CLIENT ALERT

Analysis of the House Republican Repeal and Replace Bills for the Affordable Care Act

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On March 6, House Republicans introduced two bills to repeal and replace key provisions of the Affordable Care Act (ACA). The bills are designed to use the budget reconciliation process to repeal key elements of the ACA and to replace others with less expansive versions. The ACA expanded coverage for individuals based on a three-legged policy stool which includes: (i) Market reforms such as the mandated Essential Health Benefits (EHBs) and guaranteed issue requirement that prohibits plans from refusing to cover persons with pre-existing conditions. These mandates enriched benefits but made coverage more expensive. (ii) Individual and employer mandates that were intended to broaden the size of the insurance risk pools and limit the cost of insurance coverage by penalizing the failure to buy coverage. (iii) Advance premium tax credits (APTCs) and cost-sharing reductions for certain consumers to mitigate the increased cost of ACA coverage and make it affordable.

The repeal/replace bill addresses some, but not all of these elements: First, it would modify the EHB provisions by eliminating the actuarial value standards and metal tiers (bronze, silver, gold, platinum) thereby providing more benefit design flexibility with potentially lower costs. Second, it would eliminate the penalties for the individual and employer mandates, meaning that "young invincibles" would no longer be required to bolster insurance risk pools and lower aggregate premiums by purchasing coverage. But it would impose a premium penalty on individuals who do not maintain continuous, creditable coverage. Third, it would not eliminate—but would limit—federal subsidies to purchase insurance, by replacing the current APTC program with a program that has both age and income caps. The bill also would eliminate the cost-sharing subsidies program, which provides lowered copays, deductibles, and other out-of-pocket expenses for qualifying individuals who purchase coverage through an Exchange. The bills do not address the risk adjustment program for Exchange plans, so its future is uncertain.

The ACA expanded the Medicaid program by permitting adults with incomes up to 138 percent of the Federal Poverty Level (FPL) to enroll. While not all States adopted it, the expansion added millions of new Medicaid enrollees. Medicaid is jointly funded by the federal and State governments. The federal government percentage is called the Federal Medical Assistance Percentage (FMAP). FMAP varies by State and is generally between 50 percent and 75 percent of total Medicaid expenses. The ACA supported expansion by providing a higher FMAP for the "expansion" population than for other enrollees. Initially, it provided a 100 percent FMAP for the States' expansion populations, with a phase-down to 95 percent in 2017 and 90 percent in 2020.

In what may be a surprise to many, the bill would not repeal the ACA's expansion of the Medicaid program, although it would reduce its cost to the federal government. The repeal/replace bill would allow States to maintain the expansion with the ACA higher federal funding until 2020. After this, individuals enrolled in the expansion could remain in Medicaid at the higher federal payment rate, but individuals eligible under the expansion who newly enrolled in 2020 and beyond would only be paid for at the lower federal payment rate used for those enrolled separate from the expansion.

In addition, the bill would restrict federal funding of state Medicaid programs by establishing a per capita block grant program with amounts based on five groups: (1) children, (2) the elderly, (3) blind and disabled persons, (4) pregnant women and parents, and (5) working adults (the Medicaid expansion population). The bill would establish spending targets and impose

payment reductions where States exceed those targets. The targets would increase only based on medical care inflation, and a State that failed to keep spending within the target would face a reduced payment the following fiscal year. Significantly, the bill also would limit retroactive eligibility for coverage to the month in which the enrollee applies instead of the up-to three months prior to the date of application currently covered under Medicaid.

The bill would also eliminate many new taxes that provide support for the ACA, such as the health insurance fee, medical device tax, and additional Medicare taxes for high income earners.

The White House has indicated its support for the bills, but also suggested that they are open to revision. While the ACA replacement legislation's final form has yet to take shape, the following is a detailed analysis of the more noteworthy sections of the bills.

The House Energy and Commerce repeal and replace bill:

Subtitle A – Patient Access to Public Health Programs

Sec. 102 - An additional $422 million in funding would be allocated to the Community Health Center program for federally qualified health centers.

Sec. 103 - There would be a one-year freeze on federal funding (including Medicaid, the Children's Health Insurance Program (CHIP) and several federal healthcare block grants) to States for a class of providers designated as "prohibited entities." This provision appears to target Planned Parenthood.

