ACA REPEAL AND REPLACE EFFORT ADVANCES WITH HOUSE GOP'S PASSAGE OF THE AMERICAN HEALTH CARE ACT

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Health Care Alert

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On May 4, 2017, the House of Representatives passed H.R. 1628, the American Health Care Act ("AHCA"), which would repeal and replace core components of the Patient Protection and Affordable Care Act ("ACA"). The move came after Republican leadership pulled an earlier version from the House floor after it became clear that the bill lacked sufficient votes for passage. In the following weeks, Representative Tom MacArthur (R-NJ) of the moderate Tuesday Group and leaders of the House Freedom Caucus continued negotiations on a proposal that could ultimately garner at least 216 Republican votes. On April 24, Representatives Mark Meadows (R-NC) and MacArthur announced a compromise that paved the way for passage by a vote of 217 to 213.

The bill now moves to the Senate, where reaching consensus among a narrow majority of 52 Republicans will be difficult. Several moderate Republican Senators have expressed concerns with repealing Medicaid expansion and potentially increasing premiums and out-of-pocket costs for poorer and older individuals and those with pre-existing conditions. At the other end of the spectrum, a handful of conservative Republican members have advocated for immediately repealing the entire ACA without enacting a simultaneous replacement—a nonstarter for many in the conference. This divide may complicate efforts to advance health care reform legislation with Republican-only support.

The Public Policy and Law practice at K&L Gates is closely engaging with Members of Congress and staff as the health care reform debate continues. In a time of such uncertainty—and opportunity—it is critical for stakeholders to consider engaging lawmakers on issues of importance to their business. We are uniquely positioned to assist stakeholders across the health care spectrum in this rapidly changing environment.

AHCA: RESTRUCTURING THE ACA

As described in greater detail below, the House-passed AHCA would make several structural changes to the Medicaid program, repeal nearly all of the ACA's tax provisions, and reform the ACA's individual insurance market. According to the Congressional Budget Office's ("CBO") analysis of an earlier version of the bill, the AHCA would reduce direct federal spending by $1.15 trillion over 10 years by, among other changes, repealing Medicaid expansion and instituting per-capita caps (or using block grants) to limit growth in Medicaid program expenditures. The bill would reduce federal revenues by nearly $1 trillion over 10 years by repealing (or delaying) substantially all of the ACA's taxes and replacing the ACA's income-adjusted tax credits and cost-sharing subsidies with flat, age-adjusted tax credits. Together, these changes would reduce federal deficits by $150 billion

from 2017 through 2026. It is important to note that these estimates reflect an earlier version of the legislation and are likely to change based on amendments adopted prior to passage.

The bill would also restructure the regulatory framework governing the individual and small group insurance markets by, for example, requiring insurers to assess a 30 percent surcharge on premiums for individuals who fail to maintain continuous coverage (or, alternatively, permitting states to obtain waivers allowing insurers to underwrite such individuals based on health status), allowing states to use a waiver to determine essential health benefits, and modifying the age-rating ratio to allow insurers to increase the variation in premiums between older and younger enrollees.

Taken together, the CBO estimates that 14 million more individuals would be uninsured in 2018 under the AHCA than under current law, with this number increasing to 24 million individuals by 2026. The CBO projected a near term increase in individual market premiums of about 15 to 20 percent resulting, in large part, from repeal of the individual mandate penalties and changes to insurance market regulations. However, CBO also projected that premiums would be 10 percent lower than under current law by 2026 as a result of premium stabilization funds made available to states and reforms to insurance market regulations. Notably, these estimates do not reflect amendments to the bill introduced prior to House passage; the CBO is expected to release a revised estimate before the Senate considers legislation.

SENATE STATE OF PLAY

Majority Leader Mitch McConnell (R-KY) previously indicated that the Senate would immediately consider the AHCA on the Senate floor following House passage; however, concerns with the House bill led several Senate Republicans to consider alternative approaches. Senator Ted Cruz (R-TX), with support from Leader McConnell, has convened a working group of 13 Republican Senators to work on health care legislation. Other Republican Senators, including Susan Collins (R-ME) and Bill Cassidy (R-LA), also remain actively involved in health care reform discussions.

