Insight

IN-DEPTH DISCUSSION

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House Passes American Health Care Act: Fate in the Senate Uncertain

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Seven years after the Affordable Care Act (ACA) was enacted, the U.S. House of Representatives voted on May 4, 2017, to dismantle the sweeping law and replace key provisions with a dramatically different vision of health care reform. After modifications were made to try to secure the votes of both GOP conservative and moderate factions, the House passed the American Health Care Act (AHCA) (H.R. 1628) by a vote of 217 to 213. No Democrats voted to approve the bill that was touted as "repealing and replacing" President Obama's signature legislative accomplishment. If enacted, the AHCA would address two of the most vexing provisions for employers by eliminating the "employer mandate" and further delaying the "Cadillac" tax on high-cost employer-sponsored health plans. Enactment of the legislation is by no means certain and faces a rocky road in the Senate.

House passage of the measure was itself far from certain after an earlier failed attempt to bring the bill to a vote in the House. In March, Republican House leadership pulled the bill from consideration when it became clear that it lacked the votes for passage. Although Republicans' push to repeal and replace the ACA appeared dead at the time, negotiations between key members of the conservative Freedom Caucus and moderate Tuesday Group coupled with a strong push by the White House yielded a big legislative win for House Republicans and President Trump. Without any Democratic support, Republicans could afford to lose only 22 members of their own caucus. The version of the legislation that was pulled from a vote in March was met with criticism from the far right claiming it did not go far or fast enough to repeal the ACA and its insurance reforms, and from centrist Republicans who were worried that it went too far and fast

House Republican leadership and the White House had a fine line to walk to secure the support of one group without losing that of the other. Their

task was made more difficult by a Congressional Budget Office (CBO) report on the earlier version of the AHCA, which concluded that there would be 24 million fewer insured by 2026 under the Republican House bill than under the ACA.

The AHCA was given new life when a deal was brokered between Rep. Tom MacArthur (R-NJ), who co-chairs the moderate Tuesday Group, and House Freedom Caucus Chairman Mark Meadows (R-NC). Other last-minutes changes coupled with a full-court press by House leadership and President Trump resulted in the narrow victory on the House floor.

Though touted as a "repeal and replace" of the ACA, the AHCA does not repeal the ACA in its entirety. By using the reconciliation process to enact their health care plan, Republicans need only 51 votes to pass the AHCA in the Senate, therefore avoiding a Democratic filibuster. However, strict procedural rules limit the type of provisions that can be included in a reconciliation bill to budget-related matters—i.e., those that change federal spending or revenues. Certain provisions of the ACA could not be repealed or modified through a reconciliation bill, nor could certain new health care-related provisions be added. Thus, the AHCA has been characterized by congressional Republicans as one of three "buckets" to effectuate their health care plan. The other two buckets include administrative action and standalone legislation that advances through so-called "regular order"—meaning that it will need 60 votes to overcome a Senate filibuster.

On the administrative front, President Trump issued Executive Order 13765, allowing the Secretary of Health and Human Services (HHS) and the heads of all other executive departments and agencies "to waive, defer, grant exemptions from, or delay the implementation" of provisions or requirements of the ACA that would "fiscally burden any state or impose a cost, fee, tax, penalty, or regulatory burden on individuals, families, health care providers, health insurers, patients, recipients of health care services, purchasers of health insurance, or makers of medical devices, products, or medications." The executive order also allows the HHS Secretary and other agency heads to provide greater flexibility to states and cooperate with them in implementing health care programs.

The ACA Versus the AHCA: What Does Not Change?

The AHCA leaves the ACA exchanges in place, although the subsidies to individuals to purchase health insurance would change significantly. The House Republican bill also leaves in place provisions in the ACA on improving health care delivery systems as well as its Medicare provisions.

A number of the insurance market reforms included in the ACA have proven to be quite popular, making it politically perilous to remove protections that have now been in place for a number of years. Those reforms the AHCA leaves in place include:

- The requirement to provide dependent coverage for children up to age 26.
- Prohibition on preexisting condition exclusions, although a surcharge can be imposed on individuals who have a lapse in coverage.
- Cap on out-of-pocket expenditures.
- Prohibition on annual and lifetime dollar limits.
- Coverage of preventative services without cost-sharing.
- Requirement to apply in-network cost-sharing for out-of-network emergency services.

