

# Examining The House Republican ACA Repeal And Replace Legislation

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On March 6, 2017, the House Republican leadership introduced Affordable Care Act repeal and replacement budget reconciliation bills in the [Ways and Means](#) (W&M) ([summary](#)) and [Energy and Commerce](#) (E&C) ([summary](#)) committees. The bills, collectively titled the American Health Care Act, are the committees' responses to the instructions they received in the [Budget Resolution](#) passed by both houses of Congress in mid-January to prepare budget reconciliation legislation to repeal the ACA.

The committees will begin [markup of the bills on March 8, 2017](#). (E&C will also on that day consider a [resolution offered by a group of Democratic House members](#) that would request President Trump to direct Health and Human Service Secretary Price to transmit to the House documents relating to the administration's plans to repeal and replace the ACA. If the bills are passed by the committees they will be combined by the House Budget Committee and sent to the House Rules Committee, and then to the full House for a vote. The Congressional Budget Office has not released cost estimates of the legislation and it appears that committee markups will proceed without out CBO reports.

In [considering the Affordable Care Act](#) in 2009 and 2010, the House held 79 hearings over the course of a year, heard from 181 witnesses and accepted 121 amendments. The current House leadership hopes to get the repeal and replacement legislation through the House in three weeks. The Senate adopted the Affordable Care Act only after approximately 100 hearings, roundtables, walkthroughs and other meetings, and after 25 consecutive days in continuous session debating the bill. It is expected that the current House bill will go directly to the floor of the Senate for a vote. Whatever passes the Senate will return for a conference with the House, if it varies from the House bill, and then go to the President for his signature.

Of course, there is no assurance that this process will go smoothly. Little or no help can be expected from the Democrats and there are signs of serious dissension within the Republicans. The Republicans hold only 52 votes in the Senate and cannot afford to lose more than two (assuming Vice President Pence casts a deciding vote), which is quite possible given the traditional independence of the Senate. But the legislation introduced in the committees give the clearest indication yet where the Republican Congress is headed.

## What The Two Bills Do, And What They Don't

Like the [leaked bill analyzed here earlier](#), the two proposed bills do not repeal the ACA. They leave in place the ACA's titles affecting Medicare, quality of care, program integrity, biosimilars, workforce reform, the Indian Health Service—indeed virtually all of the ACA except for its

insurance affordability provisions, individual and employer mandates, taxes, and Medicaid reforms.

More specifically, the legislation does not repeal the ACA's insurance reforms, such as the ACA's requirements that health plans

- cover preexisting conditions;
- guarantee availability and renewability of coverage;
- cover adult children up to age 26; and
- cap out-of-pocket expenditures, and the ACA's prohibitions against
- health status underwriting;
- lifetime and annual limits; and
- discrimination on the basis of race, nationality, disability, age, or sex.

Unlike the leaked version, the final bills do not eliminate the essential health benefits provisions (except with respect to Medicaid plans). They do repeal the ACA's actuarial value requirements and replace the ACA's three to one age ratio limit with a five-to-one ratio.

## Medicaid: Per-Capita Caps And Other Changes

Much of the E&C bill is devoted to changes in the Medicaid program. Indeed, the bill is not so much an ACA repeal bill as it is an attempt to change dramatically the Medicaid program. Most importantly, it transitions federal Medicaid funding to a per-capita cap basis by 2020, transforming the nature of the Medicaid program. The legislation's Medicaid provisions also

- contract state authority to make presumptive eligibility determinations,
- limit in a complicated way the ACA's enhanced funding for the Medicaid expansion population,
- eliminate the ACA's disproportionate share hospital cuts by 2020 (earlier for non-expansion states),
- provide \$10 billion in safety net funding for non-expansion states over five years,
- provide incentives for states to re-determine eligibility for Medicaid more often, and
- address several Medicaid eligibility issues.

The bill's Medicaid provisions will be addressed in more detail here in the near future.

## Eliminating Prevention Fund, Funding Community Health Centers, And Defunding Planned Parenthood

The E&C bill also contains a number of provisions that are not Medicaid related. First it repeals the ACA's prevention and public health fund after 2018 and rescinds all remaining unobligated funds as of that date. It appropriates an additional \$422 million for community health centers for 2017. It prohibits federal funding for Planned Parenthood for one year beginning with the enactment of the law.

