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House Republicans Introduce ACA Repeal-and-Replace Legislation

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Health Care

Last week, House Republicans introduced long-awaited legislation, through "budget reconciliation," to "repeal and replace" the Affordable Care Act (ACA). The American Health Care Act (AHCA) makes major changes to current law, including by:

- Replacing the ACA's premium tax credits and cost sharing subsidies with generally less generous tax credits;
- Repealing the individual and employer mandates;
- Imposing a per capita cap on state Medicaid expenditures and eliminating the increased federal match for the ACA's Medicaid expansion; and
- Repealing the ACA's taxes on medical devices and branded drugs.

However, the AHCA also leaves much of the ACA untouched. For example, it does not eliminate the exchanges; it does not repeal most of the ACA's insurance market reforms (e.g., the prohibition on excluding individuals based on preexisting condition, the essential health benefits requirements); and it allows States to continue to provide coverage to the ACA's Medicaid expansion population (albeit eventually with a lower federal match).

Late last week, both the House Energy & Commerce Committee and the House Ways & Means Committee marked-up the AHCA and passed it out of committee. The bill now heads to the House Budget and Rules Committee, before it goes to the House floor.

Earlier today, the Congressional Budget Office (CBO) issued its analysis of the impact of the AHCA. The CBO predicts that, if the AHCA is enacted in its current form, 14 million Americans would lose coverage by 2018 and 24 million would lose coverage by 2026. These grim predictions are likely to complicate Republicans' effort to pass the AHCA on the House floor and in the Senate.

Budget Reconciliation

As an initial matter, it is important to understand that the AHCA is a "budget reconciliation" bill, which limits what can be included in the legislation. This is likely the reason why the AHCA's drafters left many key features of the ACA intact.

While reconciliation allows the bill to pass with only a simple majority in the Senate (enabling Republicans to pass it without Democratic support), several rules constrain the budget reconciliation process and the measures that may be enacted through it. Under the "Byrd rule," any Senator may raise a "point of order" to strike from a reconciliation bill any provision that:

1. Has no budgetary effect and does not produce any change in outlays or revenues;
2. Has a budgetary effect, but that budgetary effect is "merely incidental" to the nonbudgetary components of the provision;
3. Increases the deficit in an "out year," *i.e.*, a fiscal year beyond the budget "window" (which is generally the 5 to 10 years covered by the budget resolution);
4. Increases outlays or decreases revenue and the Committee reporting the provision is not in compliance with its budgetary target;
5. Is outside the jurisdiction of the Committee that reported the provision; or
6. Changes the Social Security program.

See Congressional Budget Act §§ 310, 313 (2 U.S.C. §§ 641, 644).

There may be provisions included in the House bill (such as the age-based tax credits and the provision imposing penalties on individuals who let their health insurance lapse) that will be subject to objection under the Byrd Rule. Thus, it is possible that even more of the ACA will be left unchanged by the final version of the AHCA, if it ever reaches the Senate.

Changes to the Commercial Insurance Regulation and Subsidies

The AHCA would significantly change how the private insurance market would be regulated and subsidized. Most notably, the AHCA would:

1. Repeal the ACA's means-tested premium tax credits and cost sharing subsidies, and replace them with a new, age-based, advanceable tax credit for buying state-approved health insurance. The new tax credits would equal: $2,000 for individuals under age 30, $2,500 for individuals between ages 30 and 39, $3,000 for individuals between ages 40 and 49, $3,500 for individuals between ages 50 and 59, and $4,000 for individuals over age 60. The full credit amount would be available only to individuals who make $75,000 or less per year (or $150,000 for joint filers). The credit would be reduced by 10 percent for any income above $75,000 (individuals) or $150,000 (joint filers). The credits would be cumulative for families and capped at $14,000. This provision also would allow the IRS to simplify employer reporting requirements. This section would take effect in 2020. AHCA § 3, 15.

   The AHCA would provide tax credits to individuals whose income is well above the income cap that applied to the ACA's tax credits (400% of the federal poverty level (FPL)). However, the AHCA's tax credits would be substantially less generous than the ACA tax credits for most people who receive them: The ACA's tax credits were calculated to ensure premiums were affordable for recipients, and thus the tax credits increased if premiums increased, whereas the AHCA tax credits would not increase based on the cost of insurance and would be unlikely to cover a substantial percentage of the cost of those premiums in many areas of the country, except for young and healthy individuals.
2. *Repeal the individual mandate and the employer mandate, and add a continuous coverage requirement.* The AHCA would repeal the individual and employer mandates. Those repeals would be effective January 1, 2016. The AHCA would add a "continuous coverage requirement," under which individuals would have to show that they did not

have a gap in health care coverage of at least 63 continuous days during the previous 12 months. If the individual does not meet this continuous coverage requirement, he or she might be required to pay a 30 percent premium surcharge, effective the first day of the plan year that starts after January 1, 2019. §§ 6, 105, 133.

