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Memorandum

March 7, 2017

To: Interested Clients

From: Holland & Knight

Re: House Ways and Means and Energy and Commerce Committees Unveil ACA Repeal/Replace Bill.

I. Overview:

The Congressional Republican leadership has indicated that they will approach the repeal and replacement of the Affordable Care Act in three steps: (1) repeal and replace through the so-called "budget reconciliation" process; (2) administrative actions to the extent permitted by federal law; and (3) separate legislation for policy changes or other priorities that cannot be accomplished through the budget reconciliation process.

On Monday, March 6th, House Republicans released their Affordable Care Act (ACA) repeal and replace budget reconciliation legislation. The *American Health Care Act (AHCA)* consists of two titles – one drafted by the Energy and Commerce Committee and one by the Ways and Means Committee. The legislation is similar to a number of proposals that the GOP has circulated over the past year or two, but also excludes a number of changes that have been widely discussed.

Concurrent markup of the legislation is set for Wednesday, March 8th at 10:30 AM in the two committees. If the committees successfully agree to the legislation this week, the House Budget Committee is expected to act the following week with subsequent consideration by the House Rules Committee. House floor action would then be anticipated the week of March 27th . The Senate is then anticipated to take up the House bill with the intent of completing consideration prior to a two week recess that begins Friday, April 7th. This time frame could be shortened or lengthened and, of course, either body could fail to take final action on the legislation.

The legislation released on Monday has not yet been officially "scored" by the Congressional Budget Office (CBO) with respect to its budgetary impact. Important questions that CBO will evaluate include how the bill may affect levels of insurance coverage and whether the legislation will have a net impact on budget deficits over the next ten years. To be further considered, it is necessary for the bill to not increase the deficit. House rules require a CBO score prior to the bill being filed for floor consideration.

In general, the legislation repeals almost all of the revenue and spending provisions contained in the ACA – eliminating premium support tax credits for health insurance purchase in two years and phasing out enhanced matching funding for the States to expand their Medicaid programs. In their place, the bill creates a new tax credit to support the purchase of insurance, and a stability fund to provide resources to the states for innovative approaches to health care coverage. There is also a special funding provision for the states that did not expand their Medicaid programs. The bill also would make a very fundamental change in the state-federal Medicaid program by shifting from an open-ended entitlement structure to a per-capita allotment financing approach.

It is unclear whether any provisions might be struck by the Senate under the budget reconciliation procedural rules in effect for this bill. Those rules allow the bill to pass in the Senate with 51 votes. However, any provisions that do not have a direct impact on spending or revenues can be struck out on a point of order.

II. Tax Code Changes:

A. Repealed/Modified Taxes.

The bill repeals almost every tax that was contained in the original ACA. These revenues were included in order to finance the benefits provided by the ACA and to address issues with the insurance market for individual and small group plans.

The following revenue provisions are repealed:

- The 2.3 percent medical device excise tax;
- The small business tax credit;
- The brand manufacturer prescription drug tax;
- The over-the-counter medication tax;
- The health insurance tax;
- The ten percent tanning sales tax;
- The net investment income tax imposed on unearned income on taxpayers earning more than $200,000 ($250,000 for joint filers);
- The exclusion of coverage for over-the counter medication from tax-subsidized accounts such as HSAs;
- The ACA's increase in the penalty for the use of HSA and Archer MSA funds for non-medical purposes (reducing the penalty from 20 to 10 percent for HSAs and 20 to 15 percent for MSAs);
- The $2500 limit on contributions to flexible spending accounts;
- The repeal of the Medicare .9 percent tax surcharge on taxpayers with incomes exceeding $200,000 ($250,000 for joint filers);
- The requirement that employers reduce their deduction for expenses allowable for retiree drug costs without reducing the deduction by the amount of retiree drug subsidy;
- The increase in income threshold for medical expense deduction.

Notably, the legislation delays but does not repeal the so-called "Cadillac tax" that would tax the value of health insurance policies above a certain threshold. The tax, currently slated to take effect in 2020, would be delayed until 2025. Prior proposals had suggested repealing the Cadillac tax and replacing it with a provision that would treat some portion of employer-provided health insurance as taxable income to the

employee. No such change in the tax treatment of employer-supported health insurance is contained in the bill.

