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Client Alert

Healthcare Practice Group

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GOP Repeal and Replace Healthcare Bill Advances After Committee Votes

On March 8, 2017, the two House Committees responsible for healthcare policy related to the Affordable Care Act (ACA) held marathon-like deliberations to mark-up their respective portions of the Republican-sponsored health reform repeal and replacement bill, the American Health Care Act. Debate in both Committees extended overnight, with the House Ways & Means Committee adjourning early morning on Thursday, March 9, after over 18 hours in session. The House Energy & Commerce Committee passed its recommended bill after 27 hours of debate later that afternoon.

After these 45 hours of Committee action, the reconciliation legislation approved by each of these Committees will be combined into a single bill by the House Budget Committee. Also next week, it is expected that the Congressional Budget Office (CBO) will produce a "score" for the bill, to outline the fiscal impact. Before the end of the month, that single bill is expected to be considered on the House floor. Senate Majority Leader Mitch McConnell (R-KY) has indicated his plans to take a House-passed bill directly to the Senate floor for consideration, bypassing Committee action.

The budget reconciliation process by which this legislation is being considered provides for expedited procedures and requires only 51 votes in the Senate for passage, but it is an exacting process that allows only provisions with certain budget impacts to be included. This legislation may be subject to certain "points of order" in the Senate, which the Senate Parliamentarian decides. Any changes that the Senate may make must go back to the House for approval.

Congressional leadership and President Trump are engaged in a concerted effort to secure enough votes in the House and Senate to approve this legislation. In the House, conservative Republican members have concerns about the new tax credits in the legislation serving as a "backdoor" way to create new entitlements and support freezing new enrollment in ACA Medicaid expansion more quickly, at the end of 2017; moderate Republicans are concerned with the legislation's Medicaid changes; and no Democrats are expected to support the bill. Under this scenario, House Republicans can only lose 21 of their Members and still pass this bill. In the Senate, conservative Republicans also oppose the tax credits while some moderate Republicans and Republicans from Medicaid expansion states are concerned about the Medicaid changes in the bill. Congressional leadership has

For more information, contact:

Michael A. Andrews
+1 202 626 5609
mandrews@kslaw.com

Ander M. Crenshaw
+1 202 626 8996
acrenshaw@kslaw.com

Allison F. Kassir
+1 202 626 5600
akassir@kslaw.com

C'Reda J. Weeden
+1 202 626 5572
cweeden@kslaw.com

Christopher P. Kenny
+1 202 626 9253
ckenny@kslaw.com

King & Spalding
Washington, D.C.
1700 Pennsylvania Avenue, NW
Washington, D.C. 20006-4707
Tel: +1 202 737 0500
Fax: +1 202 626 3737

www.kslaw.com

reiterated that "repeal and replace" will consist not only of this reconciliation legislation but also of regulatory action and other health legislation, and it will be challenging for them to craft a proposal that will pass both chambers.

House Ways & Means Committee

The House Ways & Means Committee approved their portion of the proposed bill in a 23-16 Committee vote along party lines. Ways & Means has jurisdiction over revenue-related provisions in the proposed bill, including the proposed repeal of taxes to industry on branded prescription drugs, medical devices, and user fees for insurers, among others. This Committee is also responsible for the development of tax policies for the individual and employer mandates, the "Cadillac tax" on certain health plans, advanced premium tax credits, and other healthcare related tax policies. The policies in this portion of the proposed replacement bill largely hew to the language in the leaked February 10 version of the bill, which was outlined in our February 27, 2017 edition of *Health Headlines*.

Debate on the proposed repeal and/or replacement provisions extended over 18 hours, with much of the discussion from Democratic members focusing on how these proposals, if enacted, would affect access to coverage and affordability for healthcare consumers. Democratic members of the Committee offered several amendments seeking to postpone the deliberations until an official score of the measures was provided by CBO; which were tabled by Chairman Kevin Brady. The total effect of the proposed measures is still being tabulated by CBO and expected to be released early next week. The Joint Committee on Taxation has estimated that the proposed changes would account for approximately $600 billion in lost revenue to the federal Treasury over 10 years.

