March 8, 2017

The House's American Health Care Act: Rearranging the ACA Furniture or Rebuilding the Room?

On Monday, March 6, 2017, the two House committees with primary jurisdiction over matters at the core of the Affordable Care Act (ACA) each released a committee print that the committees say will, combined, become the House Republicans' American Health Care Act (collectively, the AHCA), designed to repeal and replace the ACA. Both bills are scheduled for separate mark-up by the two committees today, Wednesday, March 8. The combined recommendations will be delivered to the House Budget committee to be compiled into a single budget reconciliation package that, if it passes the House and if the Senate Parliamentarian agrees that the "Byrd rule" standards for reconciliation have not been violated, can be enacted by a simple majority of 51 Senate votes (with the Vice President breaking any tie). It is reported that the Republicans hope to have a bill to President Trump before the Easter recess, which begins on April 7, 2017.

As described more fully below, the AHCA would:

- Repeal the ACA's taxes (mostly by 2018) and individual and employer mandates and associated penalties (retroactive to 2016);
- Replace the ACA's current system of income-tested premium-support subsidies in 2020 with age-rated refundable, advanceable tax credits of between $2,000 (for those under 30) and $4,000 (for those over 60);
- Phase out the enhanced federal matching payment for the ACA's Medicaid expansion population by 2020, convert federal Medicaid support to per capita grants to states, and provide to non-expansion states additional funds to be spent in support of safety net providers;
- Deny federal funding to Planned Parenthood and deny use of tax credits to purchase insurance policies that cover what the Ways & Means Committee summary calls "elective abortion";
- Leave intact several popular provisions of the ACA, including the protection for individuals with pre-existing conditions, the provision allowing young adults to remain covered under their parents' health care plans until age 26, and, until 2020, the categories of defined "essential health benefits" that must be covered by certain plans; and
- Repeal the employer shared responsibility assessments and certain limitations and exclusions on health savings accounts ("HSAs") and flexible spending accounts ("FSAs"), eliminate the deduction for expenses allocable to the Medicare Part D retiree drug subsidy, and further delay the Cadillac Tax provisions.

Chairman Brady of the Ways & Means Committee hailed the AHCA as "answering President Trump's call to action," and statements by the Republican leadership characterize the legislation as a complete repeal of Obamacare and its replacement by building a new and better system that will return control of health care to the states and to the people. In contrast, many conservatives characterize the AHCA as doing little more than rearranging the ACA's furniture. They particularly object to the tax credits for premium support that Senator Paul has called "Obamacare Lite" and that members of the House Freedom Caucus have indicated they might vote against as a new federal entitlement. Democrats characterize the AHCA as tax breaks for the wealthy and a withdrawal of necessary support

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for middle and working class families. In addition, Senate Democrats may be expected to raise objections under the Byrd rule, which allows simple majorities to pass only budget reconciliation measures that do not contain ‘extraneous’ provisions, including provisions that do not directly affect spending or revenue, or that increase the deficit over the long term. It remains to be seen whether these objections will derail the AHCA. A more complete discussion of some of they key elements is included below.

Repeal of the Individual and Employer Mandates

The AHCA would repeal the individual mandate, along with the corresponding penalties, retroactively to 2016. Instead, beginning with open enrollment for the 2019 benefit year, health plans would be allowed to impose up to a 30% surtax on base premiums for those who have failed to maintain continuous coverage for a period of 63 days or more. The surtax would be discontinued after 12 months, at which point the affected individuals would be charged the base premium rates then in effect. As discussed in more detail below, the employer mandate also would be repealed, with employer shared responsibility assessments dropping to zero retroactive to January 1, 2016.

Repeal or Delay of ACA’s Taxes and Mandates

The AHCA would further delay, until January 1, 2025, the effective date of the Cadillac Tax provisions (this appears to be an attempt to comply with a Byrd rule requirement that budget reconciliation measures not increase the deficit in years beyond the reconciliation measure). Effective January 1, 2018, the ACA’s other taxes would be repealed, including taxes on health insurers, prescription drugs, tanning services, and certain medical devices; the 3.8% tax on certain net investment income; and the 0.9% Medicare tax. The AHCA would also eliminate the ACA’s provisions that limit certain insurers’ ability to deduct remuneration in excess of $500,000 paid to their employees.