- A prohibited entity is one that:
    1. Is designated as a non-profit by the Internal Revenue Service.
    2. Is an essential community provider primarily engaged in family planning and reproductive health services.
    3. Provides abortions in cases that do not meet the Hyde Amendment exception for federal payment (i.e., to save the life of the woman, or if the pregnancy arises from incest or rape).
    4. Received over $350 million in federal and state Medicaid dollars in fiscal year 2014.

Subtitle B – Medicaid Program Enhancement

Sec. 111 – The increased FMAP funding would be maintained for the Medicaid expansion in its current form until January 1, 2020.

Sec. 112 – Starting in 2020, the federal government would continue to provide higher FMAP funding for the expansion population that joined Medicaid prior to January 1, 2020, for beneficiaries who do not have more than a one month break in eligibility.

- States would be allowed to continue to cover those in the expansion population who were not enrolled before 2020, but the federal government would only provide the traditional, lower FMAP rate for this population.

- The bill appears to rely on the grandfathered Medicaid expansion population losing membership over time as a way to decrease the expansion population.
- The requirement that State Medicaid plans provide the same "essential health benefits" that are required by plans on the exchanges would be repealed on December 31, 2019.

Sec. 113 – The Medicaid Disproportionate Share Hospital (DSH) cuts for non-expansion States would be repealed in 2018. States that expanded Medicaid would have their DSH cuts repealed in 2020.

Sec. 114 – There are various provisions targeted at reducing expense in the Medicaid program, such as:

- Allowing States to disenroll high-value lottery winners and recover Medicaid expenses from such individuals.
- Shortening the former three-month retroactive eligibility period for Medicaid beneficiaries to the month in which the person applied for Medicaid.
- Requiring individuals to provide documentation of citizenship or lawful presence in the United States before obtaining Medicaid coverage, rather than, as under the current system, allowing individuals to receive Medicaid while they are given an opportunity to provide such documentation.

Sec. 115 – Non-expansion States would receive additional safety net funding over five years (through 2022).

- For 2018 through 2022, if a State had not implemented the ACA Medicaid expansion as of July 1st of the preceding year, it would receive increased FMAP safety net funding to adjust payment amounts for Medicaid providers. For these payment adjustments, non-expansion States would receive an increased FMAP of 100 percent for 2018 through 2021 and 95 percent for 2022.
- Each State's allotment of additional funding would be determined according to the number of individuals in the State with income below 138 percent of FPL in 2015 relative to the total number of individuals with income below 138 percent of FPL for all the non-expansion States in 2015.

Sec. 116 – States also would be required to redetermine expansion enrollee eligibility every six months and would receive an additional 5 percent of FMAP for performing the increased eligibility redeterminations.

Subtitle C – Per Capita Allotment for Medical Assistance

Sec. 121 – Per Capita Allotment for Medical Assistance – Starting with payments in 2020, Medicaid funding would be limited based on each State's historical per-enrollee cost and the number of enrollees in the State.

- Currently, the federal government pays a set percentage of a State's total Medicaid cost – without limits on the amount a State may spend on individual beneficiaries. This means that the States, not the federal government, control the federal government's spend.
- Section 121 calls for the Centers for Medicare and Medicaid Services (CMS) to set targets for state Medicaid spending, and would reduce payment to States that exceed those targets.

- If a State or the District of Columbia (but not a territory) had "excess aggregate medical assistance expenditures" for fiscal year 1 (which could be as early as fiscal year 2019), the amount of its payment from CMS for fiscal year 2 would be reduced by ¼ of the "excess aggregate medical assistance payments" made in fiscal year 1.
- Excess expenditures and excess payments would be determined by reference to "target total medical expenditures."
- Targets would be determined based on data collected by CMS for each State for fiscal year 2016 expenditures, adjusted for inflation and excluding certain expenses.
- Separate targets would be calculated for each applicable enrollee category, and the sum of those targets would be the target total medical assistance expenditures for each State for each fiscal year.
- No later than April 1, 2018, CMS would calculate and notify each State of its "base amounts" on which its 2019 and subsequent targets would be determined.

