to help stabilize the individual marketplace. The BCRA provides $112 billion over ten years to promote marketplace stability. This is $24 billion less than was allocated for the AHCA's related fund, however, much of it is frontloaded into the first 4 years. The State Stability and Innovation Program is separated into two slightly different programs, a short-term and a long-term program. There are various differences between the two programs, but both funds have the same two goals: lower premiums and marketplace stability.

The short-term program would allocate $50 billion to be spent from 2018 to 2021—$15 billion for each of the first two years and $10 billion the next two. The bill states that this funding is meant "to address coverage and access disruption and respond to urgent health care needs within States." In other words, the purpose of this funding is to keep insurers in tough marketplaces and put downward pressure on premiums. The Centers for Medicare and Medicaid Services (CMS)Administrator has the sole authority to determine how this funding would be distributed. For reference, this is basically how cost sharing reduction (CSR) funds work currently. However, the difference between this fund and the CSRs is that under this fund, the insurers would be guaranteed this money. Currently they currently only receive CSR payments for claims generated by the population eligible for CSR money.

The long-term program would allocate $62 billion to be spent from 2019 through 2026. While it is marginally less focused in its purpose than the short-term program, it still has the same primary goal: marketplace stability and lower costs. However, states are given the opportunity to decide where the money provided is best used as long as they comply with matching requirements.

Though the funding of the BCRA's marketplace stability program would be less than that of the AHCA, the BCRA has some advantages in that the allowed use of the funding would be simplified and more focused. The AHCA's funding had all of the components above with less clarity, plus the creation of a national invisible high-risk pool and requirements for prenatal care. The increased uniformity of purpose that the BCRA outlines for this funding has the potential to see similar results that might be realized under the AHCA, despite less funding because of the certainty among issuers it creates.

State Waivers

The BCRA would also reform the Section 1332 waivers for state innovation available under current law. As it currently stands, for a 1332 waiver proposal to be approved, a state's reforms must not lead to a decrease in coverage, cannot reduce quality, and it cannot lead to savings or increased spending at the federal level—it must be budget neutral. However, even if a state's proposal does these things, the Health and Human Services (HHS)

Secretary still has the power to deny a state the waiver. The BCRA would change this and makes the HHS Secretary's approval mandatory as long as the plan will not increase the deficit and states describe how their plan will provide for increased access to comprehensive coverage, lower average premiums, and increased enrollment.

Similarly, the AHCA would have allowed states to waive certain Affordable Care Act requirements—like the essential health benefits—with the goal of reducing average premiums, increasing enrollment, increasing health care choice, and so on. Unlike 1332 waivers, there were no stipulations on quality of coverage for the AHCA waivers. Both the AHCA and the BCRA state waivers have the potential to reduce costs (possibly at the expense of quality) relative to the requirements under the ACA.

Guaranteed Issue, Continuous Coverage, and Qualified Health Plans

Continuing to keep in step with the general blueprint set out by the AHCA, the BCRA does not repeal guaranteed issue. If guaranteed issue is a given then there must be extra incentives added so that younger, healthier people purchase insurance and help balance the risk pool. The BCRA's strategy to accomplish this is twofold: increased tax credits to younger consumers in the individual market (discussed earlier), and a continuous coverage provision.

Like the AHCA, the BCRA would repeal the individual mandate penalty and replace it with a continuous coverage requirement. The House bill included a provision which stated that consumers who did not maintain continuous coverage upon turning 27 were subject to a 30 percent surcharge upon enrolling in insurance again for a 12-month period. The BCRA chooses a different mechanism to encourage continuous coverage: a six-month waiting period. Those who had a gap in creditable coverage that exceeded 63 days in the 12 months prior to enrolling for coverage would be subject to a six-month waiting period before being able to access insurance. While the continuous coverage provision of the AHCA was expected to violate the Senate's reconciliation budget rules, it is still unclear whether the BCRA's will.

In a significant departure from the AHCA, the BCRA would not alter the definition of a qualified health plan to include catastrophic coverage. It is likely that this move will have negative effects on both premiums and the

overall health of the risk pool compared to AHCA. Earlier this month, the Center for Health and Economy released an analysis of the AHCA that showed 10 to 25 percent reductions in premiums largely because of the aforementioned relaxation of age-bands and the allowance of premium tax credits to be used on catastrophic plans.[6] Allowing an increased variety of coverage—and allowing premium tax credits to be used on more diverse plan designs—would certainly improve the outlook of the BCRA's marketplace conditions.

Conclusion

In summary, there is much to commend in the BCRA's proposed individual market reforms: less restrictive age rating, a more focused purpose for the stability fund, a common-sense reform of 1332 waivers, and providing tax credits to those in the coverage gap. This bill would increase tax credits for younger consumers under 350 percent FPL, yet it does not give the same freedom to insurers to diversify plan design that the AHCA included. Though it is unclear which plan would produce the more balanced individual market risk pool, both bills take significant steps towards stabalizing the marketplace.

*This insight was updated June 30, 2017

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[1] The discussion draft of the BCRA can be accessed at: https://www.budget.senate.gov/imo/media/doc/SENATEHEALTHCARE.pdf

[2] The text the AHCA as it passed the house is can be accessed at: https://www.congress.gov/115/bills/hr1628/BILLS-115hr1628eh.pdf

[3] Burns, Alice, and Philip Ellis. "Private Health Insurance Premiums and Federal Policy." Congressional Budget Office, Feb. 2016. <https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51130-Health_Insurance_Premiums.pdf>

[4] https://www.americanactionforum.org/insight/age-bands-affordable-care-act/

[5] Garfield, R.; Damico, A., Cox, C., Claxton, G. Levitt, L. "Estimates of Eligibility for ACA Coverage among the Uninsured in 2016." Kaiser Family Foundation, Oct. 2016 <http://www.kff.org/health-reform/issue-brief/estimates-of-eligibility-for-aca-coverage-among-the-uninsured-in-2016/>

[6] "The American Health Care Act".*The Center for Health and Economy*, 21 April 2017, http://healthandeconomy.org/the-american-health-care-act/.