The Committee's recommendations have been transferred to the House Committee on Budget for reconciliation with the Energy & Commerce Committee's recommendations, and a merged bill is expected to be considered by the House Budget Committee next Wednesday, March 15. Some of the prominent features of this proposed bill are described below.

New Formula for Health Insurance Tax Credits

The Ways & Means proposal repeals the current premium assistance program for individuals purchasing insurance on the Exchanges, and offers an alternative tax credit that can be used for comprehensive health plans as well as for catastrophic or high-deductible health plans that are not on the Exchanges. These tax credits would be calculated based on age, instead of household income, for individuals with incomes up to $75,000 annually. This proposed tax credit for eligible individuals is $2,000 for an individual under 30, $2,500 for those ages 30 to 39, $3,000 for those ages 40 to 49; $3,500 for those ages 50 to 59, and $4,000 for those ages 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) by 10 percent of the excess of the modified adjusted gross income above the $75,000 threshold.

This proposed tax credit program would become effective in CY 2020. The proposed repeal of the current premium assistance program would establish a transition period from CY 2018-2020, in which tax credits could be applied to catastrophic plans or other plans that are not on the Exchanges. During the transition period, individuals that received excess advanced premium tax credit will be required to repay the total amount of the excess credit (recapture payment). Current law limits the excess tax liability for households with annual income below 400 percent of the federal poverty level (FPL) (ranging from $600-$2,550 based on income).

The proposed bill would fully eliminate the small business tax credit, which was available for employers of businesses with fewer than 50 employees. That program would allow small business owners to deduct up to 50 percent of their employee health benefit expenses.

Repeal of Individual and Employer Mandates

The proposed bill also eliminates the individual and employer responsibility provisions in the ACA which required individuals to maintain, and employers to provide, a healthcare plan with minimum essential coverage. These provisions would be replaced by a proposed continuous coverage provision, which would allow insurers to apply a 30-percent surcharge on premiums for an individual with a break in coverage for 63 days or more (see discussion of Energy & Commerce Committee bill below). Notably, the bill would repeal the respective penalties for noncompliance with the mandates retroactive to January 1, 2016.

Delay Implementation of Cadillac Health Plans

The proposed bill does not repeal the so-called "Cadillac tax," as many speculated it may, but instead delayed the effective date of the 40-percent excise tax on certain plans until 2025. Elimination of the Cadillac tax has been discussed by both parties and stakeholders, however it would function as a significant revenue-raiser which may be difficult to replace.

Increased Flexibility for Health Savings Accounts

As reported in our February 27, 2017 *Health Headlines*, the proposed bill would make adjustments to the tax treatment of HSAs, including allowing eligible spouses to make "catch-up" contributions into the same HSAs; allowing healthcare purchases through an HSA to be reimbursable if established within 60 days of the start of a high-deductible plan; and increasing the maximum contribution limits for HSAs. This bill would also allow over-the-counter medications to be reimbursable for Flexible Spending Accounts (FSAs).

Repeal of Healthcare-Related Taxes, User Fees, and Deduction Limits

The proposed bill would eliminate nearly all of the taxes and annual fees implemented under the ACA, including:

- The tax on employee health insurance premiums and health plan benefits under IRC § 4980L;
- Taxes on amounts spent on over-the-counter medications in connection with employee benefits under IRC § 106;
- The increase of tax on HSAs and Archer MSAs under IRC § 223(f)(4)(A);
- The fee imposed on sales of branded prescription drugs ends December 31, 2017;
- The medical device excise tax imposed under IRC § 4191(a)
- The annual fee imposed on health insurance providers;
- The increased chronic care tax under IRC § 213(a);
- The increased Medicare tax under IRC § 3101(b);
- The excise tax on indoor tanning services;
- The net investment tax for high-income earners under IRC § 2A;

- The limitation on contributions to FSAs under IRC § 125(i);
- The $500,000 per-employee deduction limit for insurance providers on salary compensation under IRC § 162(m)(6); and
- The elimination of the deduction for expenses allocable to Medicare Part D subsidies.

