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MARK WALKER, CHAIRMAN
RSC THE REPUBLICAN STUDY COMMITTEE

H.R. 1628 – American Health Care Act of 2017 (Rep. Black, R-TN)

FLOOR SCHEDULE:

Expected to be considered May 6, 2017 under a rule. Additional information on the rule will be provided after it is reported from the Committee on Rules.

TOPLINE SUMMARY:

H.R. 1628 would repeal or modify numerous provisions of the Affordable Care Act, including effectively eliminating the individual and employer mandates, repealing most of the ACA's tax increases, modifying some insurance regulations, allowing states to remove requirements for what services insurance plans are required to cover under ACA tax credit-eligible plans, and phasing out the ACA's health insurance subsidies and Medicaid expansion.

The bill would also institute a new advanceable, refundable tax credit for health insurance purchases, and create a block grant program to fund state innovation programs such as high-risk pools and insurance risk mitigation programs.

The bill would convert the Medicaid program to a per-capita cap model and incorporate a number of additional reforms as part of an agreement negotiated by RSC Chairman Walker and House conservatives and President Trump, including a prohibition on new state expansions and an option for states to implement block grants and/or work requirements for non-disabled, non-elderly, non-pregnant Medicaid enrollees.

The bill would also place a one-year moratorium on funding for Planned Parenthood.

NOTE: This analysis refers to H.R. 1628, incorporating the two managers' amendments previously adopted as self-executed amendments. A past legislative bulletin detailing the managers' amendments separately from the base bill as reported out of the Budget Committee can be found here.

COST:

The Congressional Budget Office (CBO) estimated that implementing H.R. 1628, as amended by the March Managers' amendments, would reduce federal deficits by $150 billion over the 2017-2026 period; that reduction is the net result of a $1,150 billion reduction in direct spending, partly offset by a reduction of $999 billion in revenues. The provisions dealing with health insurance coverage would reduce deficits, on net, by $883 billion; the noncoverage provisions would increase deficits by $733 billion, mostly by reducing revenues.

This score does not incorporate the effects of any amendments filed to the bill since March 20. Several of these amendments are likely to result in significant budgetary savings, including potentially reducing the savings in the bill by large amounts. If insurance premiums are lowered by the reforms in the various amendments, more individuals would be likely to purchase health insurance, thus increasing utilization of the advanceable, refundable tax credits and federal spending and reducing or eliminating savings in the bill.

Tax Credits
Some conservatives may be concerned that the bill creates a new advanceable, refundable tax credit for the purchase of health insurance. Some conservatives may believe that it is not the appropriate role of the federal government to fund such private purchases through direct outlays, which refundable credits are, and that these credits merely replace the premium tax credits made available under the Affordable Care Act with an alternate scheme.

Some conservatives may be concerned that the aggregate budgetary impact of these credits is similar to those provided for the purchase of insurance under the Affordable Care Act.

Some conservatives will be pleased that these credits are limited to lower-income individuals. Some conservatives may also be pleased that these credits are protected by limitations on being used to fund purchases of plans that fund elective abortions.

Some conservatives may be concerned by announced agreements that the Senate may seek to reduce the amount of Obamacare tax relief or spending cuts in the bill in order to provide 'fiscal space' for increases in the value of the refundable tax credits.

Medicaid
Some conservatives may be concerned that the elimination of the enhanced federal share for Medicaid expansion does not begin until 2020. Some conservatives may believe that a future Congress is unlikely to allow this reform to take effect, especially in a presidential election year. A significant portion of the bill's reduction in spending relies on the presumption that the freeze will be allowed to take effect.

Some conservatives will be pleased that the bill makes significant reforms to reduce the rate of growth of Medicaid spending and provide additional state flexibility, including moving Medicaid to a per capita cap system and allowing states to elect a block grant for certain populations. Conservatives will also be pleased that the bill immediately prohibits new states from expanding Medicaid at the enhanced federal share retroactively to March 1, 2017, and allows states to implement work requirements for able-bodied, non-pregnant, non-elderly Medicaid enrollees.

Planned Parenthood
Conservatives will be pleased the bill includes a one-year moratorium on mandatory funding for Planned Parenthood.