Several Senators have introduced their own health care proposals that may serve as a foundation for the Senate's health care bill. Senators Collins and Cassidy introduced S. 191, the Patient Freedom Act, a compromise bill that would give states the choice to maintain the ACA's insurance exchanges and market reforms or instead opt for a more market-oriented model using tax credits and Roth health savings accounts ("HSAs"). Senator Rand Paul (R-KY) introduced S. 222, the Obamacare Replacement Act, which mirrors a bill introduced by Representative Mark Sanford (R-SC) that was supported by many conservative members. The bill would use open enrollment periods and continuous coverage to protect individuals with pre-existing conditions and institute a universal tax deduction for health insurance in place of the current tax exclusion for employer-sponsored health insurance. Senators Orrin Hatch (R-UT) and Richard Burr (R-NC) also drafted an ACA replacement proposal—the Patient CARE Act—which aligns with many components of the AHCA.

Senate Democrats have unanimously opposed Republican efforts to repeal the ACA. Since Republicans currently hold a narrow 52-vote majority in the chamber, they do not have the 60 votes needed to overcome a Democratic filibuster of legislation that would completely repeal and replace the ACA. To overcome united Democratic opposition while working toward their goal of repealing and replacing the ACA, Senate Republicans plan to use the fast-track procedures of budget reconciliation to pass legislation with a Republican-only simple majority. The

Senate's complex budget rules will significantly impact the scope of provisions included in the final bill, limiting the bargaining range and potentially complicating Republicans' ability to coalesce around a bill that loses no more than two members of their conference (assuming Vice President Mike Pence casts a tie-breaking vote in favor).

Under the Byrd rule, reconciliation legislation must have a "greater than incidental" impact on federal spending or revenue. The Senate Parliamentarian is responsible for determining whether provisions of the AHCA or other proposals satisfy the Byrd rule's strict requirements. Democrats are expected to frustrate Republican efforts by raising points of order against any offending provisions that do not pass this demanding test. If the Parliamentarian maintains that insurance market regulations do not satisfy the Byrd rule, certain aspects of the House-passed version, potentially including the 30 percent surcharge on individuals not maintaining continuous coverage, age rating ratios, changes to essential health benefits, and state waivers for health status underwriting, among others, could be stricken from the bill. The removal of these provisions from the Senate legislation could inhibit Republicans' ability to reach consensus, setting up two possibilities: overruling the Parliamentarian, an unlikely approach but one supported by Senator Cruz and other conservatives, or working with Democrats amenable to narrower fixes to the ACA.

Below is a summary of key provisions of the AHCA, as modified and passed by the House of Representatives on May 4, 2017. Should you have any questions regarding the issues addressed in this alert, please contact one of the authors or your regular K&L Gates attorney or professional.

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Coverage Mandates

The AHCA would immediately repeal the penalties associated with the individual and employer mandates and provide retroactive relief for penalties owed for the 2016 tax year. Importantly, the underlying statutory requirements associated with each mandate would remain in place; the AHCA would simply "zero out" the penalties. The remaining statutory requirements that individuals maintain qualifying coverage and that certain employers provide coverage to their employees and satisfy other reporting obligations could present compliance challenges that would likely require clarification through executive action.

Tax Credits, Subsidies, and Employer Reporting

The ACA's income-adjusted individual premium tax credits, the small business tax credit, and the cost-sharing subsidies would expire on January 1, 2020. On that date, a new refundable, advanceable, age-adjusted tax credit for health insurance coverage would become available to individuals who are not eligible for coverage through their employer or a government insurance program. The annualized amounts of the credits are as follows:

- Under age 30: $2,000
- Age 30–39: $2,500
- Age 40–49: $3,000
- Age 50–59: $3,500
- Age 60 or older: $4,000

The credits would be available for use on any insurance plan approved for sale in a state's individual market. The tax credits would be adjusted annually for inflation based on the consumer price index ("CPI") plus one percent and would begin to phase out for individuals earning $75,000 per year ($150,000 for joint filers).

