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If you have questions, please contact your regular Groom attorney or one of the attorneys listed below:

Kathryn Bjornstad Amin
kamin@groom.com
(202) 861-2604

Sravva Boppana
sboppana@groom.com
(202) 861-6338

Jon W. Breyfogle
jbreyfogle@groom.com
(202) 861-6641

Lisa M. Campbell
lcampbell@groom.com
(202) 861-6612

Thomas F. Fitzgerald
tfitzgerald@groom.com
(202) 861-6617

Katy S. Kamen
kkamen@groom.com
(202) 861-6646

Christine L. Keller
ckeller@groom.com
(202) 861-9371

Tamara S. Killion
tkillion@groom.com
(202) 861-6328

Rachel Leiser Levy
rlevy@groom.com
(202) 861-6613

Lisa K. Lowenstein
llowenstein@groom.com
(202) 861-5410

Emily C. Lucco
elucco@groom.com
(202) 861-9386

Matthew W. Muma
mmuma@groom.com
(202) 861-5405

Mark C. Nielsen
mnielsen@groom.com
(202) 861-5429

Seth T. Perretta
sperretta@groom.com
(202) 861-6335

Malcolm C. Slee
mslee@groom.com
(202) 861-6337

Ryan C. Temme
rtemme@groom.com
(202) 861-6659

Christy A. Tinnes
ctinnes@groom.com
(202) 861-6603

Vivian Hunter Turner
vtturner@groom.com
(202) 861-6324

Allison Ullman
aullman@groom.com
(202) 861-6336

Brigen L. Winters
bwinters@groom.com
(202) 861-6618

Joel D. Wood
jwood@groom.com
(202) 861-6656

SUMMARY OF KEY PROVISIONS OF THE AMERICAN HEALTH CARE ACT

INTRODUCTION

On May 4, the U.S. House of Representatives passed the American Health Care Act (“AHCA”, generally referred to herein as the “bill” in order to prevent confusion with the ACA), a budget reconciliation bill to repeal and replace the Affordable Care Act (“ACA”). The bill’s key provisions include:

- eliminating the individual shared responsibility and employer shared responsibility (the “mandates”) penalties;
- a package of insurance “market stabilizers,” including funding for state-based high risk pools, a continuous coverage requirement, and a 5:1 community rating provision with state flexibility;
- creating state waivers for age rating, essential health benefits (“EHBs”), and, where an individual’s coverage has lapsed, community rating;
- replacing the ACA premium subsidies with age-based tax credits of \$2,000-\$4,000 to help individuals pay for coverage;
- delaying the implementation of the Cadillac tax;
- eliminating various taxes and fees associated with the ACA; and
- reforming Medicaid.

The History in the House: After Speaker Paul Ryan released the draft bill on March 6, the measure moved rapidly through the House Ways and Means, Energy and Commerce, and Budget Committees, generally on party line votes. Unsurprisingly, the AHCA was met with unified Democratic opposition. What was unexpected, however, was the mixed response from Republicans across the political spectrum, with widely publicized defections by conservative Republican members of the House Freedom Caucus and some House moderates, and a lack of broad support from Senate Republicans. The release of the Congressional Budget Office (“CBO”) report on March 13 created further controversy, on one hand showing that over 20 million additional Americans may be uninsured in 10 years, but also that individual market premiums will go down over time and that the budget deficit would be reduced.

On March 20, House leadership negotiated a manager’s amendment in an effort to broaden support of the bill amongst Republicans (“Manager’s Amendment”). The Manager’s Amendment streamlined the bill’s treatment of the tax credit program, moved up the repeal of many of the ACA’s tax provisions to the end of 2016, not 2017, and made several changes to the original bill’s treatment of Medicaid: perhaps most notably, by allowing states to adopt work requirements and choose block grants for Medicaid funds instead of per capita allotments in 2020 and beyond.

Nonetheless, facing growing opposition from his own caucus, on March 24 Speaker Ryan pulled the AHCA from consideration by the full House, acknowledging that the bill did not have the votes to pass.

After the Manager's Amendment failed to convert a sufficient number of House dissenting Republicans to flip their votes, the GOP caucus adopted several more amendments. Representatives Greg Walden and Kevin Brady introduced an amendment that would have required states to establish their own essential benefits packages for premium tax credit purposes. This was followed by an amendment offered by Representatives Gary Palmer and David Schweikert, creating a \$15 billion risk sharing program to help states lower individual market costs for consumers.

When these efforts failed to garner enough votes, Representative Tom MacArthur offered an amendment (the "MacArthur Amendment") that would allow—but not require—states to set their own essential health benefits, age rating rules, and also provide a limited exception to community rating for those individuals whose coverage had lapsed.