## Repealing Cost-Sharing Reduction Payments

The E&C bill repeals the cost-sharing reduction payments that reduce cost-sharing for silver metal-level plan enrollees with incomes not exceeding 250 percent of the federal poverty level after 2019. The bill summary pointedly notes the House's position in *House v.*

*Price* (formerly *House v. Burwell*) that current reimbursements to health insurers for cost-sharing reductions are not permitted because Congress has not appropriated funding; however, it also observes that the case is being held in abeyance at least through May 22. It is very likely that Congress will appropriate money to cover these payments for 2017 and probably 2018.

## Patient And State Stability Fund For Reinsurance And Other Purposes

The E&C bill creates a Patient and State Stability Fund available to the states from 2018 through 2026. States can use funds provided under this program for a number of purposes including:

- providing financial assistance to high-risk individuals;
- providing incentive to “appropriate entities” to provide reinsurance to stabilize individual market insurance premiums;
- reducing the cost of insurance for individuals with high rates of utilization of health services;
- promoting participation and health insurance options in the individual and small group markets;
- promoting preventive, dental, vision care, and mental health and substance use disorder services;
- paying providers directly for the provision of such services; and
- providing assistance to individuals to reduce out-of-pocket costs.

States must apply for the funding, but applications will be automatically approved if not denied within 60 days. Once a program is approved it will remain approved for all subsequent years until 2026. If states do not apply by the application deadline for 2018 (45 days from enactment) or have an approved application for a subsequent year, the funding will be used for reinsurance purposes, covering 75 percent of claims between \$50,000 and \$350,000 (or for 2020 or later, such amounts as are established by the Centers for Medicare and Medicaid Services administrator.)

The bill appropriates \$15 billion each year for 2018 and 2019 and \$10 billion a year for succeeding years through 2026, a total of \$100 billion. For 2018 and 2019, the money will be allocated among the states: 85 percent of the allocation will be based on each state’s relative share of national incurred claims, based on reported medical loss ratios; 15 percent will be allocated to states that saw an increase in the number of uninsured individuals under 100 percent of the federal poverty level between 2013 and 2015 (apparently only in South Dakota), and states with fewer than three insurers offering qualified health plans through the marketplace.

For 2020 and subsequent years, the CMS administrator will allocate the funds based on a formula that considers the state’s relative incurred claims, uninsured population below 100 percent of poverty, and number of insurers in the insurance market. Funding not allocated in a year can be distributed to the states in a subsequent year or to “appropriate entities” to reinsure claims that exceed \$1 million. (The bill does not seem to expressly exclude the federal government from serving as an appropriate reinsurance entity. The ACA similarly provided for states to contract with reinsurance entities, but in the end only one state opted to take this approach and the federal government reinsurance program covered the rest).

To qualify for funding, states must make provide funding equal to 7 percent of the federal funding for 2020 with the state match increasing to 50 percent for 2027. States that receive default funding for reinsurance programs must provide funding equal to 10 percent of the federal funding for 2020, with the state match growing to 50 percent for 2024 through 2026.

## Replacing The Individual Mandate With A Continuous Coverage Requirement

The W&M committee bill repeals the ACA's individual responsibility requirement, and the E&C bill enacts in its place 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 does not vary by health status but would be greater for older people since premiums may vary with age. 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.

## Removing Penalties Connected With The Individual And Employer Responsibility Provisions

In the meantime, the penalty for the individual responsibility and employer responsibility provisions are eliminated retroactively for years beginning with 2016. This will further confuse the question of whether the mandate is being enforced for 2016 during the current tax filing season and further undermine the stability of the individual insurance market going forward. The mandates themselves are not being eliminated, presumably because of the Byrd Rule, which limits reconciliation provisions in the Senate to provisions that affect government revenues and outlays (although other provisions of the bills, such as the age rating and AV changes or continuous coverage requirements, might also seem to violate the Byrd rule). Significantly, the legislation does not eliminate the ACA's employer and insurer reporting requirements, which have arguably been more of a burden to employers than the employer mandate itself.

