

update

Compliance News for Multiemployer Plans

March 9, 2017

House Publishes Affordable Care Act Repeal and Replace Legislation

On March 6, 2017, leadership in the U.S. House of Representatives released draft legislation to “repeal and replace” certain aspects of the Affordable Care Act. The legislation, called the “American Health Care Act,”¹ is drafted as a budget reconciliation bill, a form that enables it to pass the U.S. Senate with a simple majority vote.² While this legislation appears to have the backing of the new administration, it is not clear at this time whether this bill will pass the House or the Senate and be enacted into law.

This *Update* focuses on how the bill, if enacted, would affect group health plans. It also summarizes other features of the bill, including changes to the individual insurance market, the new age-based tax credits that individuals could use to purchase health coverage and the restructuring of Medicaid.

Background on Budget Reconciliation

Budget reconciliation was created by Congress to allow expedited consideration of certain tax, spending and debt-limit legislation. Under budget reconciliation, Congress could repeal the parts of the Affordable Care Act that have a budgetary impact. This includes taxes or fees that raise money as well as expenditures by the federal government. Due to complicated rules governing budget reconciliation, Congress could not repeal portions of the Affordable Care Act that do not affect the budget, such as the mandate to cover dependent children to age 26.

Provisions in the House Budget Reconciliation Bill That Affect Employers and Plan Sponsors

Individual Shared Responsibility Penalty

The tax penalty for not having health coverage — the greater of \$695 or a percentage of income (indexed) — would be reduced to zero, as of January 1, 2016. Replacing the individual mandate would be a new continuous coverage requirement under which, beginning in 2019, individuals would pay a 30 percent premium surcharge if they have a coverage gap of more than 63 days during a 12-month look-back period. The surcharge would last for the entire plan year. The surcharge would take effect in 2018 for mid-year enrollments.



Health Compliance News Highlights:

- The House leadership has released legislation to repeal and replace the Affordable Care Act.
- The House bill would eliminate the employer penalty but not the associated reporting requirements.
- The House bill would delay the 40 percent excise tax on high-cost health plans from 2020 to 2025 but would not repeal it outright.
- It is unclear whether this bill will pass the House and move on to the Senate. The leadership is hoping for quick action, ideally moving legislation through the House and Senate by April 7.

¹ Information about the legislation is available on the [Ways and Means Committee website](#) and the [Energy and Commerce Committee website](#).

² For background information on the budget reconciliation process, see Segal Consulting's December 22, 2016 *Update*, "[Congress Likely to Amend Affordable Care Act in 2017](#)."

Employer Shared Responsibility Penalty

Like the individual mandate, the amount of the employer tax penalty — the original \$2,000 or \$3,000 penalties under Internal Revenue Code (IRC) Section 4980H(a) and Section 4980H(b) — would be reduced to zero, as of January 1, 2016. If the penalty were to be repealed, the rules related to it would also be eliminated, including the 30-hour rule for full-time employees.

40 Percent Excise Tax on High-Cost Health Plans

The bill would delay the excise tax from 2020 to 2025, but would not repeal it. The bill does not include a cap on the income tax exclusion for employer-sponsored coverage, which had previously been proposed in some Republican policy papers.

Various Provisions Affecting Account-Based Plans

These provisions would affect account-based plans:

- The salary reduction limitation for Health Flexible Spending Arrangements (FSAs) (\$2,600 in 2017) would be eliminated for tax years starting in 2018.
- Several provisions effective in 2018 would encourage the use of Health Savings Accounts (HSAs). The maximum contribution limit to HSAs would be increased significantly to the out-of-pocket limit (in 2017, \$6,550 for single coverage and \$13,100 for family coverage). Both spouses would be able to make catch-up contributions to a single HSA, and certain expenses incurred before the HSA was established would be reimbursable.
- The penalty on non-qualified distributions from HSAs would be decreased from 20 percent to the pre-Affordable Care Act level of 10 percent, effective for distributions made in 2018.

Over-the-Counter Medications

The requirement that over-the-counter medications cannot be reimbursed without a prescription would be eliminated, making these expenses reimbursable without a prescription for tax years starting in 2018. This rule affects both health plans and individual accounts such as FSAs or Health Reimbursement Arrangements.

Health Insurer Tax

The health insurance provider tax, which results in an increase in premiums for insured group health plans, would be repealed after December 31, 2017. (Congress previously suspended the tax for 2017.)

Non-Deductibility of Medicare Part D Retiree Drug Subsidy (RDS)

The Affordable Care Act eliminated the ability of plan sponsors to take a tax deduction for prescription drug expenses reimbursed by the RDS program. These expenses would become tax deductible again after December 31, 2017.