The MacArthur Amendment finally won support from the conservative Freedom Caucus, but it was widely perceived as reducing protections for those with preexisting conditions, which risked the necessary support of some moderate Republicans. In response, Representative Fred Upton negotiated one final amendment (the "Upton Amendment"), making a further \$8 billion available to help consumers in states that adopted a community-rating waiver for lapsed coverage.

The Upton Amendment finally brought enough moderates on board to pass the bill. On May 4, 2017, the House of Representatives voted 217-213 to pass the bill, with 20 Republicans opposing the bill and no Democrats voting in favor of the bill.

Prospects in the Senate: The bill now heads to the Senate, where the smaller GOP majority and procedural limitations on legislative language that can be considered under budget reconciliation legislation will likely result in important changes to the bill before passage is possible.

Several Republican Senators, within hours of passage in the House, made their continued opposition to, and concerns with, the bill public, with an expanded focus on "getting it right" rather than passing a bill quickly. The primary concern appears to be with the effects of the Medicaid expansion repeal. Another primary concern for Senate leadership is providing much needed stability to the individual markets in certain states, as well as a concern regarding the impact of reduced premium tax credits on low income and older individuals.

It also appears that conversations have been ongoing between House and Senate Republicans regarding changes to the bill that would also be acceptable to the more conservative House Republicans, with an eye toward crafting a bill that can pass in both Houses. While all indications currently point to a more measured debate in the Senate, the Trump Administration has indicated that it expects the Senate to maintain the momentum of the House passage and take up the bill quickly and there will be pressure to try to wrap up consideration before the August recess.

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While there is no doubt that the AHCA constitutes radical surgery to the ACA, it is worth noting that there are many parts of the ACA that will remain in place. Indeed, the fact that the AHCA was more of an amendment to the ACA rather than a full repeal may have been a big part of the initial conservative Republican opposition. The following ACA requirements would remain under the AHCA:

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- federal and state based Exchanges;
- guaranteed issue and renewal for individual coverage, with no ability to decline coverage due to pre-existing conditions;
- community rating (but age-rating up to 5:1 under AHCA, and limited state waivers for age and health status), with federal rate review;
- medical loss ratios;
- federal risk adjustment program for insurers;
- preventive services with no cost sharing, dependent coverage to age 26, appeals and external review standards, and provider nondiscrimination rules;
- essential health benefit (“EHB”) standards (subject to potential state waivers), and cost sharing limitations, but no actuarial value standards; and
- broad federal nondiscrimination rules under section 1557 of the ACA (but the Department of Health and Human Services has indicated, in litigation, it will reconsider the section 1557 rule).

SUMMARY OF THE AMERICAN HEALTH CARE ACT

Below is a summary of the AHCA as it was passed by the House on May 4.

Repeal of the Individual and Employer Mandate Penalties

A cornerstone of Republican opposition to the ACA has been the widespread aversion to the individual and employer mandates. The Bill addresses this by repealing the penalties (the actual mandates themselves are retained because of the rules governing the budget reconciliation process).

Specifically, the ACA generally requires individuals to be covered under major medical coverage for each month in a year or incur a penalty. Effective for 2016, the Bill proposes to eliminate this penalty, thus gutting the mandate. The ACA also generally requires large employers to offer affordable coverage that provides minimum value or incur a penalty. Effective for 2016, the Bill proposes to eliminate the penalty applicable to employers who do not offer health coverage, as well as the penalty applicable to employers who offer health coverage that is not affordable or does not provide minimum value.

Groom observation: Notably, the Bill also does not propose to repeal the Internal Revenue Code section 6055 and 6056 reporting requirements, again likely because of the rules that govern budget reconciliation. However, the Ways and Means Committee description of an earlier version of the bill states that the Secretary of the Treasury has discretion to stop enforcing the current reporting requirement if it “becomes redundant and replaced” by new reporting rules.

Insurance Market Stabilization

➤ Rating and Benefits

The Bill leaves intact the majority of the ACA’s market reforms with a few important exceptions. The ACA’s absolute prohibition on pre-existing condition limitations, dependent coverage up to age 26, guaranteed availability and renewability, and requirements related to preventive services, appeals and external review, and provider nondiscrimination would all remain. The essential health benefits also remain as a federal standard, although a state may receive a waiver allowing the state to define the essential health benefits in that state. That said, the Bill does

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make certain important changes to the market reforms that will significantly impact insurance markets if the Bill becomes law.

The Bill would amend section 2701 of the Public Health Service Act (“PHSA”), which governs permissible rating factors for health insurance, to expand permissible age variance from the current limit of 3:1, to 5:1. The Bill would also permit states to adopt a separate age-rating standard. Unlike other provisions of the PHSA, where a state may impose a more consumer-friendly standard than the federal floor but cannot impose rules less protective than the federal standard, the Bill also permits states to adopt ratios greater than 5:1, for instance through the state waiver.