## Repealing Actuarial Value Requirements

Finally, as mentioned earlier, the E&C bill ends the ACA's actuarial value and metal level requirements after December 31, 2019 and allows states to permit age ratios of 5 to 1 for plan years beginning on or after January 1, 2018. The repeal of the AV levels would allow plans to be sold with AVs of less than 60 percent, although the maximum out-of-pocket limit in the ACA is retained so insurers would not be able to sell plans less generous than the current catastrophic plans. They would also be able to sell plans with AVs of more than 90 percent, and anything in between. This could muddle what is already a difficult process for plan shoppers and further complicate the ACA's risk adjustment program.

## Repealing Revenue Provisions

The W&M bill repeals a host of ACA tax provisions including:

- The \$500,000 limit on business expense deductibility for compensation to insurance executives;
- The tanning tax;
- The branded prescription drug tax;
- The health insurance tax;
- The Medicare tax imposed on unearned income on taxpayers earning more than \$200,000 (\$250,000 for joint filers);
- The “Cadillac” plan tax (which reappears in 2025, apparently to satisfy Senate prohibitions on reconciliation provisions that increase out-year deficits);
- The prohibition against paying for over-the-counter medications with tax subsidized funds from health savings accounts (HSAs), Archer MSAs, or flexible spending or health reimbursement arrangements;
- 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 medical device excise tax;
- 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 the level of medical expenses that must be incurred to claim a tax deduction, reducing the level back from 10 percent to 7.5 percent;
- The repeal of the ACA’s Medicare .9 percent tax surcharge on taxpayers with incomes exceeding \$200,000 (\$250,000 for joint filers).
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These taxes are repealed as of the end of 2017. In 2015, CBO estimated that the repeal of these taxes would result in the loss [of over a trillion dollars in revenue over ten years](#). It is hard to see in the absence of a CBO report how the repeal bill makes up for this lost revenue, other than by cutting Medicaid spending.

## No Tax On Higher-Cost Employer Plans

In one of the biggest changes from the earlier leaked version, the bills do not impose a tax on higher-cost employer-sponsored health plans. They also do not repeal the ACA’s enactment of the “[economic substance doctrine](#)” which penalizes arrangements that serve no other business or economic purpose other than to avoid taxes.

## Changes To The ACA’s Premium Tax Credits And Introduction Of New Age-Based Credits

The W&M bill repeals the ACA’s means-tested premium tax credits after 2019. In the interim it amends the current premium tax credit program in several ways. First, it ends the current income-based caps on recapture of excess advance premium tax credits as of December 31, 2017. Any excess advance premium tax credits would have to be repaid.

Second, it allows premium tax credits to be used to purchase off-exchange plans and catastrophic plans (but not grandfathered or grandmothers (transitional) plans or plans that cover abortion other than in cases of rape or incest or to save the life of the mother (non-

excepted abortions). Plans may offer separate abortion coverage and may cover infections, injuries, diseases or disorders caused by abortions.

Advance premium tax credits are available for off-exchange coverage beginning in 2018. Insurers that provide off-exchange coverage for tax credits must file returns identifying their plans as qualified health plans and setting forth the premium for the plans, the months they covered a qualified individual, and the relevant second-lowest cost silver plan premium for determining eligibility.

The bill amends the current applicable percentages of their income that taxpayers must spend to qualify for premium tax credits so that the percentages vary based on age as well as percentage of federal poverty level. Individuals under the age of 30 would never have to spend more than 4.3 percent of their income as long as their income did not exceed 400 percent of the poverty level, but individuals above age 59 with incomes exceeding 300 percent of the poverty level would have to spend 11.5 percent. These indexes would be adjusted for inflation for 2019.

The small employer tax credit would end as of December 31, 2019, and in the interim the credit could not be used for plans that cover abortions with the exceptions noted above.

## The New Tax Credits

The W&M bill creates a new age-adjusted tax credit available for individuals purchasing insurance in the individual market beginning in 2020. The tax credit is refundable and advanceable on a monthly basis to pay for individual market premiums. The amount available each month is set at the lesser of the actual amount taxpayers paid for coverage for themselves and their families or 1/12 of the annual tax credit amount for the taxpayer and all family members (up to \$14,000 or 5 family members including spouses, dependents, and adult children under age 27). (If the monthly premiums are less than the total allowed amount, the excess may be paid into an HSA.)

