COMMONWEALTH OF VIRGINIA

HOUSE OF DELEGATES
RICHMOND

APPROPRIATIONS COMMITTEE
9TH FLOOR, GENERAL ASSEMBLY BUILDING
CAPITOL SQUARE
POST OFFICE BOX 406
RICHMOND, VIRGINIA 23218
804-698-1590

S. CHRIS JONES, CHAIRMAN
ROBERT P. VAUGHN, STAFF DIRECTOR

March 10, 2017

MEMORANDUM

TO: Member, House of Delegates

FROM: Chairman S. Chris Jones

RE: Information on Federal Health Care Reform

As you know, the Congressional House Republicans released legislation this week to repeal and replace the federal Affordable Care Act (ACA). The budget we passed in February contemplated federal action and contained budget language creating a joint subcommittee of the House Appropriations and Senate Finance Committees to monitor, evaluate and respond to such legislation. However, we did not anticipate that Congressional action would occur prior to the completion of the enrollment of HB 1500. Nevertheless, I am sure that you and your constituents are anxious to understand the provisions of the federal legislation and determine how it will impact Virginia citizens and as well as the state budget.

To that end, I would like to share with you an analysis I received this week from the Virginia Hospital and Health Care Association (VHHA) on the proposed legislation. During the Session the VHHA indicated that they were actively monitoring the ACA repeal and replacement actions and would share information with us as they completed analysis. I think you will find that their analysis provides a good overview of the key provisions of the legislation without expressing opinions on its merits. I hope you will find it helpful. In addition, there are other sources of information on the proposed legislation that I have referenced at the end of this memo. As additional sources of information are available, I have asked staff to begin compiling the information so that it can be made available to you.

Virginia Hospital and Healthcare Association Analysis of Proposed Health Care Legislation

The review below was prepared by Matt Strader, the VHHA Director of Federal Affairs, on the latest Congressional legislation to repeal and replace the ACA.

Yesterday, Republicans on the House Energy and Commerce Committee (E+C) and the House Ways and Means Committee (W+M) separately released components of legislation entitled *The American Health Care Act* ("the legislation") to repeal and replace the Affordable Care Act (ACA). The legislation is similar in many respects to the draft bill leaked two weeks ago, but has several key differences and additional details. Markups are scheduled in both committees for Wednesday morning. Assuming both committees pass the legislation, the legislation will then move to the Budget Committee to be reconciled before going to the full House.

The E+C portion of the legislation implements significant changes to the Medicaid program, creates a new Patient and State Stability Fund (essentially a modified version of the previously discussed State Innovation Grants), and implements proposals to stabilize the insurance markets. The state option to expand Medicaid is repealed effective December 31, 2019. Non-expansion states do not appear to be prohibited from expanding until that date. After January 1, 2020, states would continue to receive enhanced funding for the expansion population enrolled prior to December 31, 2019, provided enrollees do not have a break in coverage greater than one month. New enrollees after this date would be covered at a state's traditional FMAP. Medicaid DSH cuts are eliminated, and the legislation provides $10 billion over five years to non-expansion states for safety net funding.

The legislation also converts Medicaid to a per capita allotment beginning in FY 2020. Funding would be based on each state's spending in FY 2016 for each enrollee category, including expansion adults, increased annually by the medical care component of the consumer price index. The legislation also implements new Medicaid data reporting requirements. DSH payments and administrative costs are not included in the cap, and certain populations are excluded.

To lower costs and stabilize state insurance markets, which states would resume responsibility over, the legislation creates a new Patient and State Stability Fund, which would provide funding to states for several outlined purposes. The legislation allocates $15 billion in 2018 and 2019 and $10 billion each year thereafter until 2026. Instead of an individual mandate, the legislation creates new continuous coverage incentives under which insurers would be able to charge a penalty amounting to 30 percent of premium costs for individuals who were not enrolled in coverage for longer than 63 days. The legislation also repeals actuarial value standards and sets an age rating ratio of five-to-one.