- The per capita limits on payment would apply only with respect to payments based on "1903A Enrollees," which excludes CHIP, Indian Health Service, Breast and Cervical Cancer Services, and partial-benefit enrollees.
- The categories of 1903A Enrollees are:
  - Elderly,
  - Blind and disabled,
  - Children,
  - Expansion enrollees, and
  - Other nonelderly, nondisabled, non-expansion adults.
- Each State would be required to report to CMS additional data for the numbers of enrollees in each 1903A Enrollee category. To offset expenses associated with such data reporting, the bill would allow for a temporary increase in federal matching percentage during fiscal years 2018 and 2019 (after October 1, 2017 and before October 1, 2019). The bill would appear to vary the amount of the temporary increase based on the State's FMAP.
- In summary, if a State failed to maintain its current levels of per-enrollee spending, the State's federal funds would be cut by 25 percent of the margin above current levels for each successive year.

Subtitle D – Patient Relief and Health Insurance Market Stability

Sec. 131 –The cost-sharing subsidy created by the ACA would be repealed effective for plan years beginning in 2020.

Sec. 132 – Title XXII – Patient and State Stability Fund – would be added to the Social Security Act.

- A Patient and State Stability Fund (the Stability Fund) would be created to provide funding to the States and the District of Columbia (States) beginning January 1, 2018 and ending December 31, 2026. CMS would administer the Stability Fund.
- Amounts allocated to a State from the Stability Fund could be used for any of the following purposes:
  - Providing financial assistance to high-risk individuals who do not have access to employer coverage in order to enroll in coverage offered in the individual market in the State. The individual market would be defined by the State – whether through a new or an existing mechanism.
  - Providing incentives to issuers to help the State stabilize premiums in the individual market.

  - Reducing the cost for providing health insurance in the individual and small group markets to persons who have or are expected to have high utilization of health services.
  - Promoting participating in the individual and small group markets in the State and increasing insurance options in such markets.
  - Promoting access to preventive services; dental care; vision care; and prevention, treatment, or recovery support services for individuals with mental or substance abuse disorders.
  - Providing direct or indirect payments to providers for the provision of health care services specified by CMS.
  - Providing assistance to reduce individuals' out-of-pocket costs under their health insurance.
- A State would have to apply to receive allocations from the Stability Fund. Applications would be due no later than 45 days after enactment for 2018 and for subsequent years by March 31 of the previous year. Applications would be deemed approved unless denied within 60 days after submission. Approved applications would be effective for the stated purpose through 2026. Reapplication would not be required.
- Closing a gap in the ACA, any program receiving funds from the Stability Fund would be considered a State health care program for purposes of the federal health care fraud and abuse laws.
- A default program would be established for any State that did not apply for an allocation from the Stability Fund or its application was denied. CMS, in consultation with the State insurance commissioner, would be required to use the allocation that would have been provided to the State to provide premium stabilization payments to issuers.
- The formula used to calculate a State's allotment for years 2018 and 2019 would use two criteria. The first is for 85 percent of the annual funding and is based off of incurred claims for benefit year 2015, and subsequently 2016, which provides for the latest medical loss ratio data available that reflects total costs for the on-exchange individual market. The second is for States to access a proportion of the remaining 15 percent. In order to receive this funding, a State would have to meet one of two triggers: their uninsured population for individuals below 100 percent of FPL increased from 2013-2015; or, fewer than three plans are offering coverage on the individual exchange market in 2017.
- Beginning in 2020, CMS would set an allocation methodology to reflect cost, risk, low-income uninsured population, and issuer competition. To determine this methodology, CMS will consult with health care consumers, health insurance issuers, State insurance commissioners, and other stakeholders and after taking into consideration additional cost and risk factors that may inhibit health care consumer and health insurance issuer participation.
- $15 billion would be appropriated for State use for 2018 and 2019. For years 2020 through 2026, $10 billion would be appropriated annually. A State match would be phased-in beginning 2020. The phase-in schedule would depend on whether a State chose to use the money for their own program or utilize the federal default program administered through CMS.

Sec. 133 – Continuous Health Insurance Coverage Incentive – Consistent with the various GOP repeal and replacement plans, issuers would be required to charge a premium penalty of 30 percent to certain individuals who could not demonstrate continuous, creditable coverage. The penalty would be discontinued after 12 months, thereby incentivizing individuals to remain covered.

- The penalty would apply to an individual seeking coverage in the individual or small group market who:
  - Is unable to demonstrate that, during the 12-month lookback period, they did not have a gap in creditable coverage of 63 days or more; or

    - In the case of an individual who had been enrolled as a dependent and aged out of that health insurance coverage, did not enroll during the first open enrollment period following the date on which dependent coverage ceased.
- This section would be effective starting with enrollments beginning with plan year 2019 or, for enrollments during a special enrollment period, beginning with plan year 2018.