CBO Score
Three amendments have been filed to the bill since March 20. These amendments have a significant budgetary impact, as required to be included in a reconciliation bill, including at least $23 billion in direct appropriations. Despite this, an updated CBO score is not yet available.

- **Expand the Size and Scope of the Federal Government?** The bill eliminates Affordable Care Act

subsidies for insurance purchase, but institutes alternate subsidies continuing to fund the direct purchase of insurance for individuals. The bill lessens, though does not eliminate, federal overreach into insurance markets.

- **Encroach into State or Local Authority?** No.
- **Delegate Any Legislative Authority to the Executive Branch?** No.
- **Contain Earmarks/Limited Tax Benefits/Limited Tariff Benefits?** No.

DETAILED SUMMARY AND ANALYSIS:

The Affordable Care Act (ACA; also known as Obamacare) created a set of mandates, subsidies, regulations, and entitlement expansions in an effort to increase the number of individuals covered by health insurance. Specifically, Obamacare created mandates that individuals carry, and employers provide, health insurance. Further, the law set up a system of refundable tax credits and cost-sharing subsidies to reduce the cost of purchasing insurance for lower-income individuals and families on state or federally-operated exchanges. The law also included a set of insurance regulations dictating what types of benefits had to be included in a plan, how that plan could be priced, and how the value of benefits had to relate to premiums charged. Finally, the law required states to expand Medicaid to cover individual adults earning up to 138% of the federal poverty level. This last provision was effectively made optional for states through the Supreme Court's decision in *NFIB v. Sebelius*.

H.R. 1628 would repeal or amend significant portions of the ACA, eliminating that law's system of tax credits and cost-sharing subsidies, eliminating most of its tax increases, amending some insurance regulations, and phasing out its Medicaid expansion.

In place of Obamacare, H.R. 1628 would stand up a new system of advanceable, refundable tax credits for the purchase of health insurance available to individuals who do not have access to employer-sponsored or other large-group insurance. The bill would also expand access to Health Savings Accounts (HSAs). Finally, H.R 1628 would also make significant reforms to Medicaid.

Repeal Provisions

Taxes

Individual and Employer Mandate
The penalty level for both the employer and individual mandate would be set to $0, effectively eliminating the mandates.

Net Investment Income Tax
The Affordable Care Act imposed a 3.8% tax on passive income for single earners over $200,000 and couples over $250,000. This tax would be repealed effective beginning in 2017.

Medicare Surcharge
The Affordable Care Act instituted a 0.9% additional tax on individuals earning over $200,000 (couples earning over $250,000), with revenues being deposited into the Medicare Hospital Insurance Trust Fund. This additional tax would be repealed at the end of 2022.

Cadillac Tax
The implementation of the Affordable Care Act's 40% excise tax on high-value health plans would be delayed until 2026. (Note: Full repeal of this provision could create a long-term budget point of order in the Senate, thus requiring 60 votes.)

Health Insurance Tax
The annual health insurance fee would be repealed effective in 2017.

Tanning Tax
The Affordable Care Act's tax on tanning services would be repealed effective June 30, 2017.

Over-the-Counter Medications
The Affordable Care Act eliminated over-the-counter medications as an eligible use for tax-preferred health savings accounts (such as FSAs and HSAs). This bill would restore the ability for individuals to use these funds for OTC medications without penalty effective beginning in 2017.

HSA non-Qualified Expenses
The Affordable Care Act increased the penalty on HSA withdraws for non-medical expenses to 20% from 10%. This increase would be reversed at the end of 2017.

FSA Contribution Limits
The Affordable Care Act limited contributions to Flexible Spending Accounts to $2,500 per year. This limitation would be repealed effective beginning in 2017.

Medical Device Tax
The Affordable Care Act levied a 2.3% excise tax on the sale of medical devices. This tax would be repealed effective beginning in 2017.

Medical Expense Threshold
The Affordable Care Act increased the threshold individuals must cross in order to deduct medical expenses to 10% of income from 7%. This increase would be reversed effective beginning in 2017.

Prescription Drug Coverage
This bill would restore the ability of employers to deduct the cost of covering actual costs of prescription coverage for individuals on Medicare Part D, effective beginning in 2017.

Prescription Drugs
The ACA imposed a tax on pharmaceutical manufacturers and importers. This tax would be repealed effective beginning in 2017.

