

March 2017

Summary of House Discussion Draft, February 10, 2017

This summary describes key provisions of House Discussion Draft, dated February 10, 2017, reported in the media as a plan to repeal and replace the Affordable Care Act (ACA) through the Fiscal Year 2017 budget reconciliation process.

House Discussion Draft, February 10, 2017	
Date plan announced	February 10, 2017
Overall approach	<ul style="list-style-type: none"> • Repeal ACA mandates (2016), standards for minimum benefits (2020), and, premium and cost sharing subsidies (2020). • Modify ACA premium tax credits for 2018–2019 to increase amount for younger adults and reduce for older adults, also to apply to coverage sold outside of exchanges. In 2020, replace ACA income-based tax credits with flat tax credits adjusted for age. • Retain private market rules, including requirement to guarantee issue coverage, prohibition on discriminatory premiums and pre-existing condition exclusions, requirement to extend dependent coverage to age 26. Modify age rating limit to permit variation of 5:1, unless states adopt different ratios. In addition, permit pre-ACA transition plans (for which none of these rules apply) to continue indefinitely and to be sold to new enrollees outside of the marketplace. Transition plans are also eligible for premium tax credits (though not advance-payable) starting in 2018. • Retain health insurance marketplaces, annual Open Enrollment periods (OE), and special enrollment periods (SEPs). Plans first sold on or after January 1, 2014 can only be sold during OE and SEP, but transition plans can be sold at any time. • Impose late enrollment penalty for people who don't stay continuously covered. • Establish State Innovation Grants and Stability Program with federal funding of \$100 billion over 9 years. States may use funds to provide financial help to high-risk individuals, promote access to preventive services, provide cost sharing subsidies, and for other purposes • Rescind unobligated funds in Prevention and Public Health Fund at the end of Fiscal Year 2018. In addition, provide supplemental funding for community health centers of \$285 million for FY 2018 and specify that Hyde amendment applies to community health centers • Encourage use of Health Savings Accounts by increasing annual tax free contribution limit and through other changes • Eliminate enhanced FMAP for Medicaid expansion as of January 1, 2020 except for those enrolled as of December 31, 2019 • Convert federal Medicaid funding to a per capita allotment and limit growth beginning in 2020 using 2016 as a base year • Cap tax exclusion for employer-provided group health benefits • No change to Medicare benefit enhancements or provider/Medicare Advantage plan payment savings • Repeal Medicare HI tax increase and other ACA revenue provisions • Prohibit federal Medicaid funding for Planned Parenthood clinics
Individual mandate	<ul style="list-style-type: none"> • Tax penalty for not having minimum essential coverage is eliminated effective January 1, 2016

