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ACA Repeal and Replace Overview Memo

Following many hours of contentious partisan debate, the House Committees on Ways and Means and Energy and Commerce have passed their budget reconciliation recommendations to repeal and replace the Affordable Care Act ("ACA") (collectively, the "proposal"). The House Budget Committee is expected to take up the proposal next week.

Regarding The Council's priority issues, the proposal does not differ substantially from earlier draft text on which we reported, except that it ***would <u>not</u> cap the employee tax deduction for employer-sponsored coverage***.

Our overview of the remainder of the proposal is below.

The proposal eliminates the individual and employer mandates by making the penalties $0 for tax years starting after December 31, 2015.

It eliminates the Cadillac tax for years 2020 through 2024 (leaving the possibility that the tax could be imposed beginning in 2025).

The proposal would repeal several other ACA taxes and fees, as of January 1, 2018, including:
- Annual provider fee;
- Medicare tax increase;
- ACA net investment income tax;
- Prescription drug tax; and
- Medical device tax.

Unlike prior draft language, the PCORI fee is not among the taxes repealed in the proposal.

The proposal replaces the ACA's subsidies with a tax credit that is tiered by age –
- $2k per year for anyone under 30
- $2.5k per year for 30-39
- $3k per year for 40-49
- $3.5k for 50-59
- $4k for 60 and over.

The proposal would reduce the credit amount for individuals with income over $75k, or $150k for joint filers, by 10% of gross income over those threshold amounts. Credits are additive for a family and are capped at $14,000 per year. The proposal denies eligibility for the credit if coverage includes abortions or if married couples file separately.

The tax credit is available for individual market plans and unsubsidized COBRA coverage (purchased on or off of the exchanges). Credits are ***not*** available to individuals who are eligible for a group health plan (including employer plans), Medicare, Medicaid or other government coverage. They also are not available for ACA grandfathered or grandmothered (i.e., grandfathered plans that received transition relief from CCIIO) plans. The proposal directs HHS and other federal agencies to establish an advance payment program under which credit payments can be made directly to health care providers on behalf of eligible tax payers.

Notably, employers' obligation to report coverage amounts on Form W-2 remains, and an additional W-2 field is added: each month with respect to which an employee is eligible for a group health plan. The House Ways and Means section-by-section description of the proposal notes, however: "Reconciliation rules limit the ability of Congress to repeal the current reporting, but, when the current reporting becomes redundant and replaced by the reporting mechanism called for in the bill, then the Secretary of the Treasury can stop enforcing reporting that is not needed for taxable purposes."

The proposal allows excess tax credits to be paid into designated HSAs. With respect to other HSA reforms, effective January 1, 2018, the bill would:
- eliminate the prohibition on over the counter drugs as qualified medical expenses;
- raise the contribution limit to the out-of-pocket cost for high deductible health plans; and
- allow spouses to make catch-up contributions to the same HSA.

Unlike the earlier draft, this proposal would not give states authority to define their own essential health benefits packages.

Other issues covered in the proposal include –

- Repeal of the ACA's Medicaid expansion and reform of federal Medicaid financing into a per capita cap model (with per enrollee limits on federal payments to states), and
- Creation of a temporary "Patient and State Stability Fund," which allocates federal funds to the states (subject to mandatory state matching contributions ranging from 7% to 50% of the federal allocation amount beginning in 2020) that may be used for: financial assistance for high-risk individuals, incentives for entities to contract with the states to stabilize premiums in the individual market, defraying the cost of coverage in the individual and small group markets, promoting access to preventive services, and/or providing payments directly to providers;
- Promotion of continuous coverage by imposing a penalty of 30% of otherwise-applicable premium rates for 12 months on individuals who go more than 63 days without coverage;

- Sunset of the ACA's "levels of coverage" provisions (metal levels and actuarial value calculation rules) as of 2020; and
- Adjustment of the permissible age bands for premium rates from 3-1 to 5-1 (or other state-established ratio) for the individual and small group markets.