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MEMORANDUM

July 14, 2017

To: Tribal Health Clients

From: Hobbs, Straus, Dean & Walker, LLP

Re: *Senate Releases Second Draft of Health Care Reform Bill*

On July 13, 2017, Senate Republicans released the second draft of the "Better Care Reconciliation Act of 2017," and they will reportedly seek a vote on the bill next week. In terms of its effects on Indian Country, the bill remains largely the same as the previous iteration except that it makes dramatic changes to the provisions regarding when the federal government will pay a 100% federal match for Medicaid-eligible services provided to American Indians and Alaska Natives (AI/ANs).

As we previously reported, on May 4, 2017 the House of Representatives passed the American Health Care Act (AHCA), H.R. 1628, which was its version of a bill to "repeal and replace" the Affordable Care Act (ACA). Subsequently, health care reform moved to the Senate, and Republican leadership released a discussion draft of their version of an ACA repeal-and-replace bill on June 22nd. The Senate's draft bill, entitled the "Better Care Reconciliation Act of 2017" (BCRA), went much farther than the House in terms of its overall cuts to Medicaid funding and the flexibility it gives states to design their own Medicaid programs without specifying much-needed protections for AI/ANs. We provided a comprehensive section-by-section analysis of the original BCRA draft bill in our Health Care Client Report on June 23, 2017. As has been widely reported, there has been much behind the scenes discussion and negotiation regarding the discussion draft. This second, revised draft is intended to garner the votes required to proceed with the bill in the Senate.

Significantly, the new version of BCRA (BCRA II) contains a new provision that would amend an Indian-specific Medicaid provision that has been in place for over 40 years. Currently, the Medicaid law contains a provision that reimburses states for 100 percent of the costs of care provided to AI/ANs that is "received through" Indian Health Service (IHS) and tribal health facilities. Section 138 of BCRA II would eliminate the "received through" language, which would increase reimbursements to states with no guarantee of additional funding going to IHS or tribal providers or for care to individual American Indians and Alaska Natives. As discussed below, this provision is of great concern, as it would change over 40 years of Indian Medicaid policy without tribal consultation.

The Congressional Budget Office (CBO) is expected to produce a "score" of the draft bill next week, analyzing how much it will cost and providing an estimate of how many additional uninsured persons will result from the change in law. The CBO

estimated that the original version of BCRA would result in 26 percent reductions in Medicaid spending by 2026 and a 35 percent reduction by 2036. It is expected that after the CBO score the Senate Republican leadership will determine whether they believe they have sufficient support to move forward with a vote.

It is incredibly important that tribes and their allies contact their senators as soon as possible to discuss its effects on Indian Country. We provide an updated summary analysis below.

Deep Cuts to Medicaid Would Remain

Like the previous discussion draft, BCRA II would phase out Medicaid expansion from 2020 through 2023 and would eliminate the requirement that states cover Medicaid essential health benefits after December 31, 2019. It also maintains the previous draft's implementation of Medicaid cuts through either a per capita cap or block grant.

The overall Medicaid provisions of the bill remain largely unchanged. BCRA II would, however, allow states to include the Medicaid expansion population for purposes of calculating the level of a Medicaid block grant. BCRA II also attempts to decrease the disparity between expansion and non-expansion states. One way it does this is by changing the way disproportionate share hospital (DSH) payments are calculated. Instead of basing the amount of this payment on the Medicaid-enrolled population, BCRA II would calculate DSH payments based on the number of uninsured individuals in a state. This will result in higher DSH payments for states that elected not to expand Medicaid. Another way the bill seeks to reduce disparity between states is by changing the way per capita caps are calculated, shortening the base period for late-expanding states.

BCRA II also makes certain other changes, such as creating a Home and Community Based Services (HCBS) demonstration project. It also changes formulas to exclude public health emergency expenditures from counting against states' per capita caps or block grants, which will give states greater flexibility in responding to public health emergencies.

Overall, BCRA II's cuts to Medicaid remain a significant threat to the Indian health system. As in both the AHCA and the previous version of the Senate bill, Medicaid expenditures to IHS and tribal facilities do not count toward per capita caps or block grants. However, the rollback of expansion and decrease in overall Medicaid expenditures in BCRA II may require states to reduce benefits and eligibility, which will in turn reduce Medicaid-reimbursable services for AI/ANs.

BCRA II also keeps the previous draft's provisions incentivizing states to impose Medicaid work requirements without including any exemption for AI/ANs. As we have previously reported, work requirements do not incentivize work in Indian Country for a variety of reasons and they will likely result in fewer Medicaid-enrolled AI/ANs.