Tax Credits

Effective in 2020, the AHCA would replace the ACA’s means-tested advanceable and refundable premium tax subsidy with an advanceable and refundable tax credit that is largely age-rated. Until 2020, individuals may use the ACA credit only to purchase catastrophic coverage.

The proposed credit ranges from $2,000 for those under age 30 up to $4,000 for those over 60. The credit is phased out for individuals with incomes over $75,000 per year ($150,000 for married couples filing jointly), decreasing by $100 for each additional $1,000 in income.

Phase-Out of Medicaid Expansion

States that chose to expand Medicaid eligibility criteria under the ACA would continue to receive higher federal financing through the end of 2019. In 2020, such states would continue receiving the enhanced federal payments for beneficiaries previously enrolled pursuant to the ACA expansion, but not for beneficiaries enrolling in 2020 or thereafter. In addition, the 2020 conversion of Medicaid from an entitlement to a per capita payment system (described below), could mute or potentially eliminate any advantage from the legacy enhanced funding.

Medicaid Conversion to Per Capita Grants

Since its inception, Medicaid has been an entitlement program, with the federal contribution to each state based on the state’s actual expenses for Medicaid beneficiaries. The AHCA would change that. Effective in 2020, each state Medicaid agency would receive a federal grant based on the product of its Medicaid-enrolled population (under federal eligibility criteria) and a per capita amount equal to the state’s inflation-adjusted average per capita Medicaid expenditures in 2016. This means that, beginning in 2020, and subject to certain adjustments, the federal government’s contribution to each state’s Medicaid program would, on a per capita basis, be frozen at 2016 amounts.

Funding for Non-Expansion States

Apparently to discourage states that chose not to expand Medicaid eligibility under the ACA from doing so in the remaining two-plus years that the legislation would allow, states that continue to decline expansion would be eligible to receive up to an aggregate of $2 billion in additional safety net funding in each year from 2018-2022, for a total of

$10 billion over five years. Based on 2015 Census data, each non-expansion state's allocation would be based on that state's portion of individuals under 138% of the federal poverty level compared with the same population across all non-expansion states. This funding is lost if a state subsequently implements ACA Medicaid expansion.

Return of Disproportionate Share Hospital (DSH) Payments

The AHCA would, effective beginning fiscal year 2020, repeal the Medicaid DSH allotment reductions, which were intended to be implemented under the ACA as additional individuals gained insurance. The increase in DSH funding is an acknowledgement by Republicans that fewer individuals would have health insurance under the AHCA, thus increasing the burden of uncompensated care for safety net providers. It is unclear what the net financial impact would be to safety net hospitals, though some stakeholders urge that a return of DSH would not balance out the expected increase in the rolls of the uninsured.

Funding for Patient and State Stability Fund

The AHCA would provide $100 billion in federal funding to states through the establishment of the Patient and State Stability Fund for an expanded form of high-risk pools to help high-risk individuals who do not have access to employer-sponsored health insurance. Beginning in 2018 and ending in 2026, states would be eligible to use the money for purposes that are specifically designated under the AHCA, provided that the states follow an application process set forth by the Administrator of the Centers for Medicare & Medicaid Services (CMS) which necessarily includes, among other requirements, "[a] description of how the funds will be used."

The Patient and State Stability Fund would be administered by the Secretary of Health and Human Services (HHS), and would allow states to use the money for seven specific purposes, including incentivizing "appropriate entities to enter into arrangements with the State to help stabilize premiums," reducing costs of and promoting participation in the individual and small group markets, promoting preventive care and making payments to providers who provide such care, and providing assistance with out-of-pocket costs.

Denial of Funding to Planned Parenthood

Federal funds provided to Planned Parenthood clinics through Medicaid and other government programs would be removed for one year beginning on the date of the AHCA's enactment.