3. *Allow more variation for health insurance premiums among different age groups.* Under the ACA, the cost of the most generous health care plan for older patients cannot exceed three times the cost of the least generous plan for younger patients. The AHCA would change this ratio to five-to-one and allow States to determine their own ratios within this limit. This change would become effective January 1, 2018. § 135.
4. *Repeal the actuarial value requirements and "Bronze," "Silver," "Gold," and "Platinum" plan levels under the ACA after December 31, 2019.* § 134.
5. *Prohibit individuals from using tax credits to buy any health care plans that offer elective abortion, effective January 1, 2018*. § 2.

While these provisions reflect major changes to the status quo under the ACA, AHCA leaves in place a number of key ACA market reforms. For example, the following ACA market reforms remain unchanged: the prohibition on excluding or discriminating against individuals with preexisting conditions; the requirement that plans allow children to remain on their parents' plans until age 26; the prohibition on lifetime and annual dollar limits; and the requirement that individual and small group market plans cover essential health benefits.

It appears that the AHCA's drafters declined to repeal or amend some or all of these ACA provisions because they did not believe such changes could be included in a reconciliation bill, presumably because these provisions may not be considered to have a non-incidental budgetary impact.

Patient and State Stability Fund

Section 132 of AHCA would establish the Patient and State Stability Fund, which would provide funds to States to undertake a number of measures to stabilize health insurance markets and improve access to care, including: providing financial assistance to high risk individuals and to individuals to reduce out-of-pocket costs; providing direct payments to service providers; promoting participation in individual and small group health insurance markets; promoting dental, vision, and mental health services; and providing incentives to stabilize insurance premiums and reinsurance.

States would have to affirmatively apply for Patient and State Stability Fund grants within 45 days of the enactment of this provision. Approval of funds would be effective for all subsequent years until 2026. If a State did not use these funds for its own program, CMS could use these funds to stabilize premiums.

Two criteria would determine a State's allotment under this program for the years 2018 and 2019. First, 85 percent of the funding would be based on insurance claims incurred for 2015 and 2016. A State would receive the remaining funding if either: 1)its population of uninsured individuals below 100 percent of the FPL increased between 2013-2015; or 2) fewer than three plans are offered in the individual market in 2017. The criteria for funding would change in 2020. Beginning in 2020 and in subsequent years, CMS would set the allocation based on a methodology that would take into account the State's incurred insurance claims compared to

other states, the uninsured population below 100 percent of the FPL, and quantity of insurers in the insurance market.

The Patient and State Stability Fund would provide $15 billion each year for State use for 2018 and 2019 and $10 billion each year for 2020 through 2026. Beginning in 2020, a State match would be phased in to the program.

Because funding for Patient and State Stability Fund would end within 10 years, it would not add to the budget deficit in the outyears and thus may survive a Byrd rule challenge.

Health Savings Accounts (HSAs) and Flexible Spending Accounts (FSAs)

The AHCA would make a number of changes to federal law to allow individuals to make better use of HSAs and FSAs, including by making the following changes, effective in 2018:

- Repealing the prohibition on paying for over-the-counter medications with funds from HSAs. § 8.
- Lowering the tax on distributions from HSAs and Archer medical savings accounts that are not used for qualified medical expenses from 20 percent to 10 percent. § 9.
- Repealing the limitation ($2,500 under current law) on the amount an individual or employer could contribute to an FSA. § 10.
- Increasing the maximum non-taxable amounts that individuals and families could contribute to HSAs to the out-of-pocket expenses permitted under a high deductible health plan. As a result, the limit would be at least $6,550 for self-only coverage and $13,100 for family coverage. § 16.
- Allowing both an individual and his or her spouse to make catch-up contributions to a single HSA. § 17.
- Allowing HSAs to cover an individual's medical expenses up to 60 days prior to when the HSA coverage began. § 18.