Also notable, are the two "mandates" contained in the ACA are repealed – the individual income tax penalty for not having qualifying insurance coverage and the employer mandate imposing a tax penalty on employers above a certain size who do not provide qualifying insurance coverage to their employees. These would be repealed effective 2016. In place of the individual mandate, a new provision allowing an insurer to assess a 30% premium increase on those that do not maintain continuous coverage (a break of more than 63 days) is included. The intent is to incentivize individuals and families to obtain and maintain coverage.

B. The New Health Insurance Tax Credit Scheme.

The bill repeals the "premium tax credits" created by the ACA. Those credits – which are available in varying amounts to individuals and families with incomes below 400% of poverty and are tied to the cost of health insurance premiums – would be discontinued in two years. In their place, the legislation contains a new tax credit that will be available to individuals and families in 2020. The credit increases based on age based on five age bands -- starting at $2,000 for people in their 20s and increasing to $4,000 for people in their 60s. These new credits are "means tested" – they diminish for individuals earning more than $75,000 ($150,000 for joint filers), declining by $100 for every $1,000 in income above those amounts. A family could not receive a total of more than $14,000 in credits per year. The credits and the thresholds are indexed for inflation (CPI). It is worth noting that the new tax credits would not by their express terms have to be used on a health insurance product that met the ACA's "essential health benefits" (EHB) requirements. However, the proposed legislation does not change the ACA provision mandating that individual and small group insurance products meet the EHB standard.

C. Health Savings Accounts.

Consistent with the GOP's long-standing support for the use of health savings accounts coupled with catastrophic insurance policies, the bill increases the maximum tax subsidized amounts that can be contributed to HSAs to the amount of the out-of-pocket limit, it would allow both spouses to make catch-up contributions to the same HSA, and it would allow HSAs to cover medical expenses incurred up to 60 days before HSA coverage begins. These provisions are effective for 2018.

III. Insurance Regulatory Changes:

The ACA imposed significant federal regulations on the individual and small group health insurance market that had historically been regulated by the states. Much of that regulatory structure – such as requirements barring medical underwriting, charging higher premiums for individuals with pre-existing conditions, stipulating that insurance products provide "essential health benefits" and allowing children up to the age of 26 to remain on their parents policies – is unchanged by this bill. There are however some notable changes.

- **Cost -Sharing Subsidies.** In addition to premium tax credits, the ACA provided for cost -sharing reductions (CSRs) for some low income health insurance purchasers. These CSRs are the subject of a lawsuit (House v. Burwell) contending that the Obama Administration acted unconstitutionally in spending funds on the CSRs without an appropriation from Congress. That litigation is currently on hold. The CSRs would be discontinued effective December 31, 2019.

However, the bill does not include an appropriation for cost sharing subsidies for 2017 or 2018 so it is possible the litigation could result in an earlier cutoff.

- **Age-Rating.** The ACA created federal "age rating" bands limited to a ratio of 3 to 1. An older consumer could not be charged a premium more than three times the amount charged to a younger consumer. The bill would allow states to change this to as high as 5 to 1.

- **Plan Levels and Out-of-Pocket.** The ACA specified that insurance newly sold to individuals and small businesses in an Exchange or otherwise must be at one of four actuarial value levels: 60% (a bronze plan), 70% (a sliver plan), 80% (a gold plan), and 90% (a platinum plan). The ACA also requires that plans cap the maximum out-of-pocket costs for enrollees, based on the out of - pocket limits in high-deductible plans that are eligible to be paired with a Health Savings Account. This legislation removes the ACAs actuarial value (AV) standards and metal level requirements after December 31, 2019 and allows states to permit age ratios as noted above beginning on or after January 1, 2018.

- **Continuous Coverage Incentive.** As mentioned above, the individual mandate tax is repealed by this bill but replaced by a provision that enacts a continuous coverage requirement. To avoid a 30 percent premium surcharge, individuals must prove that they did not have a gap in creditable coverage of at least 63 continuous days during the 12 months preceding coverage; individuals aging out of dependent coverage must prove that they enrolled during the first open enrollment period after which dependent coverage ceased. The penalty lasts for the remainder of the plan year for special enrollments during 2018, and for the 12-month period beginning with the first day of the plan year for 2019 and succeeding years.

IV. Medicaid Reform:

The bill contains dramatic changes to the federal-state Medicaid program that provides health care coverage to low income Americans.