Sec. 134 – Increasing Coverage Options – The ACA requires issuers to label their offerings by metal tier (Bronze, Silver, Gold, and Platinum), which is determined by a calculation known as actuarial value (AV). In an attempt to improve plan choice and benefit design flexibility, the AV standards would no longer apply beginning with plan year 2020.

Sec. 135 – Change in Permissible Age Variation in Health Insurance Premiums – The Secretary would be allowed to implement through interim final regulations a change to allow premium rates in the individual or small group market to vary based on age by up to a 5 to 1 ratio for plan years beginning in 2018. The current age limit is 3 to 1.

The House Ways and Means tax repeal and replace bill:

Subtitle __—Remuneration From Certain Insurers

Sec. _1 – This section would repeal Section 9014 of the ACA, "Limitation on Excessive Remuneration Paid by Certain Health Insurance Providers," codified at 26 U.S.C. § 162(m)(6), which imposes a limitation on deductions for certain health insurers based on remuneration paid to officers, directors, and employees in excess of $500,000. Repeal would be effective for tax years beginning after December 31, 2017.

Subtitle __—Repeal of Tanning Tax

Sec. _1 – This section would repeal Section 10907(b) of the ACA, "Imposition of Tax on Indoor Tanning Services," codified at Chapter 49 of the Internal Revenue Code, 26 U.S.C. § 5000B, which imposes a 10 percent sales tax on indoor tanning services. Repeal would be effective for services performed after December 31, 2017.

Subtitle __—Repeal of Certain Consumer Taxes

Sec. _1 – This section would repeal Section 9008 of the ACA, "Imposition of an Annual Fee on Branded Prescription Pharmaceutical Manufacturers and Importers," which imposes an annual fee or tax on certain drug manufacturers and importers of branded prescription drugs. Repeal would be effective for calendar years beginning after December 31, 2017.

Sec. _2 – This section would repeal Section 9010 of the ACA, "Imposition of an Annual Fee on Health Insurance Providers." Section 9010 imposes an annual fee or tax on certain health insurers. However, the Consolidated Appropriations Act of 2016, Title II, § 201, "Moratorium on Annual Fee on Health Insurance Providers," suspended the collection of the health insurance fee for the 2017 calendar year. Repeal would be effective for calendar years beginning after December 31, 2017.

Subtitle __—Repeal of Net Investment Income Tax

Sec. _1 – This section would repeal Section 1402(a)(1) of the Health Care and Education Reconciliation Act (HCERA), "Unearned Income Medicare Contribution," codified at Chapter 2A of the Internal Revenue Code, 26 U.S.C. § 1411, which imposes a 3.8 percent tax on the net investment income of certain individuals, estates, and trusts. Repeal would be effective for taxable years beginning after December 31, 2017.

Subtitle __—Repeal and Replace of Health-Related Tax Policy

Secs. _01 – _04 – Repeal and Replacement of Tax Credits for the Purchase of Coverage – These sections would modify and eventually eliminate APTCs for individuals and small businesses.

- The ACA provides for refundable tax credits for persons with household incomes up to 400 percent of FPL to purchase "qualified health insurance" through State or Federal exchanges. 26 U.S.C. § 36B. These tax credits do not vary by age but are gradually reduced as the taxpayer's household income rises to 400 percent FPL.
- This scheme would be repealed for coverage months beginning in 2020.
- The credit would be modified beginning in 2018. The credit could not be used for health coverage for abortions, except to save the life of the mother or for rape or incest. Enrollees would be permitted to purchase abortion coverage from their own funds. Credits could not be used to purchase grandfathered, grandmothered, or off-Exchange coverage. In addition, tax credits would be indexed to both the age and income of the taxpayer (the older taxpayer for joint filers). This would substantially *decrease* credits for younger taxpayers, but marginally increase credits for older taxpayers.
- The ACA tax credit, 26 U.S.C. § 45R, available to small employers that purchase employee health insurance would be eliminated for taxable years beginning in 2020.
- For taxable years beginning in 2018, the credit could not be used to purchase health insurance that covers abortion.

Secs. _05 – _06 – Individual and Employer Mandates – These sections would eliminate the ACA's penalties for individuals and employers that fail to purchase coverage.

- Two key provisions of the ACA are the individual and employer mandates that penalize the failure to purchase coverage. 26 U.S.C. §§ 5000A and 4980H.
- The bill would repeal both of these – ***effective January 1, 2016*** – by setting the penalty amounts at zero.

