BREAKING NEWS

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Employee Benefits
MMA Western Edition

THE AMERICAN HEALTH CARE ACT ADVANCES IN THE HOUSE: WILL THIS REPLACE THE ACA?

Executive Summary

NOTE: Typically, Breaking News pieces are only used for passed legislation/regulations. However, because many of the provisions in this bill would impact a signficant number of our employers and act as a framework for future bills which will be passed, we felt it was important to prepare our clients well in advance of any potential adoptions of any of the below provisions in the future. Therefore, this Breaking News piece should only be treated as informational, and should not be construed as an actual change in the law.

- On March 9, 2017, two U.S. House of Representatives' committees, the Ways and Means Committee and the Energy and Commerce Committee, approved the American Health Care Act (AHCA), a collection of budget reconciliation bills designed to repeal and replace the Patient Protection and Affordable Care Act (ACA). The AHCA will be put on a House calendar, and considered on the House floor in the near future.
- The AHCA introduces new measures, including: refundable tax credits for individuals who purchase health insurance, a 30% premium surcharge for individuals whose coverage lapsed, a restructuring of Medicaid, a plan to defund Planned Parenthood, and a plan to allow insurers to charge elderly Americans up to five times as much in premium costs for the same coverage offered to younger Americans.
- The AHCA preserves several components of the ACA, including: the prohibition on excluding preexisting conditions, covering adult children up to age 26, and the prohibition on lifetime and annual limits.
- The AHCA repeals portions of the ACA, including: penalties under the Individual Mandate and the Employer Mandate, the small business tax credit, limiting premium tax credits, repealing annual contribution limits on Flexible Spending Accounts, taxes on medical devices and tanning beds, and the 3.8% net investment income tax.
- Next, the Congressional Budget Office will compile a budget reconciliation package and estimate the AHCA's financial impact (a CBO score). Until then, it is unclear how much the plan will cost, or how many Americans may lose insurance coverage as a result.
- If a majority of the House votes to pass the AHCA, it will be referred to the Senate for a vote. If both houses of Congress vote to pass the bill, it will be sent to President Trump for signature. If signed, the bill will become law.

Introduction

On March 9, 2017, two U.S. House of Representatives' committees, the Ways and Means Committee and the Energy and Commerce Committee, approved the American Health Care Act (AHCA), a collection of budget reconciliation bills designed to repeal and replace the Patient Protection and Affordable Care Act (ACA). The AHCA will be put on a House calendar, and considered on the House floor in the near future. The bill was previously introduced on March 6, 2017. As of the date of this Breaking News piece, small modifications may be made to this bill prior to being approved by Congress. The two bills proposed are included below.

Ways and Means Bill

On March 6, 2017, the Ways and Means Committee released its Budget Reconciliation Recommendations to Repeal and Replace the ACA. The Recommendations are broken up into five (5) different "subtitles" or sections, which are discussed in detail below:

Repealing and Replacing Health-Related Tax Policy

Employer Mandate

The Employer Mandate requires employers to offer affordable, Minimum Value coverage to their full-time employees, or potentially be subject to a tax penalty. The bill would effectively repeal the Employer Mandate by reducing the tax penalty for failure to offer minimum essential coverage to zero dollars ($0), effective for months beginning **after December 31, 2015**, which would provide retroactive relief to employers who may be subject to the Employer Mandate penalty in 2016.

Also, the bill proposes simplified employer reporting of offers of coverage on employees' W-2s. However, Congress's ability to repeal the current reporting requirements is limited due to the reconciliation rules. Therefore, if this section's simplified reporting requirements are implemented, the current reporting requirements would be redundant, and the Secretary of Treasury would be able to stop enforcing the current reporting requirements.

Individual Mandate

The Individual Mandate requires that individuals maintain minimum essential health coverage or potentially be subject to a tax penalty. This section effectively repeals the Individual Mandate by reducing the tax penalty for failure to maintain minimum essential coverage to zero dollars ($0), effective for months beginning **after December 31, 2015**, which would provide retroactive relief to individuals from the Individual Mandate penalty in 2016.

Premium Tax Credits for the Purchase of Coverage in the Marketplace/Exchange

Currently, certain individuals and families (with a household income of no more than 400% of the federal poverty level (FPL)) are eligible for a refundable premium tax credit to assist them with the payment of health insurance premiums purchased through their State Marketplace/Exchange. Under the bill, these premium tax credits are set to expire in 2020.

However, prior to the expiration of the premium tax credits in 2020, if the income of a household increases during the tax year, a household may receive a greater premium tax credit than they may be entitled to, and would need to repay those excess amounts to the government, subject to a maximum threshold for the repayment of those monies. This bill would require **full** repayment of any excess premium tax credits paid to a household, including those amounts that may be **above** the current threshold for repayments of the premium tax credit.