Groom Observation: Although changes to age rating have been an important concern for health insurance issuers for some time, this change faces significant hurdles for passage in the Senate. In simplified form, because the AHCA is a budget reconciliation bill, the Senate’s procedural rules require the bill’s provisions to “produce a change in [federal budgetary] outlays or revenues.” In this case, the effect of the age rating provision on budgetary issues may be considered incidental to its non-budgetary impact, and therefore, it could be removed from the Bill when it is considered by the Senate.

The Bill also effectively replaces the ACA’s individual mandate with a continuous coverage requirement. If an individual is unable to demonstrate that they have been enrolled in creditable coverage (generally for the prior 12 months), issuers in the small group and individual markets must impose a 30% premium surcharge. Participants would pay this premium surcharge to the insurance issuer, not to the federal government in the form of a tax. The proposed surcharge would be effective for special enrollment periods during the 2018 plan year, and open enrollment periods for the 2019 and following plan years.

A state could apply for a waiver to permit underwriting based on health status in lieu of the 30% penalty. In this system, issuers would be allowed to set premiums based on health status for those whose coverage has lapsed for at least 63 days. States that wish to waive the surcharge in favor of health status underwriting must have a high risk pool program or participate in the “invisible risk sharing program” discussed below.

Groom observation: As with age rating, the continuous coverage requirement may be required to be removed from the Bill in the Senate as a result of the budget reconciliation rules.

While the Bill leaves intact the ACA’s EHB (subject to state waivers) and cost-sharing requirements, it does provide significant new flexibility for insurance issuers. First effective January 1, 2020, the AHCA eliminates the actuarial value metallic tiers. Plans would not be required to meet certain minimum actuarial value thresholds (*i.e.*, Bronze, Silver, Gold, and Platinum). Note that because the Bill does not remove the maximum out-of-pocket requirements, it may be difficult as a practical matter to offer a plan with an actuarial value much lower than the current Bronze level.

States could also apply for waivers to create their own, potentially much more flexible, list of EHBs.

Groom observation: It was widely reported immediately before the Bill passed that the state EHB waiver provision would allow employer-sponsored, self-funded group health plans to select a state’s definition of the EHB’s for purposes of the prohibition on annual and lifetime limits. The concern is that if a state defined the EHBs narrowly that employers would select that state’s definition of EHBs and begin imposing annual and lifetime limits on benefits that were no longer considered “essential.”

We think the Bill is not entirely clear on this point. It is true that currently, self-funded employers are permitted to select any state benchmark as the employer's definition of EHBs for purposes of the annual and lifetime limit provision. But the statute actually says that group health plans may not impose annual or lifetime limits on "benefits that are essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act, as determined by the Secretary." ACA § 2711. And section 1302(b) is the list of the ten categories of benefits that are considered "essential." Because the AHCA does not actually amend section 1320(b) (it instead amends 1302(a) and 2701 of the PHSA), it is not entirely clear that self-funded plans that select a state waiver definition of EHBs would meet the statutory requirement not to place limits on benefits "under section 1302(b) ... as determined by the Secretary."

➤ **Risk Mitigation**

The Bill does not amend the ACA's risk adjustment program or extend the other two risk mitigation programs (risk corridors and transitional reinsurance), which ended in plan year 2016. It does, however, create a new Patient and State Stability ("PaSS") Fund with a total of \$100 billion, plus an additional \$15 billion in 2020 to support maternity and newborn care or care for substance abuse and mental disorders and, under the Upton Amendment, a further \$8 billion to provide consumer support in states that allow issuers to adopt a limited form of individual rating. Generally, the PaSS funding may be provided to the states between January 1, 2018 and December 31, 2026, and may be used by states for the following purposes:

- help high-risk individuals who do not have access to employer-sponsored health insurance coverage so these individuals can enroll in the individual market;
- fund incentives to appropriate entities to enter into arrangements with the state to help stabilize premiums;
- reduce costs for individual and small group market coverage to individuals who have high utilization of health services;
- promote participation in the individual market and small group market and ensure health insurance options are available through such market;
- promote access to preventive services, dental care services (whether preventive or medically necessary), and vision care services;
- provide maternity coverage and newborn care;
- promote the prevention, treatment, or recovery support services for individuals with mental health or substance use disorders;
- provide payment to certain providers; or
- provide financial assistance to reduce out-of-pocket costs.

Should a state fail to follow certain procedures detailed in the Bill, the federal default reinsurance program will be used instead. Currently, that program reimburses claims in excess of \$50,000 at seventy-five percent of claims cost, with a cap of \$350,000.

Risk mitigation amounts will vary by state depending in large part upon claims volume in the state, but also on the extent to which the state's uninsured population has changed since 2013, and the extent to which the insurance markets are functioning well.

