The Senate ACA Repeal Bill Allows States to Erode Affordable and Comprehensive Coverage

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On June 22, Senate Republicans introduced the Better Care Reconciliation Act (BCRA) to repeal the Affordable Care Act (ACA) and eliminate the current financing structure of Medicaid. The bill is a "discussion draft" and not the final version the Senate is likely to vote on, but it highlights the Senate's desire to make drastic cuts and changes to Medicaid and the individual and small group markets. BCRA allows states to waive (i.e. ignore) key provisions of the ACA related to private market plans by making significant changes to the ACA's section 1332 state innovation waiver process. This fact sheet explores: 1) how BCRA would overhaul the ACA's waiver review process, 2) the most important provisions in the ACA that may be waived, and 3) how waiving these provisions would result in less affordable and comprehensive coverage.

An Overview of Section 1332 Waivers

Section 1332 of the ACA allows states to waive key provisions of the law that apply to individual and small group plans. Provisions that may be waived include the requirement that plans cover a set of Essential Health Benefits (EHBs); annual limits on cost-sharing for all plans; the requirement that Marketplace plans comply with the actuarial value (the percentage of health care costs that a health plan will cover) within their level of coverage, as determined by the Secretary of Health and Human Services (HHS); and other marketplace regulations introduced by the ACA.

While the ACA allows states to waive these provisions, waiver applications are subject to a stringent review process. Under the ACA, the Secretary of HHS has the discretion to reject waiver requests that would have the effect of reducing the coverage gains achieved through the law's marketplace reforms. As such, HHS may grant waiver requests ***only*** if the following conditions are met:

- The state plan would provide coverage at least as comprehensive as coverage that includes the ten EHBs included in the ACA;
- The state plan would provide coverage and cost-sharing protections against excessive out-of-pocket spending that would make coverage at least as affordable as under the ACA;
- The state plan would provide coverage to at least a comparable number of residents in the state as the ACA would; and
- The state plan would not increase the federal deficit.

States must also provide a "comprehensive description" of how the waiver meets the above requirements based on sufficient data. These safeguards prevent states from waiving key parts of the ACA's marketplace reforms without having in place appropriate policies to make up for the coverage loses that such actions would entail.

How the BCRA Changes Section 1332

BCRA keeps the ACA's section 1332 waiver provisions, but weakens the protections in place and the thorough application review process established under the ACA in four ways. First, and most importantly, BCRA eliminates the ACA's safeguards described above and removes HHS' discretion when reviewing an application. Under BCRA, the Secretary of HHS ***must*** approve a waiver request as long as the proposed plan does not increase the federal deficit. States no longer have to prove that the plan would achieve comparable coverage gains, that it would retain comparable cost-sharing protections, or that it would provide for coverage as comprehensive as under the ACA. While BCRA instructs states to provide a description of how the plan would take the place of the waived requirements and a description of how the plan would provide for alternative means of access to comprehensive coverage, reduce premiums, and increase enrollment, these coverage safeguards would be meaningless because the law would not authorize the Secretary of HHS to reject an application for failure to comply with them since the only requirement is that the waiver not increase the federal deficit.

BCRA also allows states to submit waiver proposals without statutory authority. Under the ACA, states can request a section 1332 waiver ***only*** if the state legislature enacted a law authorizing the state Governor to seek such a waiver. BCRA removes this safeguard by introducing a new provision authorizing a state to request a waiver through a certification, which the bill defines as "a document, signed by the Governor, and the State insurance commissioner, […] that provides authority for State actions under a waiver under this section […]." Thus, governors who wish to waive key marketplace provisions of the ACA would now be able to do so without explicit authorization from the state legislature. While this provision of BCRA does not preempt state law, allowing the executive branch to seek section 1332 waivers without legislative approval would weaken the protections in states that have not incorporated the ACA marketplace reforms into state law.

Third, BCRA requires HHS to establish an expedited waiver review and approval process. The bill instructs the Secretary to use this process if it is "necessary to respond to an urgent or emergency situation with respect to health insurance coverage within a State." This vague instruction would be subject to agency interpretation and would allow the Secretary to approve in an expedited manner waiver requests from states that have experienced increased premiums and loss of insurers participating in the Marketplace, without a thorough review process and without due consideration to the detrimental effects that waiving certain provisions would have on the individual market.

Finally, approved waivers under BCRA would be effective for eight years, instead of five years as mandated by the ACA. The waivers can be renewed at the end of the demonstration period for an additional eight years. Under BCRA, approved waivers cannot be canceled by HHS before the expiration of the eight year period. This means that a new administration would not be able to renegotiate the terms of the waiver until they expire even if a state is misusing federal funds in implementing the waiver.

BCRA's Waivable Provisions

The following discussion focuses on the most important ACA provisions that a state could easily eliminate under BCRA. Other sections of BCRA repeal some of the ACA provisions that are waivable under section 1332, like the requirement that individuals maintain health insurance coverage, the requirement that large employers offer health insurance to their employees, and the requirement that insurers offer cost-sharing reductions to consumers in the marketplace. As such, the discussion below only focuses on the remaining marketplace protections under the ACA that states would now be able to eliminate.