Other Provisions Relating to the Commercial Market

Other provisions in the AHCA relating to the commercial health insurance market include:

- Repealing ACA's limitation of remuneration deductions for certain health insurance providers that pay more than $500,000 to an officer, director, or employee. § 1.
- Repealing the ACA's sales tax on health insurance. This provision would take effect in 2018. § 2.
- Delaying until 2025 the 40 percent tax on high-cost employer-sponsored health coverage ("Cadillac" plans) created under the ACA. § 7.
- Requiring, regardless of income, any individual who was overpaid in advance premium tax credits to repay the entire excess amount, in tax years 2018 and 2019. § 1.

Changes to Medicaid

The AHCA would make major changes to the Medicaid program; one commentator has even argued that "the bill is not so much an ACA repeal bill as it is an attempt to change dramatically

the Medicaid program." Most notably, the AHCA would significantly cut federal funding for the Medicaid program and shift risk for growth in Medicaid expenditures to the State.

Per Capita Cap

Under the AHCA, starting in 2020, States would be subject to a Medicaid expenditure cap based on the aggregate of per capita caps for five categories of enrollees: elderly; blind and disabled; children; expansion enrollees; and other adults. *See* § 121(d). Specifically, federal financial participation (FFP) would be available only for state Medicaid expenditures to the extent those expenditures were less than or equal to the aggregate of the product of the "target per capita cap" for the applicable fiscal year for each enrollee group and the number of Medicaid enrollees in each group in that fiscal year. The "target per capita cap" for each enrollee category would be calculated using a complex formula based on the State's 2016 and 2019 Medicaid expenditures, and it would be trended forward for inflation by the medical component of the consumer price index (CPI).

Several categories of Medicaid payments would be excluded from the per capita cap: disproportionate share hospital (DSH) payments; Medicare cost sharing payments for dual eligibles; the proposed "safety-net provider payment adjustments in non-expansion States" (described below); expenditures for premium assistance programs; and expenditures for the following groups of enrollees: Children's Health Insurance Program (CHIP) enrollees; individuals receiving medical assistance from the Indian Health Service; individuals eligible only through the breast and cervical cancer eligibility group; and "partial-benefit enrollees," *i.e.*, aliens entitled only to emergency coverage; individuals who are eligible for Medicaid because of a TB diagnosis; and dual eligibles entitled to only limited coverage.

There are several major concerns about this proposed per capita system. Most notably, it shifts the financial risk of per capita expenditure growth to the States, and it locks-in States to their per capita expenditure levels during the base years.

It is not surprising that Congressional Republicans are using ACA repeal-and-replace to implement a per capita cap in Medicaid, as Speaker Ryan and other Republican leaders have long supported such a policy change. However, many expected that, if and when Congressional Republican leadership introduced legislation to impose a per capita cap on States, the legislation would also provide States with increased flexibility to keep costs down and improve quality of care. The AHCA bill, as passed out of the Energy and Commerce Committee, does not include such additional flexibility for state Medicaid programs.[1]

Phasing Out the Medicaid Expansion

Under AHCA, the increased federal medical assistance percentage (FMAP) for the Medicaid expansion population would not be available after December 31, 2020, except for individuals who enroll in the Medicaid expansion on or before December 31, 2019. States would still have

[1] We will be circulating an advisory with in-depth analysis of the per capita cap proposal to interested clients in the coming days. Please let us know if you would like us to be included on the list of clients that receives that advisory.

the option to cover new enrollees in the Medicaid expansion group after December 31, 2020, but only the regular FMAP would be available for expenditures for those new enrollees. § 111.

Phasing Out Essential Health Benefits Requirements for Alternative Benefit Plans

After December 31, 2019, the AHCA would eliminate the requirement that Medicaid Alternative Benefit Plans (which must be provided to the Medicaid expansion population) must cover Essential Health Benefits. § 111(c). This means that States would no longer have to go through the arduous process of ensuring the package of benefits provided through Alternative Benefit Plans meets the detailed Essential Health Benefits requirements. This provision generated one of the more contentious discussions during the Energy and Commerce Committee mark-up because of its perceived impact on mental health benefits.

Defunding Planned Parenthood

The AHCA would suspend temporarily for one year, Medicaid, CHIP, Maternal and Child Health Services Block Grant, and Social Services Block Grant payments to certain "prohibited entities." The bill's definition of "prohibited entity" would apply only to Planned Parenthood. Specifically, a prohibited entity is an entity that: 1) is a 501(c)(3) non-profit; 2) is an "essential community provider" primarily engaged in services related to family planning and reproductive health; 3) provides abortions in cases besides rape, incest, or to save the woman's life; and 4) received more than $350 million in federal and state Medicaid funding in FFY 2014. § 103.