Bill Would Make Significant Changes to 100% FMAP Policy

BCRA II contains a new provision that would make significant changes to an Indian-specific provision of the Medicaid law. The previous version of the bill did not make any changes to current law, which provides that the federal government will provide 100% federal medical assistance percentage (FMAP) reimbursement to states for Medicaid-eligible services that are "received through" an IHS or tribal health facility. Under a new policy released in February of 2016, 100% FMAP is only paid for services rendered by providers outside of the IHS or tribal facilities when that service is provided under a care coordination agreement.

BCRA II includes a new Section 138 that provides that 100% FMAP would now be paid to states for services to AI/ANs regardless of where the service is provided. It would make 100% FMAP available for "amounts expended by a State as medical assistance for services provided ***by any other provider*** under the State plan to an individual who is a member of an Indian tribe who is eligible for assistance under the State plan." (emphasis added). This provision delinks the Indian 100% FMAP provision from services provided through the Indian health system.

This change would increase revenues for the states, without any guarantee that those funds would come into the Indian health system or be spent to improve care for AI/ANs. Congress authorized the Indian health system to bill Medicaid in 1976 in order to provide additional federal funding to the chronically underfunded Indian health system. At the same time, Congress passed the 100% FMAP provision to ensure that states did not incur any costs associated with providing this Medicaid funding stream to the Indian health system. The 100% FMAP provision was designed to ensure that the increased federal funding would go into the Indian health system at no cost to the states. Expanding the 100% FMAP for services provided by non-IHS providers with no connection to the IHS system is inconsistent with that goal. If enacted, states would receive the additional payments, but there would be no guarantee that those payments would be used to help the Indian health system or to provide better or additional care to AI/ANs.

Section 138 would change over 40 years of federal Indian Medicaid policy. Tribes have opposed this policy change in the past when it has been proposed, but tribes across the country were not consulted on the provision before it was included in the bill. It would have significant ramifications on the relationships between tribal health programs and their state Medicaid programs.

Changes to the Individual Insurance Market

BCRA II, like the AHCA and the previous Senate draft, makes certain changes to the ACA's rules governing insurance purchased through the marketplace. BCRA II, for instance, would still reduce premium assistance. Like the AHCA and BCRA, this version

would also eliminate cost-sharing protections after 2019, including cost-sharing protections for AI/ANs.

BCRA II would mark a significant departure from the ACA by allowing tax credits to be used to purchase catastrophic plans in the insurance marketplace. Catastrophic plans have low premiums and high-deductibles. These provisions were advocated for by Senators Ted Cruz (R-TX) and Mike Lee (R-UT), who argue that there should be the freedom to sell and purchase plans that have low premiums but do not meet existing ACA marketplace standards. Senators Cruz and Lee stated they would not vote for the bill without the catastrophic health plan option. Critics have voiced concern that expanding use of such plans diverts healthy young people away from signing up for more comprehensive insurance, increasing costs for insurers and driving up premiums.

BCRA II also adds new provisions designed to stabilize the private insurance market and keep premiums down. For instance, the bill increases the funds authorized for state stability and innovation programs by $70 billion. This significant increase in funding to stabilize insurance markets is intended to get hesitant senators to support BCRA II. The bill provides that 1% of all state stability and innovation program funds be set aside to assist states where the cost of premiums is at least 75% higher than the national average. Alaska is reportedly the only state with premiums that are at least 75% higher than the national average.

BCRA II also adds a section, section 301, that provides that $70 billion of the funds authorized for the state stability and innovation programs for years 2020 through 2026 would be used to provide federal funding for individual marketplace plans. These monies would be used to assist issuers in covering high-risk individuals enrolled in qualified health plans that meet certain restrictions.

Additional Provisions

Like H.R. 1628 and the previous Senate draft, BCRA II eliminates penalties for failure to comply with the individual and employer mandates. Most of its other provisions are also consistent with the previous iteration of the Senate bill. Significant changes include nearly $45 billion in additional funding to states to address the opioid crisis from 2018 through 2026 and an additional $50.4 million during that period for research dedicated to the opioid epidemic. BCRA II also eliminates two tax cuts, deleting provisions that would have repealed the Medicare tax increase and the net investment tax increase.

Conclusion

We will keep you updated as health reform moves forward in the Senate. For more information or for assistance contacting your Senators, please contact Elliott Milhollin (emilhollin@hobbsstraus.com or 202-822-8282), Geoff Strommer

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