1. *Essential Health Benefits*

BCRA lets states get rid of the requirement that insurers in the marketplace cover a minimum of ten EHBs. The ACA defines what those ten EHBs are, including maternity care, prescription drugs, and mental health and substance use disorder (SUD) services. BCRA allows states to waive the definition and categories of EHBs. As a result, states are essentially permitted to define their own set of EHBs as they please, which would lead to skimpier marketplace plans that do not provide coverage for basic health care services. Waiving the EHB protections would also affect individuals who get coverage through large employer plans because these plans are allowed to choose ***any*** state's definition of EHBs for the purpose of complying with the prohibition on annual and lifetime limits on EHB coverage. See NHeLP's Issue Brief, *Detrimental Effects of Allowing States to Waive the Essential Health Benefits*.

2. *Annual Limits on Cost-Sharing*

The ACA requires all individual plans sold through the Marketplace to limit the amount consumers and their families pay out-of-pocket for covered services. This requirement is known as *the annual limit on cost sharing*, which is defined in the law as "deductibles, coinsurance, copayments, or similar charges; and any other expenditure required of an insured individual which is a qualified medical expense." For 2017, out-of-pocket maximum is $7,150 for individuals and $14,700 for families. The limit on cost-sharing provides protection for individuals with pre-existing conditions and the elderly whose total cost of care in a given year far exceeds that amount. The limit also protect individuals who experience a medical emergency or unexpected medical costs throughout the year from having to pay unlimited medical costs, resulting in medical debt.

Under BCRA, states would be allowed to waive the cost-sharing limits for individual market plans as long as the state proposal does not raise the federal deficit. This would be an easy bar to meet because permitting insurers to increase out-of-pocket costs would lead to lower premiums, which would result in lower federal advanced premium tax credits (APTC) to individuals buying insurance through the Marketplace. But while waiving the limits on cost-sharing may lower premiums and reduce the federal deficit, it would do so at the expense of low-income individuals with high health care costs who would experience an increase in their out-of-pocket medical costs. States can also waive cost-sharing limits as a workaround for the EHB requirement. That is, even if a state keeps the EHB requirement, this protection would be meaningless if the state waives the limit on cost-sharing and insurers are allowed to increase out-of-pocket costs for basic services, like maternity care and prescription drugs.

3. *Levels of Coverage and Actuarial Value*

The ACA establishes four levels of coverage for plans being sold in the Marketplace. Plans must be at one of four actuarial value levels: 60% (bronze), 70% (silver), 80% (gold), or 90% (platinum). The actuarial value determines how much of the consumer's health care costs the plan will cover in a given year. For example, under a silver plan, the insurer covers 70% of all health care costs and the remaining 30% is covered by the insured individual through a combination of deductibles, copays, and coinsurance. The ACA allows HHS to provide for minimal variation of the actuarial value. Currently, HHS regulations allow insurers selling plans at the silver level to have actuarial values as low as 66%. This tiered system has improved shopping experiences in the Marketplace as consumers are now able to compare plans within each level of coverage. At the same time, the actuarial value limit provides an invaluable tool for consumers to understand the amount of out-of-pocket costs they will be responsible for under each plan.

BCRA would allow states to waive the tiered system and the actuarial value limits without an appropriate alternative plan with comparable protections for consumers buying insurance through the Marketplace. In states waiving the actuarial value limits, insurers would be allowed to substantially increase out-of-pocket costs consumers would have to pay, like deductibles, copays, and coinsurance. Like waiving the cost-sharing limit, eliminating the actuarial value limits would have a disproportionate effect on individuals with preexisting conditions and the elderly who rely on insurance coverage for their high medical expenses.

4. *Qualified Health Plan Classification*

The ACA defines Qualified Health Plans (QHPs) as plans that have been certified by the Secretary of HHS to be sold in the Marketplace. Among other things, QHPs must cover all ten EHBs, must offer at least one plan in the silver actuarial value level, and must ensure the participation of a reasonable number of providers within their network. Under the ACA, plans that have not been certified as QHPs may not be sold to consumers in the Marketplace. This means that individuals buying non-QHPs outside of the Marketplace are not eligible for federal APTCs and that insurers selling non-QHPs are ineligible for federal cost-sharing reduction (CSR) payments under the ACA.

BCRA allows states to request waivers to permit non-QHPs to be sold in the Marketplace, directly competing with plans that must comply with all ACA requirements. In states that waive this requirement, plans with skimpier coverage and higher cost-sharing would be allowed to sell insurance in the Marketplace. These plans will likely attract healthier individuals with less health care needs and costs, which would lower premiums for those enrollees. However, separating healthier individuals from sicker individuals would lead to higher premiums for sicker people because those plans would have higher health care costs unbalanced by premiums from healthy individuals with less health care needs. In essence, this creates a system of high risk pools, in which individuals with preexisting conditions and the elderly pay higher premiums and out-of-pocket costs for their care.