A. Rollback of Medicaid "Expansion" Coverage.

The ACA directed the states to expand their Medicaid programs to cover all adults with incomes under 138% of poverty (previously most states had limited coverage of these adults). Under the ACA, the federal government would initially cover 100% of the cost of this "expansion" population and this "enhanced match" would decline slightly over a period of years to 90%. Subsequently, the Supreme Court in NFIB v. Sebelius ruled that this expansion was voluntary not mandatory. As of January 1, 2017, 19 states have not adopted Medicaid expansion.

The bill essentially phases out the enhanced match. Effective, January 1, 2020, newly enrolled adults would not qualify for the enhanced match – the state would only receive its regular federal matching amount (FMAP). Regular FMAP amounts vary from 50 cents on the dollar in large industrial states to as high as 79% in Alabama. Thereafter, a state would no longer receive the enhanced match for any individual who had a break in Medicaid coverage of longer than one month. Such adult Medicaid recipients generally cycle on and off of Medicaid as their incomes fluctuate. In this manner, over time, the enhanced match would be phased out.

B. Alternative Federal Support.

Several other significant changes in how the federal government provides support to the states are included in the bill. These changes serve to (i) partially mitigate the loss of Medicaid funding that "expansion" states will experience, (ii) provide some additional resources to non-expansion states, and (iii) provide resources that states could use to try to stabilize insurance premiums and promote new coverage. It should also be noted that the bill provides an additional $422 million in FY 2017 for community health centers.

1. Patient and State Stability Fund.

The bill establishes and funds for nine years a "Patient and State Stability Fund". The fund provides $15 billion per year for FYs 2018 and 2019, and $10 billion is provided for the subsequent years (2020-2026). The bill very broadly defines the purposes for which the fund can be used. Expected focus areas would be stabilizing insurance markets and premiums, establishing "high-risk" pools or other mechanisms to address high-cost insureds, or directing various forms of assistance to address the low-income uninsured. States would have to provide a steadily increasing amount of matching funds in order to access these resources -- 7 percent of their grant amount in 2020; 14 percent in 2021; 21 percent in 2022; 28 percent in 2023; 35 percent in 2024; 42 percent in 2025; and 50 percent in 2026.

For 2018 and 2019, funding would be provided to states on the basis of two factors -- 85% of the funding would be determined via states' relative claims costs, based on the most recent medical loss ratio (MLR) data. The remaining 15% of funding would be allocated to states whose uninsured populations increased from 2013 through 2015 or who have fewer than three health insurers offering Exchange plans in 2017. The essential idea is to expedite distribution of these funds for immediate efforts to stabilize markets.

For 2020 through 2026, the Center for Medicare and Medicaid Services (CMS) would be charged with determining a formula that takes into account (i) states' incurred claims, (ii) the number of uninsured with incomes below the poverty level, and (iii) the number of participating health insurers in each state market.

2. Non-Expansion State Funding.

The bill would provide $10 billion over five years ($2 billion per year) in safety net funding to the non-expansion states for calendar years 2018 through 2022. These funds are to be used to support providers who serve Medicaid patients. States would not be required to provide any matching support for these funds until the final year (2022) in which they would need to contribute 5%. Each non-expansion state's share of the $2 billion annual allotments would be determined by a formula that measures its share of individuals below 138% of the federal poverty level (FPL) as a proportion of the total number of such individuals in the non-expansion states. In effect, this will provide the larger non-expansion states (e.g. Texas, Florida) with larger dollar amounts while the poorest of the non-expansion states (e.g. Alabama) would receive proportionally more dollars.

3. Disproportionate Share Payments.

The ACA imposed significant reductions over a period of years on the funding "allotments" that states receive in varying amounts to allow them to provide supplemental funding to hospitals that serve a disproportionate share of Medicaid and uninsured persons (Medicaid DSH). Congress subsequently delayed implementation of these cuts. The bill would repeal all such cuts effective in two years (2020).

However, for 2018 and 2019 it would allow the Medicaid DSH allotment reductions to go forward for the expansion states only. The cuts would be adjusted to reflect the exemption of the non-expansion states.