The MacArthur amendment allows a state to apply to a waiver from the Department of Health and Human Services to:

- Allow a greater disparity between the cost of policies for older and younger Americans that is otherwise permitted under the bill (5:1) beginning in 2018 (the ACA permitted only a 3:1 ratio, which increased the cost of policies for younger people).
- Specify their own list of essential health benefits that would need to be provided beginning 2020.
- Replace the underlying bill's continuous-coverage incentive's late-enrollment penalty with health status rating beginning in 2019, conditional upon the state's operating a risk-mitigation program or participating in a Federal Invisible Risk Sharing Program (FIRSP). Health status rating may not be waived for individuals who maintain continuous coverage.

The waiver provision drew fire from some moderate members, resulting in a last-minute amendment by Rep. Fred Upton (R-MI) that increases by $8 billion (from 2018 to 2023) the amount that will be provided to states that may be used to reduce premiums or other out-of-pocket costs for certain individuals who may be adversely affected by a waiver. Although the agreements dealing with the ACA's insurance market reforms were able to pass the House, the bill may face difficulty in the Senate.

It should be noted that the AHCA does not include a limit on the employee tax exclusion for employer-sponsored health coverage. Repeal or limitation of the tax exclusion for employer-sponsored plans has long been mentioned as a revenue-rich means of paying for other policy changes. Prior drafts of the House Republican bill did include such a cap as well as a repeal of the so-called "Cadillac" tax, which imposes a 40% excise tax on employer-sponsored plans above a certain threshold. The bill that ultimately passed the House delayed, rather than repealed, the Cadillac tax, but left the tax exclusion intact.

The ACA versus the AHCA: What Does Change?

The AHCA takes aim at the cornerstones of the ACA's efforts to expand health insurance coverage – the latter's premium tax credit and Medicaid expansion. Beginning in 2020, the AHCA would replace the ACA income-based premium tax credits with a refundable monthly tax credit—between $2,000 and $14,000 a year—for low- and middle-income individuals and families that do not receive insurance through work or a government program. The new refundable tax credits are age-based. The bill repeals the ACA cost-sharing subsidies effective January 1, 2020. The bill would also transition Medicaid to a "per capita allotment." The AHCA would terminate the ACA's mandatory requirement for states to expand Medicaid for certain childless, non-disabled, non-elderly, non-pregnant adults up to 133% of the Federal Poverty Level (FPL) and sunsets the optional ability for a state to cover adults above 133% FPL, effective December 31, 2017. Medicaid expansion enrollees who were enrolled in Medicaid expansion prior to December 31, 2019, receive "grandfathered" status. States would have the option of instituting a work requirement in Medicaid for nondisabled, nonelderly, non-pregnant adults as a condition of receiving coverage under Medicaid. The bill creates the American Health Care Implementation Fund within HHS to carry out a Patient and State Stability Fund, which states may use to provide financial help to high-risk and low-income individuals. The implementation fund also allows for additional modifications to the refundable tax credit for health insurance.

Although a number of the ACA insurance market reforms would remain, as noted above, some of the law's requirements on plans in the individual and group market would change. For example, the AHCA would remove the requirement, beginning in 2020, that insurers that offer plans in the individual- and small-group markets generally must offer plans that cover at least 60 percent of the cost of covered benefits. The bill repeals the surtax on certain high-income taxpayers' net investment income, the increase in the

Hospital Insurance payroll tax rate for certain high-income taxpayers, and the annual fee on health insurance providers. Even with repeal of the taxes, the CBO estimate of the earlier version of the AHCA would decrease the net federal deficit by $150 billion over the 2017-2026 period. The CBO projects that the earlier version of the bill "would tend to increase average premiums in the nongroup market before 2020 and lower average premiums thereafter, relative to projections under current law."