The Medicare Part D program itself would not be modified by this budget reconciliation bill. Therefore, the RDS and Employer Group Waiver Programs (EGWPs), and funding for them, are unlikely to change in the immediate future.

The State Health Insurance Exchanges/Federal Marketplace

The state Exchanges/federal Marketplace would not be eliminated. However, the current income-based subsidies that help individuals purchase coverage in the Exchanges/Marketplace would be eliminated starting in 2020, as would the cost-sharing assistance available to low-income individuals purchasing coverage. In addition, individuals who receive a subsidy in error in 2018 and 2019 would have to pay back all of the excess subsidy. (Under current law, there were limits on the amount of excess subsidy that households with income under 400 percent of the federal poverty level have to repay.)

Starting in 2020, the bill would eliminate the requirement that plans meet the Affordable Care Act's metal levels, which are determined by actuarial value (bronze/silver/gold/premium plan levels), and allow states to regulate the various health plan offerings.

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The bill also creates a new age-based tax credit, which could be used to purchase individual insurance coverage in either the individual market or an Exchange/Marketplace or to pay unsubsidized premiums for coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA). The credits are available to individuals who do not have other governmental coverage or an offer of employer-sponsored coverage. The credit could also be used to purchase catastrophic-only plans. Special rules would apply with respect to Qualified Small Employer Health Reimbursement Arrangements (QSEHRAs) and HSAs.

Credits Available to Individuals Without Other Governmental Coverage or an Offer of Employer-Sponsored Coverage

Age	Annual Credit Amount
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 additive and capped at \$14,000 for a family. The credits would be available in full to those making up to \$75,000 per year (\$150,000 for joint filers) and would phase out for those with higher incomes. Like the current subsidies, the credits could be paid directly to insurers. Unlike the current subsidies, the new tax credits would be capped at the above dollar amounts and would not assure the purchase of a particular plan (currently, the second lowest-cost silver plan).

Age-Rating for Individual Insurance and Small Group Plans

For plan years beginning on or after January 1, 2018, the bill would change the age rating ratio from 3:1 to 5:1, thus permitting wider differential between premium charges for young adults and older adults.

Medicaid Expansion

Currently, 31 states and the District of Columbia have adopted the optional state Medicaid expansion under which they cover individuals with incomes up to 138 percent of the federal poverty level without regard to categorical eligibility (e.g., pregnant women, children). As of December 31, 2019, no state could elect this expansion. In addition, the enhanced federal support that the federal government pays for individuals newly eligible for Medicaid under these expansion programs would only be available for individuals enrolled in Medicaid as of December 31, 2019, and only as long as they do not have a break in coverage of more than one month. The Medicaid program would convert from an entitlement program to one with a federal cap beginning with fiscal year 2020 (which begins October 1, 2019). Under the new per-capita-cap structure, the federal government would provide a certain amount of funding per eligible beneficiary, and the states would have to work within that cap or provide additional funding of their own.

Taxes

The following tax provisions would be repealed after December 31, 2017: the medical device tax, the fee on manufacturers and importers of branded prescription drugs, the Medicare payroll tax for certain high-income individuals (.9 percent) and the Medicare tax on investment income (3.8 percent).

The tax provision that sets the threshold for deducting medical expenses on personal income tax returns would be lowered from the current 10 percent of adjusted gross income to the pre-Affordable Care Act level of 7.5 percent.

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The bill would also repeal the Affordable Care Act's limitation on the deduction of remuneration paid to health insurance executives (currently \$500,000).

Small Business Tax Credit

This tax credit, available to very small employers (those with fewer than 25 full-time equivalent employees) that purchase coverage in the Exchanges/Marketplace and whose employees earn wages below a certain amount (\$50,000 a year per full-time equivalent (indexed annually), would be repealed for taxable years beginning after December 31, 2019.

Patient and State Stability Fund

The bill would create a federally funded Patient and State Stability Fund, which could be used by a state for various purposes, such as a high-risk pool.

Provisions Not Repealed in the House Budget Reconciliation Bill

Many provisions in the Affordable Care Act could not be repealed using the budget reconciliation process. Consequently, the requirements noted below are not addressed in the House bill.

W-2 Reporting of Health Coverage

The bill would not repeal the requirement that employers report the cost of coverage on an employee's W-2 form. Instead, it adds to the W-2 reporting requirement a new requirement that employers indicate the *months that an employee was eligible for group coverage*. This reporting apparently will be necessary because the new age-based tax credits are not available to individuals who are eligible for group health plan coverage.