The W+M portion of the legislation eliminates the penalties for the individual and employer mandates and repeals most ACA taxes and fees. It also makes changes to Health Savings Accounts (HSAs) including increasing the maximum contribution limit, allowing both spouses to make catch up contributions, and treating expenses incurred within 60 days of plan enrollment as eligible expense. The largest component of the W+M section deals with the creation of new tax credits to assist individuals purchase insurance in the individual market. The credits are advanceable and refundable and range from $2,000 for individuals 30 years or younger to $4,000 for individuals over age 60. The credits are additive for a family and capped at $14,000. Individuals earning $75,000 ($150,000 for joint filers) or less would be eligible for the full amount, and the credits would be phased out by $100 for each $1,000 in income above that level.

<u>The American Health Care Act – Energy and Commerce</u>

- Appropriations for the Prevention and Public Health Fund are repealed for fiscal year 2019 and thereafter, and any unobligated balances are rescinded.
- The legislation provides $422 million in additional funding for Community Health Centers.
- States' authority to make presumptive eligibility determinations is repealed.
- The mandatory Medicaid income eligibility level for low-income children is reverted to 100 percent FPL.
- The six percentage point bonus for community-based attendant services and supports is repealed.
- Medicaid expansion is repealed effective December 31, 2019.
  - The enhanced FMAP for the expansion population is repeal unless individuals were enrolled prior to this date and do not have a break in eligibility for more than one month after that date.

- States can enroll newly eligible individuals at their traditional FMAP thereafter.
- The legislation makes changes to the expansion state federal matching rate for states that expanded Medicaid prior to March 23, 2010.
- The requirement that states provide the same essential health benefits in the Medicaid program is repealed.

- Medicaid DSH cuts are repealed for non-expansion states in 2018 and expansion states in 2020.
- Imposes new Medicaid eligibility restrictions on lottery winners.
- Retroactive coverage of Medicaid benefits is limited to the month in which an applicant applies.
- Provides $10 billion over five years to non-expansion states for safety net funding.
  - Non-expansion states would receive an increased matching rate of 100% for CY 2018 through 2021 and 95% for CY 2022.
  - Each state's allotment would be determined according to the number of individuals in the state with incomes below 138% FPL in 2015 compared to the total number of these individuals in non-expansion states.
- States would be required to conduct eligibility determinations every 6 months and provides a temporary 5 percent FMAP increase to assist in compliance.
- Medicaid is converted to a per capita allotment beginning in FY 2020.
  - The base year would established using each states' spending in FY 201y for each enrollee category (elderly, blind and disabled, children, non-expansion adults, and expansion adults).
  - The allotment would be increased annually by the percentage increase in the medical care component of the consumer price index.
  - Any state that spends more than the targeted aggregate amount would receive reduced payments in the following year.
  - DSH payments and administrative costs would be exempt from the cap.
  - Certain populations such as individuals covered under CHIP Medicaid expansion and dual-eligible individuals eligible for coverage of Medicare cost sharing would also be exempt.
  - New reporting requirements including data on medical assistance expenditures within categories of services and categories of enrollees would be implemented.
- The cost-sharing subsidies for insurers are repealed.
- A new Patient and State Stability Fund is created with $15 billion allocated in 2018 and 2019 and $10 billion each year from 2020 through 2026.
  - States can use the funds to:
    - Provide financial assistance to high-risk individuals so they can purchase coverage in the individual marketplace;
    - Provide incentives to the appropriate entities to help stabilize premiums for health insurance coverage;
    - Help reduce the costs of providing health insurance in the individual and small group markets for individual with a high rate of utilization;
    - Promote participation in the individual market;
    - Promote access to preventive services;
    - Provide payments to health care providers for the provision of health care services (TBD by the Administrator); and
    - Provide assistance to reduce out-of-pocket costs for individuals.
  - Allocations are based on two criteria:
    - 85% of the funding is based on incurred claims for benefit year 2015 and 2016 which provides for the latest medical loss ratio data available that reflects costs for the individual market; and