C. Medicaid Per-Capita Allotments.

Medicaid has always been an open-ended entitlement program: federal matching dollars are paid on a quarterly basis to the states for all allowable expenditures in providing covered services to covered beneficiaries. The bill would make a fundamental change to this approach. Starting in 2020, the states (and the District of Columbia but not the territories) would be shifted to a "Per-Capita Allotment" (PCA) funding approach.

Under this approach, a specific dollar amount is calculated for each Medicaid beneficiary and this "per capita" amount is paid on an annual basis. The per capita payment is based on an average amount for beneficiaries in one of five "enrollment categories" – (i) elderly (individuals over age 65); (ii) blind and disabled; (iii) children (under age 19); (iv) adult "expansion" enrollees (i.e., able - bodied adults enrolled under ACA); and 5) all other enrollees (i.e non -disabled, non-elderly, non-expansion adults such as pregnant women and adults covered prior to or subsequent to expansion).

The states' Medicaid population for Fiscal Year 2016 would serve as the "baseline" for calculating the PCA amounts. The amount of the per-capita caps would be calculated based on average state spending on each of the five subpopulations. That amount would then be used to calculate the federal FMAP for individuals in each subpopulation. As the composition of a state's Medicaid beneficiaries changes from year-to-year, the number of individuals in each enrollment category will change and the average cost against which matching funds are provided would change correspondingly.

The per-capita allotments would grow at the rate of the "medical care component of the consumer price index for all urban consumers" (CPI-M) plus one percent. CMS predicts that CPI-M will grow at 4.2 percent per year from 2017 to 2025. To the extent that such inflation adjustments are greater or lesser than the actual changes in Medicaid program costs, states would either incur an increased or decreased financing burden. The legislation requires the Department of Health and Human Services (HHS) to reduce states' annual growth rate by one percent for any year in which that state "fails to satisfactorily submit data" regarding its Medicaid program.

Certain funding streams or expenditures are excluded from the calculation of the per capita allotments – Medicaid DSH payments, Medicare cost-sharing payments, and safety-net provider payment adjustments in non-expansion states.

Certain beneficiaries are excluded from the five PCA enrollment categories -- State Children's Health Insurance Plan (CHIP) enrollees, Indian Health Service participants, breast and cervical cancer services eligible individuals, and certain other partial benefit enrollees. The legislation also permits HHS to adjust cap amounts to reflect data errors, based on an appeal by the state, increasing cap levels by no more than two percent.

D. Other Medicaid-Related Provisions.

- **Data Recording.** For the period including calendar quarters beginning on October 1, 2017 through October 1, 2019, the bill increases the federal Medicaid match for certain state expenditures to improve data recording, including a 100 percent match in some instances.

- **Medicaid Program Integrity**: Beginning January 1, 2020, the bill requires states to consider lottery winnings and other lump sum distributions as income for purposes of determining Medicaid eligibility. Effective October 2017, it restricts retroactive eligibility in Medicaid to the month in which the individual applied for the program (current law requires three months of retroactive eligibility). It requires, beginning six months after enactment, that Medicaid applicants provide verification of citizenship or immigration status prior to becoming presumptively eligible for benefits during the application process. With respect to eligibility for Medicaid long-term care benefits, the bill reduces states' ability to increase home equity thresholds that disqualify individuals from benefits; within six months of enactment, the threshold would be reduced to $500,000 in home equity nationwide, adjusted for inflation annually.

- **Eligibility Re-Determinations:** The bill requires states, beginning October 1, 2017, to re-determine eligibility for individuals qualifying for Medicaid on the basis of income at least every six months.

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- **Essential Health Benefits:** Beginning in 2020, state Medicaid programs would no longer be required to provide "Essential Health Benefits" coverage.

- **Planned Parenthood:** Planned Parenthood entities that are otherwise qualified as Medicaid providers would be barred for one year from program participation.

V. Discussion:

A. What the House Legislation Does.

The bill fulfills the GOP promise of repealing virtually all of the ACA taxes, the individual and employer mandates, the enhanced match for Medicaid expansion, cost-sharing subsidies for the exchange population, and the premium tax credits as structured in the ACA. It also fulfills their promise of retaining popular insurance provisions, such as guaranteed issue, the ban on lifetime limits, and the requirement that plans allow children to stay on parents' plans through age 26. It also enables some degree of greater consumer choice over the types of coverage they can purchase.

