

update

Compliance News for Staff Plans

May 11, 2017

House Passes Legislation to Repeal and Replace Aspects of the Affordable Care Act

On May 4, 2017, the U.S. House of Representatives passed the American Health Care Act (HR 1628) by a slim majority (217-213). The efforts to repeal and replace the Affordable Care Act now move to the Senate. HR 1628 is drafted as a budget reconciliation bill, which can be passed by the U.S. Senate with a simple majority vote.¹ However, the Senate is likely to take some time to develop its own version. Many of the same tensions between conservative and more moderate Republicans that delayed House action will affect not only the Senate bill's content but whether, and how quickly, it can pass the Senate. If the Senate passes a bill, it is likely to be different from the House's version. In that case, either the bills go to a conference committee to work out the differences or the House would have to pass the Senate's bill.

Although significant changes are expected as this legislation moves through the Senate, this *Update* focuses on how the House-passed bill 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 extend coverage to dependent children until they reach age 26. As this bill moves through the Senate, there will be many discussions about which provisions in the House-passed bill will be allowed under the Senate rules.

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

State Waivers of Federal Requirements Related to "Essential Health Benefits"

A late amendment to the bill would permit states to apply for a waiver from the detailed federal requirements establishing parameters for how states define the package of "essential health benefits" that plans in the individual and small group



Health Compliance News Highlights:

- The House bill would eliminate the employer penalty but not the associated reporting requirements.
- The 40 percent excise tax on high-cost health plans would be delayed from 2020 to 2026, but would not be repealed outright.
- The House bill could result in the imposition of annual and lifetime dollar limits on a wider range of benefits than is permissible today.
- Significant changes are expected as this legislation moves through the Senate.

¹ 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.](#)"

markets must provide.² While self-insured group health plans and large insured group plans are not required to offer these benefits, the definition of essential health benefits is nonetheless extremely important for two reasons. First, the Affordable Care Act's prohibition on annual and lifetime dollar limits applies only to those benefits that are deemed essential health benefits. Second, the cost-sharing limits that apply to non-grandfathered plans apply only to benefits that are deemed essential health benefits.

Currently, plan sponsors of group health plans can choose to follow any state's definition of essential health benefits in determining whether any dollar limits in the plan are permissible and in determining what out-of-pocket expenses must count toward the cost-sharing limit. If any state receives such a waiver for 2020 and beyond and chooses to define essential health benefits narrowly, it appears that plan sponsors would be able to select that definition. This could result in the imposition of dollar limits on a wider range of benefits than is permissible today and in excluding more out-of-pocket costs from a non-grandfathered plan's cost-sharing limit.

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, retroactive to January 1, 2016. Replacing the individual mandate would be a new continuous coverage requirement under which individuals would pay a 30 percent premium surcharge for individual market coverage 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 and then apply to open enrollments beginning in 2019.

A late amendment to the bill would permit states to apply for a waiver from the continuous-coverage surcharge under certain circumstances. States could permit insurers in the individual market to set premiums based on health status (e.g., medical condition and claims history) instead of the surcharge if the state has in place a high-risk pool or participates in the "Federal invisible risk sharing program." If an individual has continuous coverage, they could not be charged a higher premium based on health status.

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, retroactive to January 1, 2016. If the penalty were to be repealed, the rules related to it would also be rendered obsolete, including the 30-hour rule for defining full-time employees.

40 Percent Excise Tax on High-Cost Health Plans

The bill would delay the excise tax from 2020 to 2026, but would not repeal it. The bill does not include a cap on the income tax exclusion available to individual taxpayers 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 statutory salary reduction limitation for Health Flexible Spending Arrangements (FSAs) (\$2,600 in 2017) would be eliminated for tax years starting in 2017. Employers would still be able to limit the amount contributed to an FSA.
- Effective in 2018, the maximum contribution to Health Savings Accounts (HSAs) would be increased significantly to the out-of-pocket limit (in 2018, \$6,650 for single coverage and \$13,300 for family coverage).

“The bill would delay the excise tax [on high-cost health plans] from 2020 to 2026, but would not repeal it.”

² Essential health benefits 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.

- Starting in 2018, two people married to each other would be able to make catch-up contributions to a single HSA, and certain expenses incurred before the HSA was established would be reimbursable to the individual.
- 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 2017.