The AHCA also includes new provisions that would simplify employer W-2 reporting requirements. In place of some of the ACA's employer reporting requirements, the AHCA would permit employers to instead list on each employee's Form W-2 the months of the year that each employee was eligible for employer coverage. In addition, individuals seeking a tax credit would be required to submit a statement from their employer indicating whether the individual is eligible for coverage in connection with his or her employment.

The AHCA includes placeholder funding of about $85 billion for the Senate to consider using to restructure individual premium tax credits. The Senate is expected to use the funds to make tax credits more generous for Americans between the ages of 50 and 64. According to the CBO, without changes, this age group would experience dramatic increases in premiums and out-of-pocket costs for health care under the AHCA, in part, due to changes in the tax credits and age-rating regulations.

Taxes

The initial version of the AHCA would have repealed most of the ACA's taxes at the end of 2017. To encourage more conservative Republicans to support the bill, the manager's amendment accelerated the repeal of these taxes by one year, providing retroactive relief for most provisions back to January 1, 2017.

The following taxes would be repealed effective as of January 1, 2017:

- 2.3 percent excise tax on medical devices;
- annual fee on health insurance providers;
- annual fee on branded prescription pharmaceutical manufacturers and importers;
- 3.8 percent tax on net investment income; and
- 10 percent sales tax on indoor tanning services (repeal effective June 30, 2017).

The AHCA would reduce the adjusted gross income threshold for the medical expense deduction from 10 percent to 5.8 percent and the tax penalty on distributions from HSAs from 20 percent to 10 percent effective January 1, 2017.

The AHCA would abandon the approach taken in an earlier draft that would have repealed the Cadillac tax effective January 1, 2020, and replaced it with a cap on the tax exclusion for employer-sponsored health insurance benefits. Instead, the AHCA would preserve the Cadillac tax but delay its effective date until January 1, 2026.

The AHCA would also delay until 2023 repeal of the 0.9 percent Medicare hospital insurance surtax imposed on high income earners.

HSAs

Beginning January 1, 2018, the maximum contribution limits to tax-preferred HSAs would be increased from

$2,250 for self-only and $4,500 for family coverage to the amounts corresponding with the annual deductible and out-of-pocket limitations for high deductible health plans (at least $6,550 for self-only coverage and $13,100 for family coverage). In addition, both spouses would be permitted to make so-called "catch-up" contributions to the same HSA. The AHCA would treat HSAs created within 60 days of beginning coverage under a high deductible health plan as being created on the date coverage under the plan begins, allowing individuals to use HSA funds to pay for medical expenses incurred before the HSA was created.

Insurance Regulations and Patient and State Stability Funding

Beginning January 1, 2018, the current 3:1 age banding ratio would increase to 5:1, or to the ratio established by each state. Under this approach, the federal default rule permitting insurers to charge older enrollees premiums up to three times greater than premiums charged to younger enrollees would be increased to five times that amount. To encourage continuous insurance coverage, beginning in the 2019 benefit year, individuals who experience a lapse in health insurance coverage lasting longer than 63 days during a 12-month look-back period would be subject to a premium surcharge if or when they decide to purchase insurance coverage. The amount of the penalty would be 30 percent of the monthly premium rate under the plan and would be assessed by the insurance provider for one year.

The AHCA would also sunset the ACA's actuarial value provisions after December 31, 2019. The ACA requires insurers to label their plan offerings based on the amount of coverage a plan provides at different metal tiers (e.g., bronze, silver, gold, and platinum). Repealing this requirement is expected to give insurers additional flexibility in structuring plans.

The MacArthur amendment preserves the ACA's essential health benefits requirement as the federal default but would allow states to obtain waivers from certain insurance market regulations. Specifically, states may request waivers that allow them to: (1) set a higher age-rating ratio than the 5:1 default established in the AHCA, allowing insurers to further increase premiums for older enrollees relative to younger enrollees; (2) determine essential health benefits that individual and small group plans must cover; and (3) permit insurers to engage in health status underwriting, if the state has established a high-risk pool or is participating in a federal high-risk pool. To receive waivers, states must submit an application explaining how a waiver would reduce premiums, increase enrollment, stabilize the market, stabilize premiums for individuals with pre-existing conditions, or increase the choice of health plans. State applications for waivers would be automatically approved unless the Secretary of Health and Human Services denies them and provides states with an explanation.