	<ul style="list-style-type: none"> • Late enrollment penalty (30% of otherwise applicable premium) applies for individuals buying non-group coverage who have not maintained continuous coverage. Continuous coverage is assessed during a 12-month look back period prior to the date of enrollment in new coverage. If individual had a lapse in coverage of 63 consecutive days or longer during the look back period, late enrollment penalty applies during the plan year in which the individual enrolls in new non-group coverage. (For SEP, penalty applies for the remainder of the plan year). Late enrollment penalty is effective for special enrollments during the 2018 plan year, for all other enrollments beginning with the 2019 plan year.
Premium subsidies to individuals	<ul style="list-style-type: none"> • For 2018-2019, modify premium tax credits as follows: <ul style="list-style-type: none"> ◦ Increase credit amounts for young adults with income above 150% FPL and decrease amounts for adults 50 and older above that income level. ◦ For end of year reconciliation of advance credits, the cap on repayment of excess advance payments does not apply. ◦ Tax credits cannot be used for plans that cover abortion. ◦ Premium tax credits can be used to purchase catastrophic plans. ◦ Premium tax credits can be used to purchase qualified health plans (i.e., covering essential health benefits) sold outside of the exchange, but are not advance-payable for such plans. • Starting in 2020, replace ACA income-based tax credits with flat tax credit adjusted for age. Credits are payable monthly; annual credit amounts are: <ul style="list-style-type: none"> ◦ \$2,000 per individual up to age 29 ◦ \$2,500 per individual age 30-39 ◦ \$3,000 per individual age 40-49 ◦ \$3,500 per individual age 50-59 ◦ \$4,000 per individual age 60 and older • Families can claim credits for up to 5 oldest members, up to limit of \$14,000 per year. • Amounts are indexed annually to CPI plus 1 percentage point. • U.S. citizens and legal immigrants who are not incarcerated and who are not eligible for coverage through an employer plan, Medicare, Medicaid or CHIP, TRICARE, or a health care sharing ministry, are eligible for tax credit. Married couples must file jointly to claim the credit. • Taxpayers who are also enrolled in qualified small employer health reimbursement arrangements (HRA) that apply to non-group coverage will have tax credit reduced, but not below zero, by the amount of the HRA benefit. • Premium tax credit can be applied to any eligible individual health insurance policy, including short term policies and transitional policies, sold on or off the exchange. In addition, credit can be applied to unsubsidized COBRA premiums. Eligible policies do not include those for which substantially all coverage is for excepted benefits; policies that cover abortion (with Hyde exceptions) are not eligible policies. The federal government must establish a program for making advance payment of tax credits no later than January 1, 2020. • Excess credit amounts (above the actual cost of individual coverage or COBRA policy) are payable to health savings accounts.
Cost sharing subsidies to individuals	<ul style="list-style-type: none"> • ACA cost sharing subsidies are repealed effective January 1, 2020.
Individual health insurance market rules	<ul style="list-style-type: none"> • Require guaranteed issue of all non-group health plans during annual open enrollment. Insurers also must offer 60-day special enrollment periods (SEP) for individuals after qualifying events. Pre-enrollment verification of SEP eligibility is required for plans offered through exchanges. Transition policies can continue to be sold year-round, can continue to deny coverage based on health status and can be sold to new enrollees, starting on the date of enactment. • For health plans first sold on or after January 1, 2014, ACA rating rules continue, except age rating of 5:1 is permitted unless states adopt a different ratio. Transitional policies sold to new applicants outside of the exchange can set premiums based on health status.

	<ul style="list-style-type: none"> Prohibit pre-existing condition exclusions in health plans first sold on or after January 1, 2014. Transitional policies sold to new applicants outside of the exchange can impose pre-existing condition exclusion periods.
Benefit design	<ul style="list-style-type: none"> ACA essential health benefit requirement sunsets on 12/31/2019. Starting in 2020, States may adopt essential health benefit requirements. No federal fallback standard in states that do not adopt benefit standards Prohibition on lifetime and annual dollar limits is not changed Limit on annual cost sharing is not changed; actuarial value requirements for non-group plans are not changed Requirement for individual and group plans to cover preventive benefits with no cost sharing is not changed. Requirement for all plans to apply in-network level of cost sharing for out-of-network emergency services is not changed Prohibit abortion coverage from being required. Federal premium tax credits cannot be applied to plans that cover abortion services, beyond those for saving the life of the woman or in cases of rape or incest (Hyde amendment). Nothing prevents an insurer from offering or an individual from buying separate policies to cover abortion as long as no premium tax credits are applied.
Women's health	<ul style="list-style-type: none"> ACA essential health benefit requirement sunsets on 12/31/2019, including maternity care. Starting in 2020, States may establish their own essential health benefit requirements. Requirement for individual and group plans to cover preventive benefits, such as contraception and cancer screenings, with no cost sharing is not changed. Retains ban on gender rating and pre-existing conditions exclusions, which historically have included pregnancy, prior C-section, and history of domestic violence. Prohibits federal Medicaid funding for Planned Parenthood clinics for one year, effective upon date of enactment. Provide supplemental funding for community health centers of \$285 million for FY 2018 and specify that Hyde amendment applies to community health centers. Prohibit abortion coverage from being required. Federal premium tax credits cannot be applied to plans that cover abortion services, beyond those for saving the life of the woman or in cases of rape or incest (Hyde amendment). Nothing prevents an insurer from offering or an individual from buying separate policies to cover abortion as long as no premium tax credits are applied.
Health Savings Accounts (HSAs)	<ul style="list-style-type: none"> Modify certain rules for HSAs, changes take effect January 1, 2018: <ul style="list-style-type: none"> Increase 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). Excess premium tax credit amounts contributed to an HSA do not count against the contribution limit. Additional catch up contribution of up to \$1,000 may be made by persons over age 55. Both spouses can make catch up contributions to the same HSA. Amounts withdrawn for qualified medical expenses are not subject to income tax. Qualified medical expense definition expanded to include over-the-counter medications and expenses incurred up to 60 days prior to date HSA was established Tax penalty for HSA withdrawals used for non-qualified expenses is reduced from 20% to 10%. -
High-risk pools	<ul style="list-style-type: none"> States may use Innovation and Stability Program grants to fund high-risk pools, and for other purposes
Selling insurance across state lines	<ul style="list-style-type: none"> No provision
Exchanges/ Insurance through associations	<ul style="list-style-type: none"> State exchanges continue, though premium tax credits can be used for non-group policies regardless of whether they are sold through an exchange Single risk pool rating requirement for plans first sold on or after January 1, 2014 is not changed. However, transitional plans can be renewed and sold to new enrollees outside of the exchange, effective upon date of enactment, and ACA rating rules do not apply to these plans.