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 2017. 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, 2016. Congress already suspended the tax for 2017, but this bill repeals it permanently.

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, 2016.

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.³ 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 are 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 (bronze, silver, gold and platinum), which are determined by actuarial value, and allow states to regulate the various health plan offerings. The bill also creates a new age-based tax credit (noted in the table on the next page), which could be used to purchase individual insurance coverage in either the individual market or an Exchange/Marketplace. The credits would be 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.

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).

“The state Exchanges/federal Marketplace would not be eliminated. However, the current income-based subsidies that help individuals purchase coverage would be eliminated starting in 2020, as would the cost-sharing assistance available to low-income individuals purchasing coverage.”³

³ The Trump Administration has not committed to paying these cost-sharing subsidies beyond May 2017. If insurers do not continue to receive these subsidies, they may decide to pull out of the Exchanges/Marketplace or increase premiums significantly to cover the loss of revenue.

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

Age Rating for Individual Insurance and Small Group Plans

For plan years beginning on or after January 1, 2018, the bill would permit wider differentials between premium charges for young adults and older adults by changing the age-rating ratio from 3:1 to 5:1. The bill would also permit states to apply for a waiver that would allow them to set a different ratio starting in 2018.

Medicaid

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). The bill would significantly change the ability of states to expand Medicaid eligibility and would cut the amount of Federal payments to states for the expansion program. In addition, 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 Affordable Care Act tax provisions would be repealed after December 31, 2016: the medical device tax, the fee on manufacturers and importers of branded prescription drugs, and the Medicare tax on investment income.⁴ However, the Medicare payroll tax for certain high-income individuals (0.9 percent) would be repealed effective in 2023.

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 5.8 percent starting in 2017. (Prior to enactment of the Affordable Care Act, it was 7.5 percent.)

The bill would also repeal the Affordable Care Act's limitation on the deduction of remuneration paid to health insurance executives (currently \$500,000) starting in 2017.

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.

“The following tax provisions would be repealed after December 31, 2016: the medical device tax, the fee on manufacturers and importers of branded prescription drugs, and the Medicare tax on investment income.”

⁴ The Medicare investment income tax is a 3.8 percent tax levied on the lesser of net investment income (e.g., dividends, capital gains) or the excess of modified adjusted gross income above \$200,000 for individuals, \$250,000 for couples filing jointly, and \$125,000 for spouses filing separately.

Patient and State Stability Fund/Federal Invisible Risk-Sharing Program

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. The bill also includes a Federal “invisible” risk-sharing program to provide payments to insurers for high claims incurred by enrollees.

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 would be necessary because the new age-based tax credits would not be 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 March 2017 summary of the draft 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,⁵ 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;⁶
- Ban on annual and lifetime dollar limits on essential health benefits;⁷
- Ban on retroactive termination of coverage (*i.e.*, rescissions);
- 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 sharing (applicable to non-grandfathered plans);
- Cost-sharing limit (applicable to non-grandfathered plans);

⁵ Retiree-only group health plans are already exempt from many of these requirements. The budget reconciliation bill would not change this exemption.

⁶ The House-passed bill does not outright repeal the ban on preexisting condition exclusions. As noted in the *Update*, it permits states to apply for waivers that would permit insurers to charge individuals who did not maintain continuous coverage more based on their health status.

⁷ As noted earlier in the *Update*, the rules governing these limits could be affected if any state received a waiver of the federal requirements relating to essential health benefits.

“Many provisions in the Affordable Care Act could *not* be repealed using the budget reconciliation process.”

- 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);
- Provider nondiscrimination rules (applicable to non-grandfathered plans); and
- Medical-loss ratio obligations for health insurers.

Section 1557 Nondiscrimination Requirements

Nondiscrimination requirements under Section 1557 of the Affordable Care Act also could not be repealed through budget reconciliation, but some aspects of the final regulations released in May 2016 are likely to 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.⁸ 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 (transitional 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.

How Segal Can Help

Segal will keep you informed about developments related to the Affordable Care Act. As always, plan sponsors should rely on their legal 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](#).

⁸ The Department of Health and Human Services is currently enjoined by court order from enforcing this aspect of the final rule.

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