Groom Observation: Beginning in 2020, in order for a state to access program funds, a state will need to undertake certain additional steps, including appropriating and contributing its own state-level funds to support the program. If states want to minimize their own required program contributions, they may need to establish their own state-level, HHS-approved, risk mitigation programs.

➤ **Federal Invisible Risk Sharing Program**

Representatives Gary Palmer and David Schweikert’s amendment added a federal invisible risk sharing program that could help states reduce costs to consumers. The program is intended to provide payments to issuers with respect to claims for eligible individuals, with the goal of lowering premiums in the individual health insurance market. The amendment appropriates \$15 billion in federal funding from January 1, 2018 through December 31, 2026. Funds left over from the PaSS fund would be available for additional funding.

The amendment delegates authority to the CMS Administrator to implement the program after consultation, though it requires the following elements to be part of the program:

- ***Eligibility.*** A definition of eligible individuals.
- ***Health status statements.*** The development and use of health status statements with respect to eligible individuals.
- ***Standards for qualification.*** Identification of health conditions that would automatically qualify individuals as eligible individuals as well as a voluntary process under which issuers could qualify individuals who do not qualify for the program automatically.
- ***Premium percentage.*** The percentage of premiums paid by eligible individuals to issuers that would be collected and ceded to the program.
- ***Attachment dollar amount and payment proportion.*** The dollar amount of claims for eligible individuals after which the program would provide payments to issuers, and the proportion of such claims above such dollar amount that the program will pay.

CMS is required to consult with health care consumers, health insurance issuers, state insurance commissioners, and other stakeholders in developing the program, and the CMS Administrator has 60 days after enactment to establish sufficient parameters to specify how the program will operate for plan year 2018. Furthermore, CMS is required to establish a process to hand operation over to the states beginning with plan year 2020.

Revisions to Tax Credits

The Bill would significantly revise the rules under which premium tax credits (“PTCs”) will be made available to individuals. Under the current PTC provisions (Internal Revenue Code Section 36B), the PTCs are generally available to taxpayers with household income between 100% and 400% of the federal poverty line who purchase a qualified health plan (“QHP”) through an exchange. The Bill would modify the PTCs for a 2-year transition period (2018 through 2019) and then replace the PTCs, effective January 1, 2020. The new PTCs would be age-adjusted, but phase out when individuals reach certain income thresholds.

Revisions to PTCs for 2018 and 2019

Between January 1, 2018 and December 31, 2019, PTCs would be amended as follows:

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- **Allowing Premium Tax Credits for Coverage Purchased Outside of an Exchange**— Currently, PTCs can only be used to purchase QHPs, and, by definition, QHPs are only available through an exchange. The Bill directs the Internal Revenue Service (“IRS”) to disregard parts of the QHP definition for purposes of determining which health insurance coverage may be purchased with PTCs. The effect is to allow eligible individuals to purchase both on- and off-exchange coverage, including “catastrophic” QHPs, and to receive PTCs. However, *advance* payments of the tax credit would only be allowed for on-exchange coverage. Also, PTCs could not be used to purchase a grandfathered or grandmothers health plan or a plan that includes coverage for abortion (with some exceptions).
- **Additional Reporting for Off-Exchange QHPs** – Providers of QHPs not offered through an exchange would have to include the following additional information on their Form 1095-B returns: (1) a statement that the plan is a QHP; (2) the premiums paid for the coverage; (3) the months during which the coverage is provided to the individual; and (4) the adjusted monthly premium for the applicable second lowest cost silver plan for each month with respect to the individual.
- **Amount of Tax Credit** –PTCs are currently calculated on a sliding scale based on the taxpayer’s household income. That scale would be amended for plan year 2019 to change the amount of the tax credit based on income and to also take into account the ages of the taxpayer and family members in determining the amount of the credit.

New PTCs Effective 2020

The new PTCs would be effective January 1, 2020. In brief, the new PTCs would be equal to the lesser of: (1) the sum of monthly credit amounts with respect to the taxpayer and taxpayer’s qualifying family members for eligible coverage months during the taxable year, or (2) the amount paid by the taxpayer for a “qualified health plan.” In order to be eligible for a PTC, the taxpayer must be covered by a “qualified health plan” and cannot be eligible for certain other specified coverage, including almost all employer-sponsored group health plans and certain government programs (*e.g.*, Medicare, Medicaid).

- **Amount of Tax Credit** – The amount of the PTC ranges from \$2,000 - \$4,000 per year (depending on age) and phases out at certain income levels. The annual credit amount is: \$2,000 if the individual is less than 30 at the beginning of the year; \$2,500 if the individual is 30 but not yet 40; \$3,000 if the individual is 40 but not yet 50; \$3,500 if the individual is 50 but not yet 60; and \$4,000 if the individual is 60 or over. The PTC is aggregated for family members (for example, a married couple both in their 40s with one child would get a tax credit of \$8,000). However, the maximum tax credit is \$14,000 and no more than the five oldest individuals in the family can be taken into account. The credit amount is reduced dollar-for-dollar by the permitted benefit of any qualified small employer health reimbursement arrangement for which the taxpayer or any qualifying family member is eligible.