The AHCA would appropriate a total of $138 billion for a "Patient and State Stability Fund" designed to assist states in lowering patient out-of-pocket costs and stabilizing their individual insurance markets. States may use their allocated funds to:

- cover high-risk individuals who lack access to affordable individual coverage;
- enter into arrangements to help stabilize the individual insurance market;
- subsidize health insurance coverage in the individual and small group market for individuals who utilize a high volume of health care services;

- promote access to preventive, dental, and vision services, mental health and substance abuse disorder treatments, and maternity coverage and newborn care;
- provide payments to health care providers for provision of health care services; or
- provide assistance to reduce out-of-pocket costs for enrollees in individual insurance plans.

States may submit a proposal to establish their own stability fund programs using their allocated funds for any of the above purposes. Alternatively, the Administrator of the Centers for Medicare and Medicaid Services ("CMS") may make payments to entities in states that choose not to establish their own programs under a federal default reinsurance program.

Within the Patient and State Stability Fund, $15 billion would be allocated over 10 years to a federal "invisible risk sharing program." Using a reinsurance-type approach aimed at reducing premiums, the program would make payments directly to health insurers providing coverage to qualifying patients generating health care claims above a specified threshold. The CMS Administrator would have considerable discretion in structuring the program, including defining eligible individuals, qualifying health conditions, and the threshold at which the program would provide payments to insurers and the proportion of claims the program would pay.

For states that obtain a waiver of the community rating requirement under the MacArthur amendment, the AHCA would provide within the Patient and State Stability Fund $8 billion over five years. Funds must be used to reduce premiums and out-of-pocket costs for individuals residing in a state with an approved waiver who have a pre-existing condition and are subject to health status underwriting because of a lapse in continuous coverage.

Medicaid Reforms

States would no longer be permitted to expand Medicaid to able-bodied, childless adults earning more than 133 percent of the federal poverty level after December 31, 2017. A grandfathering provision would permit states that expand Medicaid prior to 2018 to keep the enhanced match rate for expansion enrollees after that date; however, the enhanced rate would apply only to individuals who enroll in Medicaid prior to December 31, 2019, and do not experience a lapse in program eligibility after that date. Expansion enrollees who experience a gap in eligibility after this date would qualify for the state's traditional match rate, which would likely result in states limiting program eligibility for these individuals. States must also redetermine expansion enrollees' eligibility every six months.

In addition to repealing Medicaid expansion, starting in 2020, the AHCA would provide states the choice between receiving a lump-sum block grant or per-capita allotments based upon the number of Medicaid enrollees. States choosing per-capita allotments would receive payments for each enrollee category (elderly, blind and disabled, children, nonexpansion adults, and expansion adults) based on the state's spending in the 2016 base year trended forward using the percentage increase in the medical component of the CPI for all urban consumers. For elderly and disabled individuals, the annual inflation factor would be CPI medical plus one percent. Any state with spending that outpaces the targeted aggregate spending amount would receive reduced Medicaid payments in the following fiscal year.

States choosing a block grant would receive a yearly lump sum payment over a period of 10 years. The funding amount would be determined by the per-capita costs for the eligible population, multiplied by the number of

enrollees in the year preceding block grant adoption. Funding would increase by the growth in CPI but would not be adjusted for changes in the number of enrollees, and unused funds would roll over and could be used as long as the block grant remains in place. States would receive flexibility to determine program eligibility requirements and covered items and services in lieu of requirements in current law, with certain exceptions.

Beginning October 1, 2017, states would have the option to institute work requirements for nondisabled, nonelderly, and nonpregnant adults as a condition of receiving Medicaid coverage. States would have broad flexibility to structure the requirement as they wish, though there are certain limitations for pregnant women, children under age 19, individuals who are the only parent or caretaker of a child under age six or a child with a disability, or an individual under age 20 who is married or head of household and is attending school or participating in education directly related to employment. States would receive an additional five percent federal funding increase if they choose to implement this requirement.

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