House Energy & Commerce Committee

At the same time, the House Energy & Commerce Committee was debating the programmatic reforms to the ACA found in the proposed American Health Care Act. Much of the Energy & Commerce Committee's 27-hour markup was consumed with debate as Democrats aimed to stall consideration of the bill. Rep. Ben Ray Lujan (D-NM) requested that the bill's text be read aloud, which consumed an hour of committee time. The Committee rejected all of the Democrats' amendments, which included proposals to: delay the markup until a CBO score has been issued; rename the bill "The Republican Pay More for Less Care Act;" strike provisions in the bill to restrict funding for Planned Parenthood; strike the bill's provisions establishing Medicaid per capita caps; maintain the current Essential Health Benefits Standards as mandated by the ACA; prohibit insurers from charging older enrollees more for premiums than younger enrollees; and strike the provision allowing health plans to charge a premium penalty for individuals who have a lapse in coverage.

By a party line vote of 31-23, the Energy & Commerce Committee approved the Budget Reconciliation Legislative Recommendations Relating to Repeal and Replace of the Patient Protection and Affordable Care Act. This measure would:

Subtitle A – Patient Access to Public Health Programs

Section 101 repeals the Prevention and Public Health Fund (PPHF) established under the ACA and rescinds any unobligated PPHF funds remaining at the end of FY2018.

Section 102 increases by $422 million in FY 2017 funding for the Community Health Center program.

Section 103 freezes for one year any federal funding to a prohibited entity, which has been acknowledged is Planned Parenthood. The bill text defines, but does not explicitly name, the prohibited entity.

Section B – Medicaid Program Enhancement

Section 111 repeals states' expanded authority to make presumptive eligibility determinations for specific populations; returns mandatory Medicaid income eligibility level for poverty-related children back to 100 percent of FPL; and repeals the six-percent bonus in the federal match rate for community-based attendant services.

Section 112 would repeal the Medicaid Expansion. By the end of CY 2019, states would no longer have the option to cover adults above 133 percent of FPL. Also, effective December 31, 2019, the bill sunsets the requirement that state Medicaid plans provide the same essential health benefits required by plans on the exchanges. For states that expanded Medicaid under the ACA:

- For newly eligible beneficiaries prior to January 1, 2020, states may keep the enhanced federal match rate, but after January 1, 2020, this match rate would only apply for individuals who were enrolled in Medicaid as of December 31, 2019 and do not have a break in eligibility for more than a month.

- Hold constant the federal matching rate available for non-pregnant childless adults after CY 2017. For expenditures after January 1, 2020, this matching rate would only apply to individuals who were enrolled in Medicaid as of December 31, 2019 and do not have a break in eligibility for more than a month.

Section 113 eliminates Medicaid Disproportionate Share Hospital (DSH) cuts for non-Medicaid expansion States in 2018 and for Medicaid expansion states in 2020.

Section 114 limits Medicaid eligibility periods. As of October 1, 2017, the effective date of retroactive Medicaid coverage would be limited to the month in which the applicant applied, as opposed to in or after the third month before the application month. Individuals would be required to present evidence of citizenship or lawful presence prior to obtaining Medicaid coverage. States would no longer have the authority to substitute a higher home-equity limit above current law.

Section 115 provides $2 billion per year, from CYs 2018-2022, for states that did not expand Medicaid. These non-expansion States would receive 100 percent matching rate from CYs 2018-2021, and 95 percent for CY 2022. These state allotments would be calculated using the number of individuals in a particular state below 138 percent FPL in 2015 as compared with the total number of individuals below 138 percent FPL for all non-expansion states in 2015.