The PTC phases out for taxpayers with a modified adjusted gross income of \$75,000 or greater (\$150,000 for joint filers), as indexed annually. The PTC is reduced by 10% of the excess that the taxpayer earned over the \$75,000/\$150,000 threshold. For example, a 35 year old single taxpayer would ordinarily be entitled to a \$2,500 PTC. However, if that taxpayer earned \$90,000 in a year, the PTC would be reduced to \$1,000 (*i.e.*, the taxpayer made \$15,000 in excess of the \$75,000 threshold, and 10% of \$15,000 is \$1,500, so the \$2,500 PTC would be reduced by \$1,500 to \$1,000.)

Groom observation: The question of whether any particular individual or family benefits more or less under the new PTCs as opposed to the current PTCs will depend on their circumstances. However, it is worth noting that while the Bill provides for a 5:1 ratio with regard to age rating, the PTCs are set at a 2:1 ratio for the oldest taxpayers relative to the youngest. Also, the PTCs do not reflect a geographic adjustment, so they may be less beneficial to individuals living in high cost areas.

It has been widely reported that the Manager's Amendment sets aside \$85 billion that could be used by the Senate to improve the tax credits for individuals between ages 50 and 64. The current legislative language does not expressly provide for that funding or articulate how that additional credit would be structured. The Energy and Commerce Committee's press release says, "Under current law, Americans can deduct from their taxes the cost of medical expenses that exceed 10% of their income. Our proposed amendment reduces this threshold to 5.8% of income. This change provides the Senate flexibility to potentially enhance the tax credit for those ages 50 to 64 who may need additional assistance." This may mean that the House believes the Senate could generate additional funds that could be used to enhance the tax credits by raising the medical deduction income threshold back to the pre-ACA level of 7.5%.

- **Eligibility for Tax Credit** – An individual would be eligible for a PTC for a month if he/she is: (1) covered by health insurance coverage that is certified by the state in which it is offered as coverage as a "qualified health plan"; (2) not eligible for coverage under a group health plan (other than a plan under which substantially all of the coverage is excepted benefits) or certain governmental coverage (e.g., Medicare, Medicaid); (3) either a U.S. citizen or national or a qualified alien; (4) not incarcerated; and (5) if married, files a joint return (with some exceptions described below).

Groom observation: If a taxpayer is eligible for employer-sponsored major medical coverage, the taxpayer would be disqualified from receiving a PTC, even if the taxpayer is not enrolled in that coverage, and regardless of whether employer-sponsored coverage is unaffordable or provides minimum value. Under current law, a taxpayer is only disqualified from PTCs if they are either enrolled in employer-sponsored coverage or if the coverage offered meets the "minimum value" and "affordability" standards of the ACA. Since the mere eligibility for employer-sponsored benefits could disqualify individuals from the PTCs, some employers with lower-income employee populations may be in the position of evaluating whether to eliminate their group health plan offerings altogether because their employees might be better off retaining eligibility for the PTCs and purchasing individual insurance. It will be interesting to see how the Congressional Budget Office ("BO") treats the question of employers dropping coverage in its eventual scoring of the Bill.

- **Joint Return Requirement** – A married individual is generally not eligible for a PTC in a year unless the individual and his/her spouse file a joint return for the year. However, there is an exception to this rule if the individual is living apart from his/her spouse at the time he/she files the return and is unable to file a joint return because he/she is the victim of domestic abuse or spousal abandonment. This exception, which is present law under the ACA, can be utilized for up to three years.
- **"Qualified Health Plan"** – PTCs would only be available to pay for a "qualified health plan," which means any health insurance coverage if the coverage is: (1) offered in the individual market in a state; (2) is not a grandfathered or grandmothered health plan; (3) substantially all of the coverage is not excepted benefits; (4) the coverage is not short-term limited duration insurance; and (5) the coverage does not include coverage for abortions (with some exceptions).

