WASHINGTON
STRATEGIC
CONSULTING

MEMORANDUM

TO: WSC Clients

FROM: Ross Airington

DATE: June 22, 2017

RE: WSC Policy Update: Side-by-side comparison of House and Senate ACA Repeal Bills

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	House Bill (H.R. 1628)	Senate Bill (Discussion Draft)
Individual Mandate	• Tax penalty for not having minimum essential coverage is eliminated effective January 1, 2016. • Late enrollment penalty (30% of otherwise applicable premium) applies for individuals buying non-group coverage who have not maintained continuous creditable coverage.	• Tax penalty for not having minimum essential coverage is eliminated effective January 1, 2016. • Does not impose a late enrollment penalty.
Employer Mandate	• Tax penalty for large employers that do not provide health benefits is reduced to zero, retroactive to January 1, 2016 • Repeals tax credits for low-wage small employers, effective January 1, 2020.	• Tax penalty for large employers that do not provide health benefits is reduced to zero, retroactive to January 1, 2016 • Repeals tax credits for low-wage small employers, effective January 1, 2020.
Premium Subsidies	• Starting in 2020, replace ACA income-based tax credits with flat tax credit adjusted for age. Credits are payable monthly; annual credit amounts are: o $2,000 per individual up to age 29 o $2,500 per individual age 30-39 o $3,000 per individual age 40-49 o $3,500 per individual age 50-59 o $4,000 per individual age 60 and older • Amounts are indexed annually to CPI plus 1 percentage point. • Premium tax credit can be applied to any eligible individual health insurance policy – on or off the marketplace.	• Caps eligibility for premium tax credits at 350% FPL (current law: 400%), but makes credits available to individuals below 100% FPL. • Starting in 2020, replaces ACA income-based tax credits with an income-based tax credit adjusted for age. Amount of tax credit is determined by a tiered structure based on the percentage of the recipient's income he or she is expected to pay for coverage. • Examples of tiered structure: o Up to age 29 ▪ ≤ 100% FPL: 2% ▪ 350% FPL: 6.4% o Age 30-39 ▪ ≤ 100% FPL: 2% ▪ 350% FPL: 8.9%

		○ Age 40-49 ▪ ≤ 100% FPL: 2% ▪ 350% FPL: 12.5% ○ Age 50-59 ▪ ≤ 100% FPL: 2% ▪ 350% FPL: 15.8% ○ Over age 59 ▪ ≤ 100% FPL: 2% ▪ 350% FPL: 16.2% • Subsidy amounts are determined based on an actuarial value of 58% (down from current law value of 70%). • Lowers the "failsafe" at which secondary provisions under the ACA would apply. If total spending on premium subsidies exceeds 0.4% of GDP (down from 0.504% under current law) in years after 2018, the premium subsidies would grow more slowly.
Cost Sharing Subsidies	• ACA cost sharing subsidies are repealed effective January 1, 2020.	• ACA cost sharing subsidies are repealed effective January 1, 2020.
Individual Health Insurance Market Rules	• Continue ACA rating rules, except age rating of 5:1 is permitted starting January 1, 2018, unless states adopt a different ratio. • States that use Patient and State Stability Fund grants for high risk pools or reinsurance, or that participate in the Federal Invisible Risk Sharing Program (see bellow), can apply to waive community rating for individual market participants who do not maintain continuous coverage.	• Continue ACA rating rules, except age rating of 5:1 is permitted starting January 1, **2019**, unless states adopt a different ratio. • **States may not apply to waive community rating for individual market participants.**
Benefit Design	• ACA requirement to cover 10 essential health benefit categories is not changed; however, starting in 2020, states may apply for waivers to re-define essential health benefits. • Minimum medical loss ratio (MLR) standards for all health plans are not changed.	• ACA requirement to cover 10 essential health benefit categories is not changed; however, **beginning immediately**, states may apply for Sec. 1332 State Innovation Waivers to waive some of the ACA's insurance regulations (including Essential Health Benefits). • **Permits states to determine their own medical loss ratios**, beginning for plan years on or after January 1, 2019.
Medicaid Expansion	• Eliminates option to extend coverage to adults above 133% FPL effective December 31, 2017. • Limits the enhanced match for the Medicaid expansion to 133% FPL to	• Eliminates option to extend coverage to adults above 133% FPL effective December 31, 2017. • Limits the enhanced match for the Medicaid expansion to 133% FPL to states