While much of the focus of debate has been on the AHCA's impact on the nongroup or individual health insurance market, the legislation would have important implications in the large group market as well. The AHCA makes significant changes to the ACA impacting employer-sponsored coverage. Among these changes are:

- **Elimination of the Employer Mandate Penalties:** The AHCA effectively eliminates the employer mandate on a retroactive basis, effective January 1, 2016. The ACA's employer mandate imposes a penalty on employers with 50 or more full-time and full-time equivalent employees who fail to offer affordable, minimum value health coverage to full-time employees. For purposes of the ACA employer mandate, full-time employment is considered 30 or more hours of service per week. IRS regulations allow employers to use a complex "lookback" measurement method to calculate full-time status. The AHCA does not actually repeal the employer mandate. However, by reducing to zero the penalties for failing to offer health coverage, the House-passed bill renders the employer mandate toothless. To comply with strict requirements to use the reconciliation process to facilitate filibuster-proof passage in the Senate, the bill can only include provisions that have a direct budgetary impact. Thus, repeal of the complex and unpopular employer health care reporting requirements and penalties under Section 6055 and 6066 of the ACA could not be included in the bill. The House Ways and Means Committee explains that: "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." Beginning in 2020 and beyond, employers would report offers of coverage on the W-2 Forms.

- **Elimination of the Individual Mandate Penalties.** The penalty for individuals who fail to have "minimum essential coverage" is eliminated effective January 1, 2016. As with the employer mandate, the AHCA does not actually repeal the individual mandate, but zeroes out the penalty.
- **Delay of the Cadillac Tax:** Originally slated to take effect in 2018, this excise tax on high-cost employer plans above a certain threshold is currently scheduled to go into effect in 2020. The AHCA delays the effective date an additional six years until 2026. This unpopular tax has been met with criticism from labor and business alike and from both sides of the aisle. However, budgetary concerns likely prevented full repeal of the tax.
- **Health Savings Account Enhancements:** The bill includes a number of provisions designed to expand Health Savings Accounts (HSAs). Among the changes, the AHCA:
  1. Increases the maximum annual tax-free contribution limit to equal the limit on out-of-pocket cost sharing under qualified high deductible health plans ($6,550 for self only coverage, $13,100 for family coverage in 2017, indexed for inflation).
  2. Allows both spouses to make catch up contributions to the same HSA.
  3. Expands the qualified medical expense definition to include over-the-counter medications and expenses incurred up to 60 days prior to date the HSA was established.
  4. Reduces the tax penalty for withdrawals used for non-qualified expenses from 20% to 10%.

As for the law's impact on employer-sponsored coverage, the CBO projected a savings of $70 billion in the Budget Committee-passed bill, mostly associated with projected net decreases in the number of people estimated to enroll in employment-based health insurance coverage. As the CBO explained in its estimate of the Budget Committee-passed bill:

> over time, fewer employers would offer health insurance because the legislation would change their incentives to do so. First, the mandate penalties would be eliminated. Second, the tax credits under the legislation, for which people would be ineligible if they had any offer of employment-based insurance, would be available to people with a broader range of incomes than the current tax credits are.

The CBO concludes that these changes could make non-group coverage more attractive to a larger share of employees, with the consequent withdrawal of employer–provided coverage. However, in the CBO's view, two factors would partially offset employers' incentives not to offer insurance. First, the average subsidy for those who are eligible would be smaller under the AHCA than under current law and would grow more slowly than health care costs over time. Second, non-group insurance under the legislation is projected to be less attractive to many people with employment-based coverage than under current law because it would, on average, cover a smaller share of enrollees' expenses. Additionally, shopping for and comparing plans would probably be more difficult. In general, the CBO expects that businesses that decide not to offer insurance coverage under the legislation would generally have younger and higher-income workforces than businesses that choose not to offer insurance under current law. The CBO estimate is that under the AHCA, roughly 2 million fewer people would enroll in employment-based coverage in 2020, and that number would grow to roughly 7 million in 2026. Some employers would probably delay making decisions because of uncertainty about the viability of and regulations for the non-group market and about implementation of the new law.

The CBO acknowledges the uncertainty surrounding its projections. How and when employers respond to the AHCA, should it become law, remains to be seen. The fate of the House-passed American Health Care Act itself is uncertain. Modifications made to the legislation to secure passage in the House make its road to passage in the Senate even more difficult. A CBO report on the final House-passed bill has not yet been released. It may project an even greater number of uninsured than did the prior report. Some Senate Republicans have already signaled that significant changes could be in order to pass the chamber. Senate Republicans can afford to lose only two members of their caucus, leaving their task perhaps even more challenging than in the House.

Unless and until a bill passes both Houses of Congress and reaches the president's desk, uncertainty about the legislative fate of the ACA and its "repeal and replace" efforts will remain. Uncertainty about the ultimate impact on employer-sponsored coverage will likely remain even longer.