Subsidies

Premium Tax Credit

H.R. 1628 would alter the structure of the ACA's health insurance premium tax credits in 2018 and 2019 before eliminating them in 2020.

For 2018 and 2019, the credits would be available for the purchase of currently approved plans, as well as catastrophic health insurance that provides protection only against extremely high health costs. The bill would also prevent credits from being used to purchase a plan that covers elective abortion.

Further, H.R. 1628 would alter the value of the tax credit and direct the Secretary of the Treasury to prescribe regulations to enforce eligibility requirements. Under the ACA, individuals are eligible for a credit that is the lesser of their actual premium costs or the amount premium costs exceed a maximum percentage of household income that varies based on income size, with a maximum of 2% of income for individuals under 133% of the federal poverty level and escalating to 9.5% of income for those at or above

300% of the federal poverty level. H.R. 1628 would amend this formula to vary both by income and age of recipient, and to increase the maximum percentage of income an individual would pay before receiving credit assistance to 11.5%. Any excess value of the refundable tax credits would be returned to the Treasury, as negotiated as part of an agreement between RSC Chairman Walker and House conservatives and President Trump. Some conservatives had previously expressed concerns that excess value could be used to federally fund elective abortions.

The table below indicates the maximum percentage of income an individual of a given age in a given income tier would need to pay before becoming eligible for credit assistance:

Household Income as percentage of federal poverty level	Up to Age 29		Age 30-39		Age 40-49		Age 50-59		Over Age 59	
	Initial %	Final %	Initial %	Final %	Initial %	Final %	Initial %	Final %	Initial %	Final %
Up to 133%	2	2	2	2	2	2	2	2	2	2
133%-150%	3	4	3	4	3	4	3	4	3	4
150%-200%	4	4.3	4	5.3	4	6.3	4	7.3	4	8.3
200%-250%	4.3	4.3	5.3	5.9	6.3	8.05	7.3	9	8.3	10
250%-300%	4.3	4.3	5.9	5.9	8.05	8.35	9	10.5	10	11.5
300%-400%	4.3	4.3	5.9	5.9	8.35	8.35	10.5	10.5	11.5	11.5

Small Business Tax Credit
H.R. 1628 would repeal the small business tax credit at the end of 2019. For 2018 and 2019, the credit would not be available for the purchase of plans that fund elective abortions.

Cost-Sharing Subsidies
The ACA provided direct subsidies to reduce out-of-pocket costs of deductibles, coinsurance, and copayments for low and moderate-income individuals who purchase insurance plans with higher actuarial value. These subsidies would be repealed alongside the ACA tax credits at the end of 2019.

Other Repeal Provisions

Prohibition on New State Expansions
The ACA required states to expand Medicaid coverage to cover adults earning up to 138% of the federal poverty level, with the federal government providing an enhanced payment share for this population beginning at 100% in calendar year 2014 and falling to 90% in 2020 and thereafter. This mandatory expansion was effectively made a voluntary state option in the Supreme Court's ruling in *NFIB v. Sebelius*. Subsequently, 31 states and the District of Columbia chose to adopt the expansion.

H.R. 1628 would set in place a phase-out of the enhanced federal support for states that adopted expansion. States would continue to receive the enhanced federal share for all grandfathered enrollees who enrolled prior to December 31, 2019 and do not have a break in eligibility exceeding one month. For enrollees entering the program beginning January 1, 2020, states would receive their normal FMAP rate. Individuals on Medicaid tend to move off the program as their incomes rise, even if they eventually return to eligibility within a few months. Because of this population turnover, it is expected that a majority of enhanced share-eligible enrollees will cycle off of Medicaid within a few years of the freeze.

H.R.1628 would prohibit states that had not previously adopted expansion from receiving the enhanced federal share for new enrollees retroactively to March 1, 2017. States would be allowed to expand Medicaid to newly eligible populations while receiving their normal FMAP.

Prevention and Public Health Fund
H.R. 1628 would repeal the Public Health and Prevention Fund, which is a slush fund for the Secretary of Health and Human Services created by the ACA. In recent years, the secretary has used the Prevention Fund to support grants for activities including free pet spaying and neutering, Zumba classes, and urban gardening.