	states that adopted expansion as of March 1, 2017, and sunset enhanced FMAP for those states as of January 1, 2020 (except for grandfathered enrollees 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). • For states that opt to expand after March 1, 2017, limits the enhanced match rate transition percentage to CY 2017 levels of 80% for as long as grandfathered enrollees remain eligible. • Does not phase out enhanced match rate for the existing expansion population past the current floor of 90% in 2020.	that adopted expansion as of March 1, 2017, and sunset enhanced FMAP for those states as of January 1, 2020 (except for grandfathered enrollees 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). • For states that opt to expand after March 1, 2017, limits the enhanced match rate transition percentage to CY 2017 levels of 80% **through 2023.** • Phases down the enhanced match rate for the expansion population past its current floor of 90% in 2020 to 85% in 2021, 80% in 2022, 75% in 2023. • Includes $10 billion in funding for nonexpansion states for 2018-2022. States may receive a 100% federal match (92% in 2022), up to their share of the allotment. State allotments are determined by the share of individuals below 138% FPL compared to other nonexpansion states.
Medicaid Financing	• Converts federal Medicaid financing to a per capita cap beginning in FY 2020. • The inflationary factor for the elderly and blind/disabled groups is medical CPI plus 1 percentage point. The inflationary factor for children, expansion adults, and other adults is medical CPI. • Does not make changes to permissible Medicaid provider taxes.	• Converts federal Medicaid financing to a per capita cap beginning in FY 2020. • Annual growth in caps would be initially tied to medical inflation (CPI-M) and then switched to general inflation (CPI-U) starting in 2025. • Reduces permissible Medicaid provider taxes from 6% under current law to 5.8% in FY 2021, 5.6% in FY 2022, 5.4% in FY 2023, 5.2% in FY 2024, and 5% in FY 2025 and future fiscal years.
Medicaid Block Grant Option	• States may elect Medicaid block grant instead of per capita cap for certain populations for a period of 10 fiscal years, beginning in FY 2020 – if option is not extended at the end of the 10 FY period, per capita cap provisions apply. o States may elect block grant for children and nonexpansion adults or only for nonexpansion adults. o States can set conditions of eligibility (except that states must cover mandatory pregnant women and children and infants born to eligible pregnant woman for 1 year, depending on the category elected). • The total block grant amount for the	• States may elect Medicaid block grant instead of per capita cap for certain populations for a period of 10 fiscal years, beginning in FY 2020 – if option is not extended at the end of the 10 FY period, per capita cap provisions apply.

	initial FY is based on the state's target per capita medical assistance expenditures for the FY multiplied by the number of enrollees in the category(ies) elected and the federal average medical assistance matching rate for the state for FY 2019. In subsequent FYs, the total block grant amount for the prior FY is increased by annual CPI for urban consumers. • The federal portion of block grant funds payable to states is based on the CHIP enhanced FMAP, with the state funding the difference. • States can rollover unused block grant funds into the next FY as long as they continue to elect the block grant option.	
Medicaid General	• Repeals hospital presumptive eligibility provisions and presumptive eligibility for expansion adults, effective January 1, 2020. • Requires states to perform eligibility redeterminations no less frequently than every 6 months beginning October 1, 2017. Provides 5% FMAP increase (from October 20177 through December 2019) for state administrative activities in connection with more frequent redeterminations. from October 2017 through December 2019. • Repeals the retroactive eligibility standard that requires states to begin the date of coverage up to three months prior to the month of application in the case of individuals who would have satisfied eligibility requirements at the earlier date. • Gives states the option of requiring some Medicaid recipients to work or pursue job training.	• Repeals hospital presumptive eligibility provisions and presumptive eligibility for expansion adults, effective January 1, 2020. • Gives states the option to perform eligibility redeterminations no less frequently than every 6 months beginning October 1, 2017. Provides 5% FMAP increase (from October 20177 through December 2019) for state administrative activities in connection with more frequent redeterminations. from October 2017 through December 2019. • Does not repeal retroactive eligibility standard. • Gives states the option of requiring some Medicaid recipients to work or pursue job training.
State Waivers	• Starting in 2018, states may apply for waivers to permit age rating ratios higher than 5:1 • Starting in 2020, states may apply for waivers to redefine essential health benefits for health insurance coverage offered in the individual and small group market.	• Starting in **2019,** states may apply for waivers to permit age rating ratios higher than 5:1. • Beginning immediately, states may apply for Sec. 1332 State Innovation Waivers to waive some of the ACA's insurance regulations (including Essential Health Benefits). A $2 billion incentive fund (2017-