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- **Advance Payments of Tax Credit** – Individuals can receive an advance payment of the PTCs. The individual must reduce the PTC claimed on his/her tax return by any advance payments of the PTC received during the year. Individuals must repay excess advance payments of the PTC. The Bill generally retains the current advance payment of the tax credit rules in ACA section 1412, but also provides that the Secretary shall prescribe regulations to establish and operate the advance payment system for individuals covered by qualified health plans “whether enrolled in through an Exchange or otherwise” and in such a manner that protects taxpayer information (including names, taxpayer identification numbers, and other confidential information), provides robust verification of all information necessary to establish a taxpayer’s eligibility, ensures proper and timely payments to appropriate health providers, and protects program integrity to the “maximum extent feasible.”
- **Code section 213(d) Medical Expense Deduction** – For purposes of calculating the medical expense deduction, individuals cannot take into account amounts paid for a qualified health plan for which they received a PTC, but can take into account amounts paid for a qualified health plan that exceed the PTC amount.
- **Penalty for Erroneous PTC Claims** – Increases the penalty on an individual who improperly claims a PTC from 20% to 25% of the excess amount.
- **Reporting** – Employers must report on an employee’s Form W-2 “each month with respect to which the employee is eligible for coverage under a group health plan (other than a plan under which substantially all of the coverage is excepted benefits) in connection with employment with the employer.
- **Coordination with Code section 35 Health Coverage Tax Credit** – An individual is not eligible for a PTC in a month in which he/she elects the health coverage tax credit. The Bill also provides rules for coordinating the health coverage tax credit with advance payments of the PTC.
- **Coordination with Code section 162(l) Health Insurance Deduction** – A self-employed individual’s deduction for health insurance costs generally is reduced by the PTC he/she received for the year.

Consumer Accounts (HSAs, MSAs, HRAs and FSAs)

Consistent with statements made by President Trump regarding his plan to overhaul healthcare, the Bill includes numerous changes to the rules governing health savings accounts (“HSAs”) and other consumer accounts. The Bill appears aimed at promoting the use of consumer accounts through increased contribution limits and more flexibility regarding the use of funds in such accounts, as summarized below.

- **Cost of Non-Prescription Medication is a Qualified Medical Expense** – Generally, amounts in HSAs that are used to pay qualified medical expenses are not subject to taxation. Effective 2011, the ACA amended to the HSA rules to provide that expenses for the cost of drugs are considered qualified medical expenses only if the drug is a prescribed drug or insulin. Effective 2017, the Bill proposes removing this restriction, thus restoring the pre-ACA position taken by the IRS that amounts paid towards the cost of a drug can be qualified medical expenses, regardless of whether the drug is prescribed. See Rev. Rul. 2003-102. See also, Notice 2010-59 and Notice 2011-5, both of which will be obsolete if this legislation is enacted.

The Bill proposes conforming changes to the Archer Medical Savings Account (“MSA”), health flexible spending arrangements (“FSA”), and health reimbursement arrangement (“HRA”) rules, so that amounts in each of these types of accounts can be used to reimburse non-prescription medication on a pre-tax basis.

- **Reduced Tax Penalty on Amounts Not Used for Qualified Medical Expenses** – Amounts in HSAs that are used to pay for expenses that are not qualified medical expenses are not only includible in income, but are also subject to an additional tax. Effective 2011, the ACA amended the HSA rules to increase the tax from 10% to 20%. Effective 2017, the Bill proposes reverting back to the pre-ACA rule, reducing the penalty from 20% to 10%.

The Bill proposes a similar change to the Archer MSA tax penalty, reducing the tax from 20% (as implemented by the ACA) to 15% (the pre-ACA amount).

- **Repeal of FSA Contribution Limit** – The Affordable Care Act revised the health FSA rules to impose a dollar limit on individuals’ pre-tax contributions to health FSAs. For 2017, the IRS has set the limit as \$2,600. Effective 2017, the Bill proposes to revert to the pre-ACA rule by eliminating this annual dollar limit on pre-tax contributions to health FSAs.
- **Increased HSA Contribution Limit** – To be HSA-eligible, an individual must be covered under a high deductible health plan (“HDHP”), which is major medical coverage that must meet a minimum annual deductible and maximum annual out-of-pocket limit set forth by the IRS. Under current law, contributions made to an HSA are not subject to taxation if they are below a certain threshold. This threshold is a separate dollar amount set forth by the IRS, which is higher than the minimum annual deductible required for the HDHP, but not as high as the maximum out of pocket limit required for the HDHP. Effective 2018, the Bill proposes to increase the HSA contribution limit so that it equals the maximum limit on the sum of the annual deductible and other out-of-pocket expenses applicable to HDHPs.

Groom Observation: The Bill would make the HSA limits align with the maximum out of pocket HDHP limit, allowing individuals to contribute a greater amount to their HSAs on a tax-free basis, and ensuring that an individual is able to contribute enough money to his/her HSA to pay for all expenses incurred prior to the point at which the HDHP is required to pay 100% for covered expenses.

- **Change Rules for Tax Deduction for Married Individuals** – Under current law, if two individuals are married to each other and each spouse has family coverage under separate HDHPs as of the first day of the month, both spouses are treated as having the family coverage with the lowest annual deductible for purposes of determining the amount of HSA contributions that can be deducted. Effective 2018, the Bill generally retains this rule but removes the reference to the coverage with the lowest annual deductible.