Employer Assessments

The AHCA would repeal the employer shared-responsibility assessments under IRS Code sections 4980H(a) and 4980H(b) as of January 1, 2016, although employers and insurers appear to continue to have to comply with the Code section 6055 obligation to report whether they offer minimum essential coverage to their employees and eligible dependents. If retained, this provision would have the effect of providing retroactive relief to employers who would otherwise be subject to an assessment for failing to offer minimum essential coverage to full-time employees in 2016. While not expressly repealed by the AHCA, presumably employers would no longer have to report the offer of coverage to full-time employees under Code section 6056.

Age Discrimination and Minimum Essential Benefits

Whereas the ACA capped the age-based multiplier with which plans offered in the individual or small group market could charge higher premiums for older individuals at a factor of 3, the AHCA would increase the multiplier to a factor of 5 (or such other ratio as the state involved may provide). This change would be effective for plan years beginning in 2018. While the AHCA would not disturb the ACA's essential minimum benefit requirements for exchange-acquired plans, it could render them effectively irrelevant after December 31, 2019, because the existing ACA premium subsidies that support purchase of such plans go away, and the new credits may be used to purchase any off-exchange health insurance that is offered in the individual market. In addition, the minimum essential benefit requirements for Medicaid formally sunset as of December 31, 2019.

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HSAs and FSAs

The AHCA proposes a number of changes to FSAs and HSAs as of January 1, 2018, including:

- Repeal of the limitation on contributions to health FSAs. For tax years beginning January 1, 2018, the $2,600 limitation currently in effect would be eliminated and employers would have the discretion to set the contribution limits under their health FSA plans;
- Repeal of the exclusion of over-the-counter medications from the definition of qualified medical expenses. If this change is retained, individuals who have established FSAs and HSAs would be able to use funds in those accounts to reimburse expenses for over-the-counter medications on a tax-free basis;
- An increase in the amount that eligible individuals would be able to contribute to an HSA;
- Clarification that it would be permissible to use HSA distributions to pay for qualified medical expenses incurred before the HSA was established, provided that the HSA is established during the 60-day period beginning on the date that an individual's coverage under a high deductible health plan begins; and
- Repeal of the increase in the penalty applied to distributions from an HSA or Archer MSA that are not used for qualified medical expenses. The tax, which increased to 20% under the ACA, would revert to 10% for any such distributions made as of the date above.

Medicare Part D Retiree Drug Subsidy

The AHCA would reinstate the deduction for expenses allocable to Medicare Part D Retiree Drug Subsidy. For taxable years beginning January 1, 2018, employers would be permitted to take as a business expense deduction retiree prescription drug costs without reducing the deduction by the amount of any federal subsidy.

Some Things that the AHCA Would Not Do

An earlier draft of the AHCA would have reduced the tax deductibility of employer-sponsored health insurance, an issue that drew loud complaints from business. The AHCA does not take advantage of the revenue that would have been available from such change.

The AHCA also does not attempt to implement long-standing Republican objectives to change Medicare to a premium support program.

Additionally, the AHCA does not appear to impose any changes on the Center for Medicare and Medicaid Innovation (CMMI), which was created under the ACA as a testing ground for payment reform, including many value-based health models. HHS Secretary Tom Price has been critical of certain aspects of CMMI, notably its creation of mandatory programs, which he viewed as an overreach of CMMI's authority.

Prospects?

Early indications are that the AHCA may face an uphill battle, as it has appeared to appease neither the most conservative GOP members, who oppose providing income-based tax credit, nor more moderate GOP members, who have expressed concern regarding the potentially negative impact that the bills could have on Medicaid populations. Additionally, the Congressional Budget Office has not yet marked up the AHCA to estimate potential costs and coverage impacts, which could be of concern for some lawmakers and could provide a vehicle for derailing the budget reconciliation eligibility under the Byrd rule. Republicans can afford just 21 defections in the House and three in the Senate in order to pass the AHCA as a reconciliation measure that requires a simple majority vote in the Senate. In sum, the AHCA may simply be the opening volley in the long-promised Republican plans to do away with the ACA, but may not yet be the final event ready for prime time.

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