Disproportionate Share Hospital Cuts
The federal government makes payments to hospitals that treat a large number of low-income patients to offset losses from treating uninsured patients and low Medicaid reimbursement rates. The ACA capped the amount of DSH payments that could be made, effectively cutting these payments. H.R. 1628 would restore these payments to their pre-ACA levels for non-expansion states immediately, and for all states in 2020 when the bill terminates new enrollment at the enhanced federal share for the expansion population.

Replacement Provisions

Advanceable, Refundable Tax Credits
H.R. 1628 would create a new stream of advanceable, refundable tax credits for the purchase of health insurance that would vary in amount by age. Individuals would be eligible for the credits if they do not have access to employer-based coverage or other large group plan, or if they are a veteran who is not eligible for a VA plan.

A tax credit directly reduces an individual's tax liability: for example, if an individual owed $10,000 in federal taxes, a $2,000 credit would reduce that liability to $8,000. A refundable credit converts any excess of credit over liability into a direct payment from the government: for example, if an individual owed $1,000 in taxes, a $2,000 refundable tax credit would first eliminate the $1,000 liability, and then the government would write the individual a check for the $1,000 in excess credit value.

The credits created by H.R. 1628 would also be advanceable, which means they would be paid in advance based on the individual's estimated income for a given year. Any discrepancy between estimated tax liability and actual liability would need to be reconciled on the individual's annual return. Credits would be paid directly to insurance providers, with any excess of credit value over premium retained by the Treasury.

The credit would be cumulatively calculated for a household, with the five oldest individuals being counted and a maximum total credit value of $14,000. The credit would phase out for individuals earning greater than $75,000 and couples earning greater than $150,000, with the value of the credit being reduced by 10% of the amount an individual's or couple's income exceeds the threshold.

The credit would have the following values for each respective age group:

Under Age 30	$2,000
Age 30-39	$2,500
Age 40-49	$3,000
Age 50-59	$3,500
Age 60 and over	$4,000

The Secretary of the Treasury is directed to establish a system for administering the tax credits including enforcing eligibility requirements, and is directed to use, to the maximum extent possible, the mechanisms already established to distribute Obamacare premium tax credits. Further, the bill would require employers to report as to whether an individual has access to employer-sponsored coverage as part of their annual W-2 reporting.

HSA Limits
H.R. 1628 would increase the maximum amount individuals are allowed to contribute to HSAs annually to $6,500 for individuals and $13,100 for families, from $2,250 and $4,500 respectively. These limits would be increased for inflation.

State Innovation Grants
H.R. 1628 would provide a series of grants for states beginning in FY 2018 and totaling $115 billion through FY 2026. These funds would be eligible for use to fund financial assistance or otherwise subsidize insurance for high-risk and high-utilization individuals in the individual market, provide cost-sharing subsidies for individuals in the individuals or small-group market, or reduce the cost of health insurance coverage for individuals in rural areas. These funds would also be eligible for use to provide risk-mitigation funding, such as reinsurance or risk corridor funding, for insurance providers, or to make direct payments to providers for services. Out of the $115 billion, H.R. 1628 would dedicate $15 billion in 2020 for States to provide maternity coverage and newborn care, inpatient and outpatient care for mental illness, and early identification of mental health conditions in children.

If a state does not submit a plan of its own for use of the grants, then the Administrator of the Center for Medicare and Medicaid Services would be directed to coordinate with the state's insurance commissioner to establish incentives to appropriate entities to enter into arrangements to help stabilize premiums in the individual market. This would create a default risk mitigation program for insurers. Some conservatives may be concerned that this provision furthers the ACA's policy of bailing out insurance companies for losses incurred as a result of ill-priced products or federal mandates.

Insurance Regulations
H.R. 1628 would make changes to some ACA insurance regulations. Specifically, beginning in 2019, the bill would loosen the ACA's restriction on the variation of premiums based on age, widening from 3-to-1 to 5-to-1 for what older adults can be charged relative to younger adults. Further, the bill would sunset the ACA's actuarial value requirements beginning in 2020. Both of these changes are intended to allow for a wider variety of plans to be offered.

Essential Health Benefits
(Note: this provision would be superseded by the MacArthur Amendment)
H.R. 1628 would allow states, beginning in 2018, to determine essential health benefits for the purposes of health plans eligible to receive the refundable tax credits included in the bill.