Section 116 requires expansion states to redetermine individual Medicaid eligibility every six months. Section 116 also allows for an increased civil monetary penalty of $20,000 for each individual or claim for intentionally defrauding the program, and it provides an increased 5 percent Federal Medical Assistance Percentage (FMAP) to states for increased frequency of Medicaid eligibility redeterminations.

Subtitle C – Per Capita Allotment for Medical Assistance

Section 121 creates a federal Medicaid per capita cap starting in FY 2020. Using each State's FY 2016 spending as a base year, targeted spending would be set for enrollee categories (elderly; blind and disabled; children; expansion enrollees; and other nonelderly, nondisabled, non-expansion adults) starting in FY 2019. Going forward, each state's targeted spending would be increased by the percentage increase in the medical care portion of the consumer price index for all urban consumers over the current fiscal year. States with Medicaid spending higher than their targeted amount would receive less Medicaid funding in the following year. DSH and administrative payments would be exempt from the caps, as would individuals covered under a CHIP Medicaid expansion program, receiving care through an Indian Health Service facility, eligible for breast and cervical cancer treatment as a result of screening from the Breast and Cervical Cancer Early Detection Program, as well as partial-benefit enrollees, such as unauthorized aliens eligible for Medicaid emergency care, individuals eligible for Medicaid family planning, dual-eligible individuals eligible for coverage of Medicare cost sharing, individuals eligible for premium assistance, and individuals with TB eligible for coverage of TB-related services. Section 121 would also modernize Medicaid data and reporting and would provide a temporary, two-year increase in the FMAP to support States in improving their data reporting systems.

Subtitle D- Patient Relief and Health Insurance Market Stability

Section 131 would repeal the ACA cost-sharing subsidy.

Section 132 would create the Patient and State Stability Fund, beginning on January 1, 2018 and ending on December 31, 2026. States would receive $15 billion annually in 2018 and 2019; and $10 billion annually from 2020-2026. States may use the Fund for: providing financial assistance to high-risk individuals without access to employer coverage to purchase insurance on the individual market; "providing incentives to appropriate entities to enter into arrangements with the sZtate to help stabilize premiums for health insurance coverage in the individual market, as such markets are defined by the State;" reducing cost of coverage in the individual and small group market; promoting participation in the individual market and small group market; promoting access to preventive, dental care, mental health, and substance abuse disorder services; "providing payments, directly or indirectly, to healthcare providers for the provision of such healthcare services" as specified by the CMS Administrator; and providing assistance to reduce individuals' out of pocket costs.

Section 132 also provides that the majority (85 percent) of state annual allotments for 2018 and 2019 would be calculated from incurred claims for 2015 which includes medical loss ratio data to ensure an accurate reflection of costs of the individual market. States would receive a proportion of the remaining 15 percent if either their uninsured population of individuals below 100 percent FPL increased from 2013-2015 or fewer than three plans offer coverage on the exchange individual market in 2017. Beginning in 2020, the CMS Administrator will consult with healthcare stakeholders and set an allocation methodology taking into account cost, risk, low-income uninsured population, and issuer competition.

Section 133 would incentivize individuals to maintain continuous coverage by requiring a 12-month lookback period, beginning with open enrollment for benefit year 2019. If an individual had a lapse in health insurance coverage of greater than 63 days, plan issuers will assess a 30-percent late enrollment surcharge, in addition to their base premium.

Section 134 repeals the ACA actuarial value standards that plan issuers were required to use to label their tiers of coverage.

Section 135 changes the ACA's current limit on cost of the most generous plan for older Americans to three times the cost of the least generous plan for younger Americans. **Section 135** changes the ratio from 3:1 to 5:1 and provides states with flexibility to determine their own ratio.

King & Spalding's Healthcare and Government Affairs and Public Policy practice groups will continue to monitor these developments as they advance through the legislative process. We will have additional updates to our clients and in *Health Headlines*.