Senate Republicans are also considering an amendment to BCRA, originally proposed by Senator Ted Cruz, which would allow insurers selling at least one QHP in the Marketplace to sell non-QHPs as well. If enacted, this provision would have the same effect as letting states waive the QHP classification for plans being sold in the Marketplace. However, even if this amendment is rejected, the final version of BCRA is likely to keep the Section 1332 waiver provision. Thus, even if the ACA protection against non-QHP in the Marketplace is maintained, states would still be able to waive this provision. In fact, allowing states to waive the QHP classification requirement would have a greater effect on Marketplace instability than Senator Cruz's proposal because insurers would not even be required to sell at least one QHP. Under a 1332 waiver, insurers would have less incentive to sell comprehensive and affordable plans.

As a result, skimpier plans that cover fewer benefits would dominate the Marketplace in waiver states.

5. *Mental Health Parity Requirements*

Under the Mental Health Parity and Addiction Equity Act (MHPAEA), group health plans offering mental health (MH) and SUD benefits are prohibited from imposing limitations (i.e. higher cost-sharing, different lifetime or annual limits, different limits on the number of visits to providers, different prior authorization requirements, among others) on MH or SUD services that are more burdensome than limitations on other medical and surgical benefits. The ACA extended the parity rule to QHPs offered through the Marketplace. Without the parity rule, plans would have to offer MH/ SUD coverage as part of the EHBs, but they could impose burdensome limitations on coverage like prior authorization and quantity limits. BCRA allows states to waive the applicability of the parity rule to QHPs, which would enable insurers to impose limitations on MH and SUD coverage that are more burdensome than limitations on other covered services. These limitations serve as a barrier for individuals with mental health disorders or SUD to access evidence-based, life-saving care.

6. *Other Waivable Critical Marketplace Protections*

In addition to the above requirements, there are other individual market reforms in place through the ACA that could be easily waived under BCRA. These requirements are essential to maintain quality and affordable coverage as part of the available options for consumers buying health insurance through the Marketplace. Some of these reforms also markedly improved consumer experiences navigating the Marketplace. Among the remaining provisions that BCRA permits states to waive are:

- **Requirement that plans increasing premiums submit justification for the increase.** Under the ACA, insurers offering plans through the Marketplace must submit justification for any increase in premiums. Insurers must also post this information on the plan's website. The Marketplace is then permitted to exclude such health plan from the Marketplace after taking into consideration the reasons provided for the premium increases. BCRA would permit states to waive this requirement, allowing insurers to increase premiums arbitrarily and without justification without any consequences regarding the availability of their plans in the Marketplace.
- **Requirement that plans make available cost-sharing information.** The ACA requires plans selling insurance through the Marketplace to permit consumers to learn about the amount of out-of-pocket costs for which consumers would be responsible under the plan. This transparency requirement provides consumers with information regarding the level of cost-sharing for each plan at the moment the consumer is shopping for and comparing

plans in the Marketplace. If states waive this requirement, individuals would be on the hook for surprise out-of-pocket costs and competition among health plans would be weakened.

- **Requirement that states provide for special enrollment periods.** Under the ACA, states are required to have open enrollment periods for consumers to sign up for coverage through the Marketplace. Limiting the open enrollment period prevents individuals from signing up for coverage only after they get sick. However, the ACA also requires states to provide for special enrollment periods for people who experience special circumstances, like moving to a new state or loss of employment. Under BCRA, states would be able to waive this special enrollment period and individuals experiencing unexpected circumstances during the year would be left unprotected.
- **Requirement that plans make available information in plain language.** Under the ACA, insurers selling plans through the Marketplaces must make certain information available to the public, including data on enrollment, information on payments with respect to out-of-network coverage, and information on enrollee rights. The ACA requires that this information be made available in "plain language." That is, the information must be concise and well-organized in a way that consumers, including those with limited English proficiency, can readily understand the language. Under BCRA, states can easily waive this requirement, which would increase consumer confusion when shopping for plans in the Marketplace.

Conclusion

BCRA allows states to waive key ACA individual marketplace reforms without requiring them to come up with a new plan that would provide coverage as comprehensive and as affordable as under the ACA. Among the protections that states would be allowed to waive are coverage of EHBs, annual limits on cost-sharing, and limits on actuarial value. Other reforms that have significantly improved consumers' experiences shopping for health insurance in the individual marketplace could also be eliminated. Since the ACA was enacted, these provisions have ensured that consumers have access to basic health care services at an affordable cost. If states are allowed to waive these provisions without appropriate safeguards in place, health care coverage would be inadequate, leaving consumers facing higher costs and less access to the health care they need.

Correction: An earlier version of this fact sheet argued that BCRA gave states more flexibility to waive a requirement that catastrophic plans be sold in the ACA Marketplace. The fact sheet has been updated to reflect the fact that the ACA only requires catastrophic plans to be sold in the individual market, regardless of whether they are sold in the Marketplace or off-Marketplace. While BCRA would amend ACA restrictions on catastrophic coverage by, for example, allowing individuals over 30 years of age to buy catastrophic plans, states would not need a section 1332 waiver for this provision to be effective.