The ACA created a list of 10 categories of essential health benefits that all plans must include. The mandatory inclusion of these benefits have increased premiums and reduced choice in the market, even though they were often not required, desired, or even possibly utilized by those insured by them.

While H.R. 1628 would only allow states to adjust EHB for tax credit-eligible plans, this change should allow greater flexibility when combined with the repeal of the actuarial value regulation in 2020. Allowing states to determine the content and level of essential health benefits should allow for a wider variety of plans to be offered at lower prices than if the federally mandated requirements remained in place. Further, increased competition in the marketplace resulting from this increase in the number of available plans should also reduce premiums.

Non-Continuous Coverage Penalty
H.R. 1628 would require insurance providers to charge a 30% penalty to any individual purchasing coverage who had a lapse of coverage longer than 62 days in the previous 12 months. Some conservatives may be concerned that this provision inappropriately sets the price of a private market product, interfering in the free market. Further, conservatives may be concerned that the provision functions to increase the costs for healthy individuals to enroll, thereby dis ncentivizing such enrolment and acting counter to its intended effect.

Payments to non-Expansion States
H.R. 1628 would provide payments to non-expansion states via an increase in the federal share of Medicaid funding for those states for each year 2018-2022. The amount each state would receive would be calculated as $2 billion multiplied by the ratio of the state's eligible expansion population to the total eligible expansion population of all non-expansion states. That is:

State funding = $2 billion X (state expansion population)/(total non-expansion state expansion population)

Medicaid Reforms

Per-Capita System
Under longstanding Medicaid law, the federal government reimburses states for a set percentage of Medicaid expenditures with no cap or limit. The size of the federal share can range from 50-83 percent according to statute, and is defined by a formula linked to per capita incomes in each state, with the federal government making smaller payments to wealthier states. H.R. 1628 would substantially reform this financing mechanism by implementing a "per-capita cap" system, which would set per-enrollee limits on federal Medicaid payments made to the states.

A baseline per capita amount would be developed based on FY16 expenditures in each state for each of five enrollee categories: elderly, blind and disabled, children, non-expansion adults, and expansion adults. The baseline per capita amount for each enrollee category would be adjusted each fiscal year by the percentage increase in the medical component of the consumer price index for urban consumers (CPI-U Medical), with the exception of the elderly and blind and disabled categories, which would be adjusted by CPI-U Medical plus 1%. This growth rate is intended to reflect year-over-year increases in per-enrollee medical costs. Numerous factors, including Obamacare's Medicaid expansion and increase to payments for Medicaid primary care physicians, complicate direct comparisons of CPI-U Medical to annual growth in Medicaid expenditures. According to the Medicaid Payment Advisory Commission (MACPAC), however, about 70 percent of Medicaid spending growth between 1975 and 2012 can be linked to growth in enrollment rather than growth in per enrollee spending. Beginning in FY19, states would receive an aggregate payment for the federal share of the sum of total enrollment across all enrollee categories, adjusted by the growth rate as appropriate, and would be fully responsible for Medicaid expenditures exceeding this amount.
States that exceed their federal cap would receive reduced Medicaid funding in the next fiscal year, with funding being reduced on a pro rata basis each quarter. This exceedance could not be driven by increase in a state's Medicaid-eligible population, as federal funding would increase commensurately with population in the per capita model. States would also be unlikely to exceed federal caps due to an aging population or shift in case mix, because federal funding would generally increase in these instances, given that the elderly and blind and disabled categories would generally have a larger baseline per capita amount, and these categories are tied to a higher growth rate. States could exceed targets, however, if costs per enrollee grow faster than the growth rate. This could happen if, for example, states dramatically change provider payment rates, enrollees use a substantially higher amount of health care services (perhaps in connection with a natural disaster), or if the mix of services enrollees access is not reflected by the growth rate. In general, per capita caps would thus encourage states to provide appropriate benefit packages that would keep Medicaid enrollees healthy and avoid or reduce expensive hospitalizations.

Block Grant Option

H.R. 1628 would create an option beginning in 2020 for some states to elect to receive a single block grant for a ten-year period to provide medical assistance for certain populations in lieu of per capita allocations. States would be able to elect a block grant for either non-elderly, non-disabled, non-expansion adults, or for these adults and children. If the state chooses not to renew its block grant plan at the end of the ten-year period, then the per-capita model would be reapplied and calculated as though no election had ever been made. So long as an election is in effect, states can roll over unused block grant funds to future years.