The President and many Republicans have called for providing access to health care via insurance coverage to the greatest extent possible. It is noteworthy that, to some degree, the House legislation structurally retains two of the three ACA pillars of expanding health insurance coverage through Medicaid and the tax code with some significant modifications. The bill retains the ability of states to expand Medicaid coverage to non-pregnant childless adults – states may opt to provide coverage up to 133% of the federal poverty level– however, only at regular federal matching rates starting in 2020. Low and middle-income Americans otherwise without access to government or employer sponsored coverage will receive advance-able, refundable tax credits to purchase insurance (the new credits are different in their structure in basing the credit primarily on age categories, with a phase out for higher income Americans). To what extent these changes would impact (positively or negatively) levels of health insurance coverage is unknown.

The proposed changes to the Medicaid program are significant -- most importantly the restructuring of federal funding into per capita allotments that, for the first time, would limit federal spending on a per beneficiary basis. The legislation seeks to provide greater parity for expansion and non-expansion states

by reducing the enhanced match for non-pregnant childless adults, and by providing safety net funding for providers serving Medicaid beneficiaries.

B. What the House Legislation Doesn't Do:

The legislation does not make a number of changes either requested by stakeholders or otherwise proposed by numerous Republicans over the past seven years.

- It does not make fundamental structural changes to the Medicare program, such as combining Parts A and B or moving to a defined contribution for Medicare beneficiaries.
- It does not reauthorize the CHIP program, or address various "extender" provisions in the Medicare program.
- It does not block grant the Medicaid program, nor does it provide States the full flexibility sought by many Governors in designing their Medicaid programs or reform the Section 1115 Waiver process.
- It does not alter the tax treatment of employer sponsored insurance.
- Other than Medicaid DSH payments to hospitals, the legislation does not reverse the ACA's cuts to provider payments, such as the Medicare productivity adjustment, the Medicare DSH program, or cuts to inflationary updates for hospitals and other providers.
- It does not alter a number of quality requirements placed upon providers including value-based purchasing and penalties for preventable readmissions or health care acquired conditions.
- It would not impact CMS Innovation Center (CMMI) funding or programs, the Medicare Shared Savings Program (ACOs), or MACRA's Quality Payment Program.
- As discussed in this memorandum, it does not change many of the health insurance regulatory provisions contained in the ACA, such as the essential health benefits requirement. Nor does it implement new insurance reforms such as association health plans or new rules allowing insurance to be sold across state lines.

Some of these issues may be addressed via administrative changes or future legislation as part of the second and third prongs of the GOP's "repeal and replace" framework.

VI. Outlook:

Release of the House bill is the first step in a process that may or may not lead to legislation reaching President Trump's desk. Because there is expected to be no Democratic support for this legislation, near unanimity among Republican lawmakers will be required to pass the bill. Congressional Republicans are under a great deal of pressure to make good on their repeated promise to repeal and replace the ACA. But there are a number of potential flashpoints – including funding changes affecting states with Republican Governors, concerns regarding whether a new health insurance tax credit is appropriate or workable, and provisions respecting coverage of abortions and funding for Planned Parenthood – that could ignite into major disputes. Presently, a handful of very conservative Republican Senators have expressed concerns with the legislation as have several moderate Republican Senators – each group for very different reasons. Whether any of these Senators (or a significant number of House Republicans) will ultimately oppose passage of "repeal and replace" legislation remains to be seen.

It is also likely that the bill will see changes as the process moves forward. First, there may be modifications made in the House committee markups on Wednesday. Prior to the bill being considered on the House floor, there could be another package of changes adopted to either address technical issues

or to make substantive changes. And, while the Senate may not move the bill through its committee process, it could very well be amended on the Senate floor or even have some provisions struck on budget rules-related points of order. Finally, if this legislation were to be enacted, it would not be the final word on this subject. As mentioned, it is expected that the Trump Administration will make a number of changes in regulations and guidance that will also impact public and private health coverage. And additional legislation would likely be proposed and advanced in the process.

For further information, please contact Miranda Franco, Robert Bradner, Lisa Tofil, Nicole Elliott, or Ethan Jorgensen-Earp.

Resources

- Energy & Commerce Committee Press Release
- Energy and Commerce Bill Text
- Energy & Commerce Committee Section-by-Section
- Ways & Means Committee Press Release
- Ways and Means Bill Text
- Ways & Means Committee Section-by-Section
- Ways & Means Committee Two-Pager