Sec. _07 – Repeal of the Tax on Employee Health Insurance Premiums and Health Plan Benefits – This section would further delay the applicability of the "Cadillac" plan tax on high-cost plans. The excise tax was to become effective in 2018, but was delayed until 2020. 26 U.S.C. § 4980I. The tax would be further delayed until 2025.

Secs. _08 – _10 – Repeals of Tax on Over-the-Counter Medications, Increase of Tax on Health Savings Accounts, and Limitations on Contributions to Flexible Spending Accounts –

- These sections would expand the permissible use of Health Savings Accounts (HSAs) and Flexible Spending Accounts (FSAs).
- These provisions would become effective after December 31, 2017.

Sec. _11 – Repeal of Medical Device Excise Tax – This section would eliminate the 2.3 percent excise tax on medical devices. 26 U.S.C. § 4191. A moratorium was placed on this tax for 2016-2017. The tax would be repealed for sales after 2017.

Secs. _13 – _14 – Repeal of Increase in Income Threshold for Determining Medical Care Deduction and Repeal of Medicare Tax Increase – These provisions would reduce individual tax burdens.

- The deductibility of medical expenses would be increased by decreasing the threshold for deductibility from 10 percent to 7.5 percent of adjusted gross income. The additional 0.9 percent Medicare tax on individuals with incomes over $200,000 for individual filers and $250,000 for joint filers that had gone into effect in 2012 would be eliminated.
- These changes would generally go into effect in 2018.

Sec. _15 – Refundable Tax Credit for Health Insurance Coverage – This section would create a new refundable tax credit to be used for the purchase of health coverage.

- *Tax credit parameters*: A "refundable tax credit for health insurance coverage" would replace the APTC program in 2020.
    - Unlike the ACA credit, which had no fixed cap, the proposed credit would be capped at the *lower* of the taxpayer's cost to purchase "eligible health insurance" for the taxpayer and his/her family for a month *or* the combined "monthly limitation amount" for the family unit (for up to five persons).
    - Notably, the insurance purchased with this credit would not have to meet "qualified health plan" standards.
    - The per-person monthly limit would vary based on age from $166/month ($2,000 per year) for persons under age 30 to $333/month ($4,000 per year) for persons 60 years or older. Under the proposal, a young family of two adults in their 30s with two children would qualify for a monthly limit of $750.
    - These credits would be reduced by 10 percent of the taxpayer's adjusted gross income over $75,000 for individual filers and over $150,000 for joint filers – a limit that would affect only the top 10 percent of joint filers. The maximum allowable credit in a year would be capped at $14,000.
    - Eligible health insurance is defined as insurance offered in the individual market or unsubsidized COBRA coverage, that is not a grandfathered or grandmothered health plan, does not consist of excepted benefits and does not include coverage for abortion (except to save the life of the mother or for rape or incest – although such coverage may be paid for by the taxpayer without the use of the credit). Each State would need to certify that the insurance meets these requirements.
    - An individual would not be eligible for credits in any month in which he/she was eligible for other specified programs including a group health plan, Medicare, Medicaid, CHIP, etc. To be eligible for the credit, a married couple would have file a joint return.
- *Advance payments to insurers*: As with the ACA credit, the tax credits could be paid by Treasury directly to health insurance issuers. The Secretary of Health & Human Services (HHS) would be directed to create this payment program, which is to follow the procedures used for the ACA credit except that payment may be made for off-Exchange coverage. Health insurance issuers would be required to file monthly returns with the IRS regarding their and their customers' participation in the program.
- *High-deductible health plans*: To encourage the purchase of high deductible health plans, HHS would be directed to pay the difference between the monthly credit maximums and the cost of the taxpayer's monthly premium to the taxpayer's

HSA account – at the taxpayer's request – if the taxpayer or another member of his/her family group was enrolled in a high deductible plan.

Secs. _16 – _17 – Increases in Health Savings Account Maximums.

- Effective 2018, the annual maximum allowable contribution for HSAs, for persons enrolled in high-deductible health plans, would be increased to $5,000 for individuals and $10,000 for families. This would match the maximum deductibles permitted under such plans.
- Both spouses would be permitted to make catch-up contributions to the same HSA.

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[1] Copies of the bills are available here and here.

[2] https://www.irs.gov/uac/soi-tax-stats-tax-stats-at-a-glance.

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