The bill would also allow premium tax credits to be used to pay for "catastrophic only" plans (which is currently disallowed under the rules), but the bill would disallow use of premium tax credits on policies that cover elective abortions.

Finally, the bill would revise the way subsidies are paid, and rather than being solely contingent upon the income of a household, the calculation would also be based upon the ages of individuals within the household.

Refundable Tax Credit for Health Insurance

The bill creates a new advanceable and refundable age-adjusted tax credit for eligible individuals to use to purchase individual health insurance (Note: It is unclear as to whether these refundable tax credits would be immediately available after passage of the bill, or after the expiration of the current premium tax credits prior to 2020). To be eligible for the tax credit, an individual must be a citizen, national, or qualified alien of the United States, and may not be incarcerated. Eligible individuals must also be enrolled in either state-approved individual health insurance that does not cover non-excepted abortions or unsubsidized COBRA coverage, and may not have access to government health insurance programs, or any offer of coverage from any employer.

The tax credit amount available to pay for coverage on a monthly basis would be the lesser of: (1) the actual amount taxpayers paid for coverage for themselves and their families, or (2) 1/12 of the annual age-adjusted tax credit amount for the taxpayer and family members.

The annual age-adjusted tax credits are as follows:

- Under age 30: $2,000
- Age 30 to 39: $2,500
- Age 40 to 49: $3,000
- Age 50 to 59: $3,500
- Over age 60: $4,000

The credits are additive for a family, up to an annual maximum of $14,000. The credits are annually adjusted by the consumer price index plus one percentage point for inflation after 2020. Tax credits will be reduced by any amounts received by an individual through a qualified small employer health reimbursement arrangement (QSEHRA).

The full amount of the tax credit is available to individuals making $75,000 per year ($150,000 for joint filers). However, the tax credit phases out by $100 for every $1,000 in income above the $75,000 threshold. For example, if a 29 year old earned $95,000 annually, they would be $20,000 over the threshold, and therefore would not be receive any tax credit.

Under the bill, the federal government is responsible for ensuring individuals' eligibility for the tax credits and the Secretary of the Treasury is tasked with administering the tax credits to insurers. Insurers that receive tax credits must file monthly reports with the Internal Revenue Service (IRS) which include information about the individuals receiving tax credits, the cost of premiums, and the amount of the tax credit. Insurers are also required to provide annual statements to the individual receiving tax credits. In addition, if an individual is receiving tax credits but is employed, in order to confirm their eligibility for the tax credit, that individual would be required to submit written documentation from his/her employer stating whether that individual is eligible for employer coverage, and an employer would be required to provide that statement.

Small Business Tax Credit

Under current rules, certain small businesses are eligible for a healthcare tax credit of up to 50% of premium costs. This section repeals that small business tax credit beginning January 1, 2020. In addition, between 2018 and 2020, this small business tax credit would not be available with respect to qualified health plans that provide coverage for elective abortion services.

Delay of the Cadillac Tax

The Cadillac Tax is a 40% excise tax on high cost employer-sponsored health plans, which is assessed on every dollar above a specified threshold set by the government. This section states that the Cadillac Tax would not apply for any taxable period beginning after December 31, 2019 and before January 1, 2025. In other words, the Cadillac Tax may still apply for taxable periods beginning **after December 31, 2024**.

Non-Taxable Accounts for Health Care

Health Savings Accounts

Generally, distributions from a Health Savings Account (HSA) are excludable from an individual's gross income if those monies are used for qualified medical expenses. If they are not used for qualified medical expenses, those monies would be treated as normal income to the employee, with an additional penalty of 20%. The bill reduces the tax penalty from 20% to 10% for non-qualified health expenses that are paid from an HSA.

In future years, the bill also increases the HSA maximum contribution limit to equal the high-deductible health plan (HDHP) out-of-pocket (OOP) limit (for 2017, the HDHP OOP limit is $6,550 for individual coverage and $13,100 for family coverage), which would become effective on **January 1, 2018**.

In addition, the bill states that spouses (age 55 or older) would be permitted to make their catch-up contributions to the same HSA, beginning **January 1, 2018** (currently, spouses can only make catch-up contributions to their **own**, **separate** HSA account).

Finally, the bill proposes that HSA funds may be used to pay for qualified medical expenses incurred **before** an HSA is actually established (currently this is left to a State to decide on when HSA funds may be used). If an HSA is established within 60 days of the date an individual's HDHP coverage becomes effective, the HSA may reimburse expenses retroactively to the effective date of the HDHP coverage.

Flexible Spending Accounts

Previously, Flexible Spending Accounts (FSAs) were limited to an annual employee contribution amount of $2,500 (indexed for inflation). The bill would provide employees with the ability to contribute an unlimited amount to an FSA, for taxable years beginning **after December 31, 2017**.