Employer and Plan Reporting Requirements under IRC Section 6055 and 6056

The complex employer and plan reporting obligations under IRC Sections 6055 and 6056 (the 1094 and 1095 forms) would not be repealed. A summary of the bill from the House Ways and Means Committee states that when the current required reporting becomes redundant and is replaced by the new W-2 requirement mentioned above, the Treasury Department can stop enforcing reporting requirements that are not needed for tax purposes. However, plan sponsors should continue to prepare reporting until directed otherwise by the Internal Revenue Service.

Comparative Effectiveness Research Fees

These fees (sometime called the "PCORI" fees for the Patient Centered Outcomes Research Institute funded by the fees) would not be repealed. They continue to sunset in 2019 after being paid for seven plan years.

Coverage or Benefit Mandates

Many provisions in the Affordable Care Act could not be repealed using the budget reconciliation process. These include many provisions that directly affect group health plans,³ such as the following coverage or benefit mandates (not an exhaustive list):

- Extension of coverage to adult children to age 26;
- Ban on preexisting condition exclusions;
- Ban on annual and lifetime dollar limits on essential health benefits (EHB);⁴
- Ban on retroactive termination of coverage (*i.e.*, rescissions);

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³ Retiree-only group health plans are already exempt from many of these requirements. The budget reconciliation bill would not change this exemption.

⁴ EHBs are defined in the Affordable Care Act to include 10 services: Ambulatory patient services, emergency services, hospitalization, pregnancy, maternity, and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services, laboratory services, preventive benefits, and pediatric services, including oral and vision care.

- Ban on waiting periods exceeding 90 days;
- Requirement to provide a Summary of Benefits and Coverage (SBC);
- Requirement to pay for certain preventive services without cost sharing⁵ (applicable to non-grandfathered plans);
- Cost-sharing limit (applicable to non-grandfathered plans);
- Revised internal appeals procedures and external review by an Independent Review Organization (IRO) (applicable to non-grandfathered plans);
- Provisions governing payment for emergency room services in hospitals (applicable to non-grandfathered plans);
- Coverage for routine patient costs incurred in connection with certain approved clinical trials for cancer or other life-threatening conditions (applicable to non-grandfathered plans); and
- Provider nondiscrimination rules (applicable to non-grandfathered plans).

Section 1557 Nondiscrimination Requirements

Nondiscrimination requirements under Section 1557 of the Affordable Care Act also could not be repealed through budget reconciliation, but the final regulations released in May 2016 could be re-proposed. These rules prohibit covered entities (including plans that receive the Medicare Part D RDS program) from discriminating on the basis of race, color, national origin, sex, age or disability. The most controversial aspect of these rules is the interpretation that discrimination on the basis of sex encompasses discrimination on the basis of gender identity. In effect, that requires covered entities to cover transgender health benefits.⁶ Other provisions in these regulations require notices, protections for individuals with limited English proficiency and require that electronic health systems, such as websites, be accessible to those with a disability.

Risk-Stabilization Programs

Collections and expenditures under the three risk-stabilization programs created by the Affordable Care Act (reinsurance, risk adjustment and risk corridors) would not be affected by this budget reconciliation bill. Transitional reinsurance expired in 2016, and the collection efforts in 2017 would not be affected by this bill. Litigation concerning some of these programs is ongoing.

Next Steps

The House Ways and Means Committee approved its bill in the early morning hours of March 9, 2017. The House Energy and Commerce Committee approved its bill that same afternoon after a marathon session lasting over 27 hours. The two bills will now be considered by the House Budget Committee. The Senate could take up this bill or one of its own drafting.

While President Trump has spoken favorably about the bill, it has met criticism from both Democratic and Republican legislators, so its fate is uncertain. The House and Senate leadership hope to move a bill through the House and the Senate by April 7, 2017, the start of a two-week congressional recess.

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⁵ While this provision in its entirety could not be repealed through budget reconciliation, many believe that the incoming administration might amend the list of required women’s preventive services to, for example, eliminate or modify the requirement to pay for all FDA-approved contraception methods. This list was created by the Health Resources & Services Administration, which is part of the Department of Health and Human Services. Additionally, the administration might seek to expand the group of plan sponsors who could decline to provide this coverage (or other coverage) for religious or moral reasons.

⁶ The Department of Health and Human Services is currently enjoined by court order from enforcing this aspect of the final rule.

How Segal Can Help

Segal will keep you informed about developments related to the Affordable Care Act. As always, trustees should rely on fund counsel for authoritative advice on laws and regulations.

Questions?

To discuss how possible changes to the Affordable Care Act could affect your plan, please contact your Segal consultant or the [Segal office nearest you](#).

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