    - 15% is based on a state either having an increase in the uninsured population for individuals below 100% FPL in 2013-2015 or fewer than three plans offering coverage in in the individual market in 2017
- A new continuous coverage incentive is created where by insurers can utilize a 12-month lookback period to determine if an individual was uninsured for more than 63 days. If so, the insurer can charge a penalty amounting to 30% of premium costs for 12 months.
- Actuarial values – the ACA's metal tiers [bronze, silver, gold, etc.] – are repealed.
- The age rating for insurance is established at five-to-one instead of the current three-to-one.

<u>American Health Care Act – Ways and Means</u>

- In 2018 and 2019, individuals who receive more premium tax credit than owed are required to repay the entire excess amount.
- Premium tax credits are made available for catastrophic-only plans and the schedule under which an individual's or family's share of premiums is determined by adjusting for household income and age is revised.
- The ACA's premium tax credits are repealed beginning in 2020.
- The ACA small business tax credit is repealed beginning in 2020.
- The individual and employer mandate penalties are zeroed out retroactively to cover the 2016 tax year.
- New advanceable, refundable tax credits are created.
    - Individuals lacking ESI or access to federal health care programs are eligible.
    - Credit amounts to:
        - $2,000 under age 30;
        - $2,500 between 30 and 39;
        - $3,000 between 40 and 49;
        - $3,500 between 50 and 59; and
        - $4,000 over age 60.
    - The credits are additive and capped at $14,000 for families.
    - The credits are adjusted by CPI+1 annually.
    - Individuals earning $75,000 or less ($150,000 for joint filers) are eligible for the full amount of the credit. The credit is reduced by $100 for every $1,000 in income above this threshold.
    - A new simplified system for reporting coverage on a W-2 will be developed.
- Several changes to HSAs are made including increasing the maximum contribution to $6,550 for individuals and $13,100 for families, allowing both spouses to make catch up contributions, and treating expenses made within 60 days of plan enrollment as eligible expenses.
- Implementation of the "Cadillac Tax" is delayed until taxable periods beginning after December 31, 2024.
- Taxes and fees implemented or modified by the ACA are repealed including:
    - The tax on over-the-counter medications
    - The increase tax on non-qualified HSA distributions;
    - Limitations on contributions to flexible spending accounts;
    - The medical device tax;
    - The increase in the adjusted gross income for the medical expense deduction;
    - The Medicare Hospital Insurance surtax;
    - The tanning tax;
    - The net investment tax;

  - The limit on the deduction of a coverage health insurance provider for compensation attributable to services performed by an applicable individual;
  - The annual fee on certain brand pharmaceutical manufacturers; and
  - The annual fee on health insurers.
- The business expenses deduction for retiree prescription drug costs is reinstated.

This legislation preserves the following insurance market reforms, including:

- Pre-existing conditions (Note: The bill modifies the existing requirements, by allowing insurers to vary premiums by up to 30 percent for those without continuous coverage.)
- Community rating by age (Note: States may opt-out of the federal standard if they so choose under certain circumstances.)
- The Under-26 mandate
- Prohibition on annual and lifetime limits
- Medical loss ratio requirements
- Preventive service mandate (including coverage of contraception)
- Insurance Exchanges

Listed below are additional resources which summarize the proposed federal legislation. Please feel free to contact me if you have additional questions.

https://waysandmeans.house.gov/wp-content/uploads/2017/03/03.06.17-Section-by-Section.pdf

http://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/documents/Section-by-Section%20Summary_Final.pdf

http://files.kff.org/attachment/Proposals-to-Replace-the-Affordable-Care-Act-Summary-of-the-American-Health-Care-Act

http://nashp.org/wp-content/uploads/2017/03/NASHP-ACARepealImpactsChart_MarchHouseBills_3.7.17.pdf