	• Starting in 2019, or for Special Enrollment Period enrollments in 2018, states that use Patient and State Stability Fund grants may apply for waiver of the ACA community rating requirement. An additional $8 billion in Patient and State Stability grants will be allocated over 5 years to states that elect this waiver. o Under the waiver, states could allow insurers to use health status as a rating factor for applicants in the individual market who have not maintained continuous coverage. For these individuals, health status rating could be used instead of the 30% late enrollment penalty.	2019) is created to encourage states to apply for these waivers. • States may not waive ACA community rating requirements.
Medicaid DSH	• Repeals Medicaid DSH cuts for FY2020 - FY2025; exempts non-expansion states from DSH cuts for FY2018 - FY 2019.	• Repeals Medicaid DSH cuts for FY2020 - FY2025 • Non-expansion states receive an increase based on level of uninsured.
Revenues	• Tax penalties associated with individual and large employer mandate reduced to zero effective on January 1, 2016. • Delays the excise tax on high cost employer-sponsored health coverage (the "Cadillac Tax") until 2026. The tax would remain in effect for CY 2018, the first year of its implementation. • Repeals the high-income payroll tax on high earners, beginning after December 31, 2022. • Repeals the annual fee paid by branded prescription drug manufacturers, beginning after December 31, 2016.s • 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.	• Tax penalties associated with individual and large employer mandate reduced to zero effective on January 1, 2016. • Delays the excise tax on high cost employer-sponsored health coverage (the "Cadillac Tax") entirely from 2018 to 2026. • Repeals the annual fee paid by branded prescription drug manufacturers, beginning after December 31, 2016.

Market Stabilization and High-risk Pools	• Establishes a new Patient and State Stability Fund to provide state grants for high-risk individuals. o $100 billion over 9 years ($15 billion per year for 2018-2019, $10 billion per year for 2020-2026) for grants to states or, if states do not apply for these grants, for a default reinsurance program (see below); o $15 billion for the year 2020 to be used solely for maternity coverage and newborn care and mental health and substance use disorders. o $8 billion over 5 years (2018-2023) for states that elect community rating waivers to provide financial assistance to people whose premiums are surcharged based on health status under that waiver; o State matching funding of 7% is required in 2020, phasing up to 50% in 2026. • Allocates $15 billion (2018-2026) for a default reinsurance program (called a "Federal Invisible Risk Sharing Program" (FIRSP)) to offset claims costs of certain high-risk individuals. In states that do not successfully apply for Patient and State Stability Fund grants, the funds for those states will be added to the FIRSP allotment.	• Establishes a new State Stability and Innovation Program to provide state grants for high-risk individuals. o $62 billion over 8 years ($8 billion for 2019, $14 billion per year for 2020-2021, $6 billion per year for 2022-2023, $5 billion per year for 2024-2025, $4 billion for 2026) in state grants that may be used for high-risk pools, insurance market stabilization, direct payments to providers, or assistance with out-of-pocket costs. o **$2 billion for the year 2018 to be used solely for mental health and substance abuse disorders.** o Does not allocate additional funds for states that elect community rating waivers, as these are not authorized by the bill. o State matching funding of 7% is required in 2022, phasing up to 35% in 2026. o States may keep their allotments for two years, but unspent funds after that point may be re-allocated to other states. • Allocates $50 billion over 4 years ($15 billion per year for 2018-2019, $10 billion per year for 2020-2021) paid directly to health insurance issuers for a short-term reinsurance program.
Abortion Funding	• Ends all federal funding for Planned Parenthood for one year. • Prohibits federal funds from going to insurance plans that cover abortions, other than those necessary to save the life of the woman, or in cases of rape or incest.	• Ends all federal funding for Planned Parenthood for one year. • Prohibits federal funds from going to insurance plans that cover abortions, other than those necessary to save the life of the woman, or in cases of rape or incest.