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TO: The Council

FROM: Scott Sinder
Kate Jensen
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RE: American Health Care Act Passes House

Today, the House passed the American Health Care Act ("AHCA"), Republicans' measure to repeal and replace significant portions of the Affordable Care Act ("ACA") through the budget reconciliation process. Since the bill was last considered on the House floor in March—without culminating in a vote—two significant changes have been made:

(1) MacArthur Amendment – permits state waivers (which last for 10 years and get default approval by HHS) for one or more of the following purposes:

- For plan years beginning on or after Jan. 1, 2018, to apply a **higher ratio for age-based premium rating** in the individual and small group markets;
- For plan years beginning on or after Jan. 1, 2020, to establish and apply their own **essential health benefit** requirements (rather than those under the ACA) for coverage in the individual and small group markets; and
- For states with an AHCA-approved high-risk pool program (e.g., financial assistance for high-risk individuals, reinsurance, federal high-risk pool established by the AHCA), beginning with 2019 enrollments, to engage in **health status underwriting** for individuals in the program who cannot demonstrate they had continuous coverage over the prior 12 months (in lieu of the 30% surcharge otherwise imposed for non-continuous coverage under the AHCA).

The amendment clarifies that insurers may not discriminate in rates by gender or limit access to coverage for individuals with preexisting conditions.

(2) Upton Amendment – appropriates an additional $8 billion for the period between 2018 and 2023 to be allocated to states with health status underwriting waivers (discussed above); funds must be used by the state to provide assistance to reduce premiums or other out-of-pocket costs for individuals who have seen premium increases as a result of the waiver.

Below is an overview of other notable provisions in the AHCA on which we previously reported.

Regarding The Council's priority issues:

- ***The bill does not cap the employee tax benefit for employer-sponsored coverage***.
- The individual and employer mandates are effectively eliminated by making the penalties $0 for tax years starting after December 31, 2015.
- The Cadillac tax is eliminated for years 2020 through 2025, leaving the possibility that the tax could be imposed beginning in 2026.

The bill repeals the following ACA taxes and fees (among others) beginning in 2017:

- annual provider fee;
- net investment income tax;
- prescription drug tax; and
- medical device tax.

The additional Medicare payroll tax for higher-income earners is repealed for tax years after 2022. Notably, the PCORI fee is not among the fees repealed in the bill.

The AHCA replaces the ACA's federal exchange subsidies with a refundable tax credit 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 tax credit is available for individual market plans and unsubsidized COBRA coverage (purchased on or off of the exchanges). Credit amounts are reduced 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 bill denies eligibility for the credit if coverage includes abortions.

Notably, 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 plans or so-called grandmothered plans (i.e., grandfathered plans that received transition relief from CCIIO). The bill 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.

With respect to employer reporting obligations, the requirement 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. A House Ways and Means section-by-section description of the AHCA states: "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."

Unlike earlier drafts of the bill, the final House package would not allow 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.

Other issues covered in the bill which may be of more general interest to Council members include –

- Promotion of continuous coverage by requiring a 30% surcharge on otherwise-applicable premium rates for 12 months for individuals who go more than 63 days without coverage (subject to state waivers discussed above).

- Sunset of the ACA's "levels of coverage" provisions (metal levels and actuarial value calculation rules) as of 2020.

- Adjustment of the permissible age bands for premium rates from 3-1 to 5-1 for the individual and small group markets (again, subject to state waivers).

- Repeal of the ACA's Medicaid expansion and reform of federal Medicaid financing into a per capita model (with per enrollee limits on federal payments to states).

- An option for states to institute a work requirement for non-disabled, non-elderly, non-pregnant adults eligible for Medicaid coverage.

- Creation of a temporary "Patient and State Stability Fund," which allocates federal funds to states 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; providing payments directly to providers; maternity coverage and newborn care; and mental health and substance use disorder services. Within the Fund, the AHCA creates a Federal Invisible Risk Sharing Program to provide payments to insurers for claims made by eligible individuals (i.e., individuals with certain health conditions determined by CMS).