Over-the-Counter Medications and Non-Taxable Accounts for Health Care

Finally, individuals currently cannot use funds from an HSA, FSA, or HRA (health reimbursement arrangement), to pay for over-the-counter medications. The bill would allow monies from a tax-advantaged health care account (HSA, FSA, HRA) to pay for over-the-counter medication, which would be effective **January 1, 2018**.

Retiree Drug Subsidies

Under the new bill, the ability for employers to take a business-expense deduction for an employer-sponsored retiree drug prescription plan would be available without having to reduce the deduction by the amount of the federal subsidy under the Retiree Drug Subsidy program (which is currently disallowed under the ACA).

Decrease in Percentage of Medical Expense Deduction

As a general rule, taxpayers who itemize their deductions may deduct qualifying medical expenses for expenses that exceed 10% of the taxpayer's adjusted gross income (AGI). There is also a temporary special rule that if a taxpayer or their spouse is age 65 or older, the AGI threshold is 7.5%. This bill decreases the AGI threshold to 7.5% for **all** (including those age 65 or older) taxpayers beginning in **2018**.

Repeal of Other Taxes

Currently, a 2.3% excise tax is imposed on the sale of certain medical devices. The bill would do away with that excise tax beginning **January 1, 2018**.

Tanning service providers are required to pay a 10% sales tax on the tanning services they provide. This bill would do away with this tax on these tanning services beginning in **2018**.

A net investment tax at a rate of 3.8% is imposed on net investment income of high income individuals, estates, and trusts with income above a certain threshold ($200,000 for a single individual). This section does away with this net investment tax beginning in **2018**. In addition, currently an Additional Medicare tax of 0.9% for high income earning employees (or a self-employed individual's income) is imposed on incomes in excess of a specified threshold ($200,000 for a single individual). The bill would repeal the 0.9% Additional Medicare tax on high income earners, beginning in **2018**.

Certain brand pharmaceutical manufacturers are subject to a tax. The bill does away with the annual tax on brand pharmaceutical manufacturers for years beginning **January 1, 2018**.

Finally, the Health Insurance Providers Fee, which is a fee that health insurers are required to pay on an annual basis, would go away beginning **January 1, 2018**.

Energy and Commerce Bill

On March 9, 2017, the House Energy and Commerce Committee voted to advance legislation seeking to repeal and replace the ACA, based on budget reconciliation recommendations introduced on March 6, 2017. The budget reconciliation bill advanced by the Energy and Commerce Committee (ECC Bill) contains four (4) major components: Patient Access to Public Health Programs (outlining federal funding changes for the Prevention and Public Health Fund, Community Health Center Fund, Medicaid/CHIP, etc.), Medicaid Program Enhancement (designed to reduce Medicaid spending by revising the Medicaid eligibility determination process and repealing Medicaid expansion), Per Capita Allotment for Medical Assistance (limiting federal payments to states on a per-enrollee basis), and Patient Relief and Health Insurance Market Stability (various fiscal mechanisms designed to stabilize the Exchange).

Patient Access to Public Health Programs

The Prevention and Public Health Fund

The Prevention and Public Health Fund (PPHF), established under the ACA and administered by the Department of Health and Human Services (HHS), provides funding for public wellness initiatives, including Alzheimer's disease prevention, education, and outreach, diabetes prevention, and suicide prevention. The bill does away with the PPHF program effective 2019, and rescinds any funds remaining in that program at the end of 2018.

Committee Health Center Program

The ACA originally established the Community Health Center Fund and provided $11 billion over five (5) years for operating, expanding, and constructing health centers across the U.S. The Fund awards grants to Federally Qualified Health Centers (FQHCs) which provide outpatient medical, dental, mental health, and reproductive services to medically underserved populations. This section would increase funding for the Community Health Center Fund.

Federal Payments to States

This section imposes a one-year freeze on mandatory funding from Medicaid and the Children's Health Insurance Program (CHIP) to certain prohibited entities, such as Planned Parenthood.

Medicaid Program Changes

Repeal of Medicaid Provisions and Expansions

The ACA expanded Medicaid eligibility to individuals under age sixty-five (65), with income up to 133%[1] of the Federal Poverty Level (FPL). Because of this, States that elected to expand Medicaid are able to file claims with the Federal government for increased Federal assistance (in addition to what States were previously granted, prior to the ACA). In addition, States have significant flexibility in enrolling and determining presumptive eligibility by authorizing health care providers, schools, and other sources to screen for Medicaid and CHIP eligibility, and immediately enrolling these individuals.