Changes to DSH Reductions

The AHCA would permanently eliminate the ACA's DSH payment reductions, except for the reductions scheduled for 2018 and 2019. In addition, the AHCA would not impose DSH reductions in 2018 and 2019 on States that have not expanded Medicaid under the ACA. § 113.

Additional Funding for Non-Expansion States

The AHCA would provide additional funding for increased payments to providers in States that have not expanded Medicaid under the ACA. Specifically, in 2018 through 2021, AHCA would provide a 100 percent match for additional payments to providers in non-expansion States; in 2022, that match would decrease to 95 percent. Total payments in any given year to a non-expansion State would be capped at $2 billion, multiplied by the ratio of the State's population below 138 percent of the FPL to the sum of all non-expansion States' populations below 138 percent of the FPL. § 115.

Other Changes to Medicaid

The AHCA would make several additional changes to the Medicaid program, including:

- Generally prohibiting individuals with lottery winnings over $80,000 from qualifying for Medicaid. § 114(a).
- Limiting the effective date for retroactive Medicaid coverage from three months prior to the application to the month in which the applicant applied. § 114(b).
- Requiring Medicaid applicants to provide documentation of citizenship or lawful presence in the United States before obtaining coverage. § 114(c).

- Requiring States to conduct eligibility redeterminations for the expansion population at least every six months. § 115(a).
- Providing a civil monetary penalty for anyone who is knowingly enrolled in the Medicaid expansion and no longer eligibility for the Medicaid expansion. § 115(b).
- Decreasing mandatory Medicaid eligibility for children ages 6 to 19 from 138 percent of the FPL to 100 percent of the FPL.
- Repealing the enhanced FMAP for the Community First Choice Option to provide attendant care services.

Additional Financial Support for Federally Qualified Health Centers

The AHCA also would provide modest additional financial support to Federal Qualified Health Centers (FQHCs). Specifically, Section 102 would provide $422 million in funding for the Community Health Center Fund, which would provide grants to FQHCs. This is in addition to the funding FQHCs already receive from Health Resources & Services Administration.

Repeal of Other ACA Taxes and Programs

The AHCA would repeal a number of the ACA's taxes and programs. Specifically, the AHCA would repeal:

- Effective January 1, 2018, the tax on certain branded pharmaceutical drugs. § 1.
- Effective January 1, 2018, the 2.3 percent tax on medical devices. § 11.
- Effective January 1, 2018, the 3.8 percent investment tax for individuals earning more than $250,000. § 1.
- Effective January 1, 2018, the 10 percent tax on indoor tanning services. § 1.
- Effective on enactment, the ACA's revision of the amount of medical expenses an individual must incur to claim a tax deduction (returning the level back to 10 percent of gross income from 7.5 percent under the ACA). § 13.
- Effective January 1, 2018, the 0.9 percent Medicare tax surcharge on taxpayers with incomes exceeding $200,000 (or $250,000 for joint filers). § 14.
- Effective January 1, 2020, the ACA's small business tax credit. § 4.
- Effective January 1, 2018, the elimination of the business-expense deduction for retiree prescription drug costs. § 12.
- Effective January 1, 2018, the prevention and public health fund created under the ACA. § 101.

There is a significant risk that the above-listed provisions repealing the various ACA taxes would not survive a Byrd rule challenge, as it would seem that they add to the deficit in the outyears.

Prospects for Becoming Law

At this time, it is unclear whether the bill will pass on the House floor, given the opposition of the conservative Freedom Caucus to the tax credits and retention of many of the ACA provisions (in addition to uniform opposition from Democrats). CBO's analysis that 24 million people will lose coverage under the bill is likely to further complicate the process. President Trump and Vice President Pence are working closely with the House Republican leadership to garner the necessary votes for the bill, and such involvement of the White House could result in the House passing the AHCA.

Even if it passes the House, however, the AHCA's fate in the Senate is very uncertain. Under reconciliation, the Senate needs at least 50 Republicans to vote for the bill, given the fact that no Democrats plan to vote for repeal. Several Republicans recently indicated that they will not support the current version of the Medicaid reform package, and others have expressed opposition to the tax credits. We would expect that a different version of the bill will have to emerge in the Senate for it to pass. That said, given the campaign by Republicans against the ACA for the last six years, as well as the promises made in the most recent Presidential election, we can expect that every effort will be made to find a compromise version of the bill that can pass Congress this spring.

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