Groom Observation: As a practical matter, the rule likely does not have an impact on the amount of deduction that could be claimed by married individuals under current law, as the HSA contribution is a flat dollar amount set forth by the IRS. The change proposed in the Bill seems to be a technical correction and is also not likely to have a material impact on how the deduction operates.

- **Allow Both Spouses to Make Catch-up Contributions to Same HSA** – Current law provides for a contribution limit that is increased by \$1,000 for individuals who are age 55 or older. To the extent individuals are married, the contribution limit (without regard to the catch-up contribution) is divided equally between the

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spouses, unless they agree on a different division. This means that under current law, a spouse's catch-up contribution may only be contributed by the spouse to his/her own HSA, resulting in unnecessary administration.

The Bill eliminates this rule by providing that, effective 2018, for spouses who are both age 55 or older, the annual contribution limit that can be divided between them includes catch-up contributions for both spouses, if either spouse has family HDHP coverage. This means that a married couple can put all contributions, including the catch-up contributions for both individuals into a single HSA.

- **Medical Expenses Incurred Prior to HSA Being Established are Reimbursable** – Under current law, qualified medical expenses only include expenses incurred after the establishment of a health savings account. Effective 2018, the Bill proposes to allow expenses incurred prior to the establishment of the HSA to be considered qualified medical expenses if the HSA is established during the 60-day period beginning on the date that coverage under the HDHP begins. The Bill would limit such expenses to those incurred after the date that the HDHP is established. This would provide individuals who newly enroll in an HDHP with additional flexibility to establish an HSA after the date the HDHP coverage becomes effective without a downside.

Repeal of Other ACA Taxes

In addition to the tax changes described above, the Bill repeals many of the fees, taxes, and credits added by the Affordable Care Act. These changes include the following:

- **Repeal of Limitation on Deduction for Excess Remuneration Paid by Insurers** – Code section 162 allows a deduction for ordinary and necessary business expenses. The ACA revised these rules to generally limit the deduction allowable for remuneration paid by health insurance providers to \$500,000. Effective 2017, the Bill proposes to remove this dollar limitation on the deduction.
- **Repeal of Tanning Tax** – The ACA implemented a 10% tax on amounts paid for indoor tanning services. Effective July 1, 2017, the Bill proposes to eliminate this tax.
- **Repeal of Fee on Prescription Medications** – The ACA imposes an annual fee on manufacturers and importers of branded prescription drugs. Effective 2017, the Bill proposes to eliminate this fee.
- **Repeal of Health Insurer Fee** – Section 9010 of the ACA imposes an annual fee on health insurers with respect to premiums attributable to their U.S. health risks. Effective 2017, the Bill proposes to eliminate this fee.
- **Repeal of Net Investment Income Tax** – The ACA implemented a 3.8% tax on net investment income of individuals, trusts, and estates, subject to certain limitations. Effective 2017, the Bill proposes to eliminate this tax.
- **Limitation and Repeal of Small Business Tax Credit** – The ACA allows for a credit to be paid to small employers who provide health insurance, generally based on the amount of nonelective employer contributions towards the cost of health care. Effective 2018, the Bill proposes to limit the credit so that it does not apply to amounts paid towards the cost of a health plan that includes coverage for abortions (except in certain instances). Effective 2020, the Bill proposes to eliminate the credit completely.

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- **Postponement of Excise Tax on High Cost Health Coverage (Cadillac Tax)** – The ACA imposes an excise tax on high cost employer-sponsored health coverage. Pursuant to delays approved by Congress, the tax has not yet been implemented. The Bill proposes to further delay this tax, providing that it shall not apply from 2018 through 2025.
- **Repeal of Medical Device Excise Tax** – The ACA imposes a 2.3% tax on the sale of taxable medical devices by manufacturers, producers, or importers. Effective 2017, the Bill proposes to eliminate this tax.
- **Repeal of Elimination of Deduction for Part D-Related Expenses** – Code section 139A, as amended by the ACA, generally provides that retiree drug subsidies are excludible from a plan sponsor’s gross income, except that expenses incurred with respect to the subsidies, that are taken into account in determining the amount of the subsidies (*i.e.*, prescription drug costs), are generally not deductible. Effective 2017, the Bill proposes to revert to the pre-ACA rule, allowing expenses taken into account in determining the amount of the subsidies to be part of the deduction.
- **Reduction of Income Threshold for Medical Care Expense Deduction** – Code section 213 allows individuals to claim an itemized deduction for unreimbursed medical expenses, to the extent that the expenses exceed a certain threshold. The ACA increased the applicable threshold from 7.5% to 10%. Effective 2017, the Bill proposes to reduce the threshold to 5.8%.
- **Repeal of Medicare Tax Increase** – The ACA imposes an additional 0.9% Medicare tax on employees and self-employed individuals with income above a certain threshold. Effective 2022, the Bill proposes to eliminate this additional Medicare tax.