The bill would rein in Medicaid expansion by narrowing a State's authority to make presumptive eligibility determinations (except for children, pregnant women, and patients with breast cancer or cervical cancer), which would largely impact the newly eligible Medicaid population. In addition, this reverts the mandatory Medicaid income eligibility for children living in poverty back to 100% of the FPL (currently, income eligibility in some States is 300% of the FPL or greater for children living in poverty).

[1] The law allows a 5% disregard of the FPL, so the effective limit is 138% of the FPL (i.e., 133% + 5%).

The ACA increased Federal assistance to States by 6% for providing Medicaid eligible individuals with community based attendant services (e.g., services assisting individuals with activities of daily living), and covering the costs related to moving individuals from an institution to the community. This section would repeal the increased six (6) percent of Federal assistance to States.

The bill also revokes the option to extend coverage to individuals with incomes above 133% of the FPL, effective **January 1, 2020**. In addition, the AHCA repeals the enhanced Federal assistance to States for newly eligible beneficiaries on **December 31, 2019**. Also, the bill proposes that starting **January 1, 2020**, States would begin receiving the traditional Federal assistance rates for newly Medicaid eligible individuals, instead of phased-up rates.

Finally, the bill does away with the requirement that State Medicaid plans provide essential health benefits (required for Exchange plans) starting **January 1, 2020**.

Reducing State Medicaid Costs

An applicant's financial eligibility for Medicaid is determined by calculating their Modified Adjusted Gross Income (MAGI). When evaluating an applicant's financial eligibility for Medicaid, states have some flexibility in determining income and resource requirements, and generally do not consider the value of an applicant's primary residence (home equity value) when calculating an individual's MAGI for eligibility determinations. However, the individual's home equity value above certain statutory limits could limit their eligibility for Medicaid long term care services. States have the option to set higher home equity value limits and many, including California, have done so. The bill would restrict States from allowing higher limits, and would limit Medicaid eligibility for individuals with home equity above the statutory minimum (set at $500,000 in 2010, plus inflation), beginning with eligibility determinations made more than 180 days **after** this bill is enacted. However, under the bill, lottery winnings would no longer be included in determining an individual or family's MAGI.

Currently, eligible individuals may receive retroactive benefits for up to three (3) months before the month of application. However, the bill proposes that for Medicaid applications submitted on and after October 1, 2017, retroactive coverage is limited only to the month of the application.

Under the bill, individuals would be required to provide documentation of citizenship or lawful presence in the U.S. before obtaining Medicaid coverage.

Per Capita Allotment for Medical Assistance

This section creates a per capita cap model which caps Federal payments to States per enrollee, effective January 1, 2019. States that spend more than their targeted amount (calculated using each state's 2016 spending as a base year) in one year will have their Medicaid funding reduced the following year. The Secretary of HHS will audit each state's enrollment and expenditures for 2016 (base year), 2019, and subsequent years.

Certain individuals are exempt from these caps, including CHIP recipients, patients receiving medical assistance through an Indian Health Service facility, and those covered under the Breast and Cervical Cancer Early Detection Program.

Patient Relief and Health Insurance Market Stability

Repeal of Cost-Sharing Subsidy

The ACA implemented a cost-sharing subsidy program which lowers the out-of-pocket costs for deductibles, coinsurance, and copayments for individuals who purchased Silver plans through the Exchange. However, the ACA did not set an appropriation for this program. The bill would do away with the ACA's cost-sharing subsidy.

Continuous Health Insurance Coverage Incentive

The bill imposes a flat, thirty percent (30%) late-enrollment premium **surcharge/penalty** on individuals who go **longer** than **63 days** without continuous health insurance coverage in the last 12 months, beginning with special enrollment period applicants in 2018. This premium surcharge, which functions as a penalty on individuals for not having coverage, would replace the Individual Mandate penalty imposed by the ACA.

Increasing Coverage Options

This bill does away with the requirement that plan issuers use an actuarial value calculation in order to label their plans as Bronze, Silver, Gold, and Platinum, in an attempt to improve flexibility for plan designs.

Change in Permissible Age Variation in Health Insurance Premium Rates

Currently, insurance carriers in the Exchange and small group market are permitted to charge older policyholders premiums up three times higher than premiums charged to younger policyholders (referred to as a 3:1 ratio). The bill **increases** the ratio from 3-to-1 to **5-to-1**, meaning potentially, carriers can charge a sixty (60) year old policyholder **five times** the premium charged to a twenty (20) year old. The bill does give States the flexibility to set their own ratio.

Conclusion

At the moment, it is unclear which of the above provisions will remain, and which provisions will be amended. Until a final version of the AHCA is approved by both houses of Congress and signed into law by President Trump, the ACA remains in effect. However, because the Republicans currently control both houses of Congress, and President Trump has reiterated his intention to pass the AHCA swiftly, employers should familiarize themselves with the major components of the legislation and prepare themselves for the upcoming changes.

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