Dependent coverage to age 26	<ul style="list-style-type: none"> Requirement to provide dependent coverage for children up to age 26 for all individual and group policies is not changed.
Other private insurance standards	<ul style="list-style-type: none"> Minimum medical loss ratio standards for all health plans are not changed. Requirement for all health plans to offer independent external review is not changed. Requirements for all plans to report transparency data, and to provide standard, easy-to-read summary of benefits and coverage are not changed.
Employer requirements and provisions	<ul style="list-style-type: none"> Tax penalty for large employers that do not provide health benefits is reduced to zero, retroactive to January 1, 2016 Effective January 1, 2020, individual income tax exemption for employer-provided health benefits is limited. A threshold equal to the 90th percentile of group health plan values is established for 2020. The value of employer-sponsored health benefits above the threshold provided to a taxpayer shall be included in the gross income of the taxpayer. Threshold amount is indexed annually by CPI plus 2 percentage points. The value of coverage includes both the employer- and employee-paid share. It also may include the amount of employer contributions under salary reduction elections under flexible spending arrangements (FSAs), and amounts contributed under qualified small employer health reimbursement arrangements. The value does not include employer contributions to long term care insurance, or to separate policies covering dental or vision benefits. The cap on the income tax exemption does not apply to job-based coverage provided to law enforcement officers or emergency medical responders. Wellness incentives permitted under the ACA are not changed Repeal tax credits for low-wage small employers, effective January 1, 2020.
Medicaid	<p><i>Financing</i></p> <ul style="list-style-type: none"> Codify that the Medicaid expansion is a state option; eliminate the enhanced match for the Medicaid expansion as of January 1, 2020 (except for individuals who were enrolled through the Medicaid expansion as of December 31, 2019 and who do not have a break in eligibility of more than one month). Convert federal Medicaid financing to a per capita cap beginning in FY 2020. <ul style="list-style-type: none"> Per enrollee caps for five enrollment groups—elderly, blind and disabled, children, expansion adults, and other adults—are based on 2016 expenditures (excluding administrative costs, DSH, and Medicare cost-sharing, and certain categories of individuals, including CHIP, those receiving services through Indian Health Services, those eligible for Breast and Cervical Cancer services, and partial-benefit enrollees) divided by full-year equivalent enrollees in each category and trended forward to 2019 by medical CPI plus 1 percentage point. For states opting to adopt the Medicaid expansion after 2016, the per enrollee amount for this group would be the same as the other adult group under the per capita cap. Per enrollee amounts are adjusted to exclude non-DSH supplemental payments The target expenditures in 2020 are calculated based on the 2019 per enrollee amounts for each enrollment group adjusted for non-DSH supplemental payments and increased by medical CPI plus 1 percentage point multiplied by the number of enrollees in each group. In 2021 and beyond, per enrollee amounts are based on the prior year amounts increased by medical CPI plus 1 percentage point. States with medical assistance expenditures exceeding the target amount for a fiscal year will have payments in the following fiscal year reduced by the amount of the excess payments. Provide 100% FMAP for MMIS and eligibility systems for FY 2018 and FY 2019 and increase other administrative matching to 60% for expenses related to implementing new data requirements. Repeal Medicaid DSH cuts