Changes to Medicaid

The Bill, as amended by the Manager’s Amendment, makes significant structural changes to the Medicaid program by eliminating increased federal funds for the ACA’s Medicaid Expansion and shifting the federal payment methodology from the current federal matching program to a per capita-cap federal payment approach or block grants, at the option of the state. The Bill also provides additional funding for specific safety net providers and limits Medicaid eligibility for certain individuals.

- **Medicaid Expansion**

The ACA expanded Medicaid by providing enhanced federal funding to states that covered childless adults up to 133% of the federal poverty level (referred to as “expansion enrollees”) for whom the federal government would match state funds for this population at 90% or more. For a state with expansion enrollees who are enrolled before December 31, 2017 and who do not have more than a month break in eligibility for Medicaid, the state will continue to receive the enhanced federal match for these ‘grandfathered’ expansion enrollees, but only if the state expanded Medicaid before March 1, 2017. After December 31, 2017, states that choose to enroll ACA expansion enrollees will only receive the traditional match, which in many cases will be a significant reduction in federal funding for this population. Further, after December 31, 2017, a state would no longer be able to cover individuals who are under 65 years of age and whose income exceeds 133% of the poverty line. As an additional layer of limitation and change, beginning on October 1, 2017, the Bill would require states to redetermine eligibility for ACA expansion enrollees at least once every six months and after December 31, 2019, the EHB requirements will no longer apply to the Medicaid

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benchmark plan. The Manager's Amendment also allows states to elect to condition medical assistance for certain individuals (nondisabled, nonelderly, and non-pregnant adults) on satisfying a work requirement. States that implement a work requirement will receive an increased federal match of five percent for the administrative costs associated with implementing the work requirement.

➤ **Per Capita Funding**

One of the most significant changes in Medicaid included in the Manager's Amendment is the provision allowing states the option to receive block grants instead of a per capita-based caps on federal payments, beginning in fiscal year 2020. Under the per capita-based cap funding, the base year for determining the states' cap level would be fiscal year 2016, adjusted to 2019 levels using the medical care component of the consumer price index ("CPI") for all urban consumers to set targeted spending for each enrollee group (elderly, blind and disabled, children, expansion enrollees, and other nonelderly, nondisabled, non-expansion adults). Any state that exceeds the cap for a year will face reduced payments the following fiscal year, however there are certain expenditures that are excluded from the per capita-based cap. If a state chooses the block grant option instead, the election is for a 10-fiscal year period and would fund the state's adult and child populations. States choosing a block grant would have some flexibility in the adult and child populations and the services covered under the program. States are required to submit a plan to HHS, however that plan would be deemed approved unless the Secretary of HHS finds within 30 days that the plan is incomplete or actuarially unsound. Block grants would not be available for the elderly and the disabled. The Bill includes a formula for calculating the funding under the block grant.

➤ **Additional Limits and Funding**

As an additional restriction on Medicaid eligibility (which has received some attention), beginning January 1, 2020, states are required to include lottery winnings (for lotteries occurring after January 1, 2020) or certain lump sum income in an individual's modified adjusted gross income ("MAGI"). Also, effective beginning October 1, 2017, eligibility for Medicaid will begin the month in which an individual applied for coverage, rather than beginning three months before the individual applied for Medicaid coverage.

The Bill provides additional funding for non-expansion states to make payments to safety net providers, beginning in fiscal year 2018 and ending in fiscal year 2022. These non-expansion states will receive a 100% federal match for fiscal quarters in calendar years 2018 through 2021 and a 95% match for calendar quarters in fiscal year 2022 for provider payment adjustments, up to the state's annual allotment limitation. The bill also repeals the reduction in Medicaid DSH payments; for non-expansion states, the reductions to DSH payments would end immediately, and for expansion states, the reductions to DSH payments continue to apply through fiscal year 2019.

Groom observation: With the cuts to the federal funds for the expanded ACA enrollee population, many states will find it challenging to continue covering this population. In addition, because of the 'churn' in the Medicaid population, it is likely that the expanded ACA enrollee population will dramatically decrease over a few years, particularly with the new requirement to redetermine eligibility every six months for this population. Another challenge for states will be the change in Medicaid funding to a per capita cap or block grant, under which states will be limited in the amount of federal funding for their Medicaid enrollment and will undoubtedly have to cut the number of individuals covered under the Medicaid program in their state. The Congressional Budget Office ("CBO") estimated a savings of \$880 billion over the 2017 to 2026 time period in federal funding for Medicaid as a result of these changes, with 14 million fewer Medicaid enrollees.

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