The annual tax credit amount is established at \$2,000 for an individual under 30, \$2500 for those age 30 to 39, \$3,000 for those age 40 to 49; \$3,500 for those age 50 to 59, and \$4,000 for those age 60 and over. The tax credit begins to phase out when a taxpayer's modified adjusted gross income reaches \$75,000 (\$150,000 for joint filers) adjusted annually by the consumer price index plus one percentage point for inflation after 2020. It phases out by 10 percent of the excess of the modified adjusted gross income above this amount, so the tax credit would disappear for a 29 year old when income reached \$95,000 and for a 60 year old when income reached \$115,000.

The tax credit is not be adjusted for geographic differences in health care costs, and the 2 to 1 age adjustment would fall far short of making up for the 5 to 1 ratio allowed under for age rating. Younger and wealthier individuals in low cost areas of the country would be better off than under the ACA, but older and poorer individuals and individuals in higher cost areas would be worse off. The Kaiser Family Foundation website offers an [interactive map](#) illustrating who wins and who loses.

Individuals only qualify for the tax credit if they are

- covered by state-approved individual health insurance that does not cover non-excepted abortions (not including excepted benefits coverage such as indemnity policies, or

grandfathered or grandmothered coverage, but possibly short-term coverage) or unsubsidized COBRA coverage;

- not eligible for employer coverage (regardless of its adequacy or affordability) or government programs (the leaked draft required ineligibility for health care sharing ministries, but the final bills do not refer to them);
- citizens or nationals of the United States or qualified aliens; and
- not incarcerated other than pending disposition of charges.

Married taxpayers must file a joint return to qualify and rules are specified for covering dependents. Advance tax credit payments must be reconciled with annual credits due. Tax credits must be reduced by amounts received by the taxpayer through qualified small employer health reimbursement arrangements.

The IRS, HHS, Homeland Security, and the Social Security Administration are charged with developing a program resembling “to the greatest extent practicable” the ACA’s programs for administering the advance tax credits, except that for off-exchange coverage certain administrative functions can be delegated to insurers, agents, or brokers. If individuals or their family members are employed, they will be required to submit a written statement from their employer as to whether they are eligible for employer coverage; and employers will be required to provide such statements.

Insurers that receive premium tax credits are required to file monthly reports with the IRS that include identifying information regarding individuals receiving advance tax credits, the amount of the premiums, and the amount of the tax credit. They must also provide annual statements to covered taxpayers. Employer W-2 reporting requirements for health insurance coverage would be modified. IRS tax information disclosure provisions would be amended to reflect changes in the tax credit program. The bill would increase penalties for erroneous claims of the tax credit and include provisions for coordinating the new tax credit with the Health Insurance Coverage Credit for recipients of Trade Adjustment Allowances.

## Liberalization Of HSA Rules

Finally, the bill would increase the maximum tax subsidized amounts that can be contributed to HSAs to the amount of the out-of-pocket limit, would allow both spouses to make catch-up contributions to the same HSA, and would allow HSAs to cover medical expenses incurred up to 60 days before HSA coverage begins, with all provisions effective for 2018.

## Summing Up

In summary, the legislation’s tax cuts will be very attractive to wealthy Americans and health insurers and providers, who would get a trillion dollars in tax breaks. It could cause consternation for Medicaid recipients and state Medicaid programs, which would see federal funding for Medicaid steadily diminish, potentially thinning out coverage. The legislation could be bad news for recipients of current tax credits who are older, sicker, and poorer, and who live in areas where care is expensive. They may be able to afford low actuarial value coverage with the tax credits the bills would provide them, but they are unlikely then to be able to afford the cost sharing that coverage will impose.

Higher-income younger people, on the other hand, would find coverage much more affordable than it is now under the legislation—the tax credits might fully cover their premiums and leave

extra for their health savings accounts. Some insurers could find the state reinsurance money and continuous coverage requirement enough of an incentive to stay in the market, but others may not

Finally, one cannot know without a CBO report how this all works out. But it is hard to see how the bills pay for themselves, and they could result in significant losses in coverage.