Other Changes

- Repeal the essential health benefits requirement for the expansion group as of December 31, 2019.
- Repeal increase in Medicaid eligibility to 138% FPL for children ages 6-19 as of December 31, 2019. Income eligibility for these children will revert to 105% FPL unless states have adopted a different eligibility level.
- Repeal hospital presumptive eligibility provisions effective January 1, 2020
- Repeal enhanced FMAP for the Community First Choice Option effective January 1, 2020
- Prohibit federal Medicaid funding for Planned Parenthood for one year, effective upon date of enactment

Medicare

Revenues

- Repeals the HI payroll tax on high earners
- Repeals the annual fee paid by branded prescription drug manufacturers
- Reinstates the tax deduction for employers who receive Part D retiree drug subsidy (RDS) payments to provide creditable prescription drug coverage to Medicare beneficiaries, beginning after December 31, 2016.

Coverage enhancements

- ACA benefit enhancements (no-cost preventive benefits; phased-in coverage in the Part D coverage gap) are not changed

Reductions to provider and plan payments

- ACA reductions to Medicare provider payments and Medicare Advantage payments are not changed

Other ACA provisions related to Medicare are not changed, including:

- Increase Medicare premiums (Parts B and D) for higher income beneficiaries (those with incomes above \$85,000/individual and \$170,000/couple).
- Authorize an Independent Payment Advisory Board to recommend ways to reduce Medicare spending if the rate of growth in Medicare spending exceeds a target growth rate.
- Establish various quality, payment and delivery system changes, including a new Center for Medicare and Medicaid Innovation to test, evaluate, and expand methods to control costs and promote quality of care.

State role

- States may determine age rating ratio; otherwise federal standard of 5:1 applies.
- States may define essential health benefits starting in 2020; otherwise no definition applies.
- Establish new State Innovation Grant and Stability Program. Funds can be used by states for financial help for high-risk individuals, stabilize private insurance premiums, promote access to preventive services, provide cost sharing subsidies, and for other purposes. \$100 billion over 9 years appropriated (\$15 billion per year for 2018-2019, \$10 billion per year for 2020-2026). State matching funding of 7% required in 2020, phasing up to 50% state match in 2026.
- State option to establish a state based health insurance exchange is not changed.
- State consumer assistance/ombudsman program is not changed, and is not funded.
- State option to establish a Basic Health Program is not changed. State option to obtain a five-year waiver of certain new health insurance requirements (Section 1332 waiver) is not changed.

	<ul style="list-style-type: none"> States continue to administer the Medicaid program with Federal matching funds available up to the federal cap.
Financing	<ul style="list-style-type: none"> ACA taxes repealed, effective January 1, 2017, except where otherwise noted: <ul style="list-style-type: none"> Tax penalties associated with individual and large employer mandate, reduced to zero effective on January 1, 2016 Cadillac tax on high-cost employer-sponsored group health plans repealed effective January 1, 2020 Increase in Medicare payroll tax (HI) rate on wages for high-wage individuals; also 3.8% tax on unearned income for high-income taxpayers Tax on tanning beds Tax on health insurers Tax on pharmaceutical manufacturers Excise tax on sale of medical devices, effective January 1, 2018 Provision excluding costs for over-the-counter drugs from being reimbursed through a tax preferred health savings account (HSA) Provision increasing the tax (from 10% to 20%) on HSA distributions that are not used for qualified medical expenses. Chronic care tax Codification of economic substance doctrine and penalties Annual limit on contributions to Flexible Spending Accounts (FSAs) repealed Annual limit on deduction for salary in excess of \$1 million paid to employees of publicly held corporations repealed New limit on income tax exclusion for employer-provided group health benefits starts 2020 Federal Medicaid funding capped, effective FY 2020; enhanced match for Medicaid expansion population eliminated beginning January 1, 2020; and Medicaid DSH cuts repealed, effective FY 2017
Sources of information	http://www.politico.com/f/?id=0000015a-70de-d2c6-a7db-78ff707e0000