States would generally be able to determine eligibility for this program, except that states would be required to provide coverage for pregnant women and, in the case of a state electing to cover children via block grant, children. While states would be allowed flexibility in determining the amount, duration, scope, cost-sharing, and delivery methods of medical assistance to block grant populations, the state must still provide for: hospital care, surgical care, medical care, obstetrical and prenatal care, prescription drugs and prosthetics, medical supplies and services, and health care for children under the age of 18.

The block grant allocation would be calculated in the first year of the ten-year election as an amount equal to that which would have been received for medical assistance under the per-capita allocation for each population for that year. In subsequent years, the first year base amount would be increased by the compounded growth of the consumer price index (CPI). Because the per capita caps for these populations will grow at CPI-M, which is higher than CPI, some states may choose not to elect a block grant, or not to renew a block grant plan after the initial ten-year election, because the amount of federal funding available under per-capita caps will be larger over time than the block grant funding.

Work Requirement Option
H.R. 1628 would allow for states to implement a work requirement for able-bodied, non-pregnant, non-elderly adults on Medicaid. The requirements would also not be allowed to be applied to single parents or caretakers, or individuals who are married or the head of the household and enrolled in school or participating in education directly related to employment.

These work requirements could require, at a state's direction, individuals to be working or involved in a wide-variety of education, job training, or searching for employment. These are the same activities that satisfy the work requirement under TANF. A full list of eligible activities is available at 42 USC 607(d).

The bill also provides an additional 5 percentage point increase in state administrative costs FMAP to compensate for the costs of implementing a work requirement option.

Special New York Provision
H.R. 1628 would enact a special policy for New York, referenced via a specific description of a state with a DSH allotment more than six times the national average in 2016. Specifically, H.R. 1628 would reduce federal Medicaid funding to New York by the amount the state requires local political subdivisions to contribute to New York's state share of Medicaid. There would be an exemption for payments made by any subdivision with a population in excess of 5 million and that levies a specific Medicaid tax. This would prohibit the State of New York from requiring political subdivisions other than New York City to pay contributions to the state Medicaid share without seeing a concomitant reduction in federal Medicaid funding.

Planned Parenthood

Defund Planned Parenthood
H.R. 1628 would place a one-year moratorium on federal mandatory funding for any 501(c)(3) nonprofit organization primarily engaged in providing family planning and reproductive health services that provides abortions and that received over $350 million in Medicaid funding in Fiscal Year 2014. This

provision blocks federal funding for Planned Parenthood under Medicaid, CHIP, Social Services Block Grant (SSBG), and the Maternal and Child Health Block Grant program.

Community Health Center Program
H.R. 1628 would provide $422 million in mandatory funding for the Community Health Center Program in FY 2017. Community health centers provide a range of health services in medically underserved areas, including primary care family planning services, cancer screenings, and women's health exams. According to the Alliance Defending Freedom and the Charlotte Lozier Institute, "there are currently 13,540 clinics providing comprehensive health care for women, versus 665 Planned Parenthood locations."

AMENDMENTS:

Palmer/Schweikert Amendment: This amendment establishes a Federal Invisible Risk Sharing Program (FIRSP) within the underlying bill's Patient and State Stability Fund, intended to be modeled after a successful reinsurance program enacted in Maine in 2011. It would also provide an additional $15 billion to support operation of the program between 2018 and 2026. States will assume responsibility for program operation after 2020.

The reform this provision is modeled after established a reinsurance program in known as the Maine Guaranteed Access Reinsurance Association (MGARA), which helped minimize risk associated with providing coverage to certain individuals with pre-existing conditions while still ensuring that these individuals did not face higher premiums. Specifically, the law required consumers to complete a health assessment form in order to purchase coverage in the individual market, and insurance companies could use this information to enroll people with certain pre-existing conditions into MGARA. Enrollees were charged the same regardless of whether they were placed in MGARA, and were not made aware of the determination. Insurance companies, however, were reimbursed for 90 percent of each MGARA-placed enrollee's claims between $7,500 and $32,500, and 100 percent of claims exceeding $32,500. The majority of claims reimbursements were financed by a $4 tax on plans in all insurance market segments. Insurance companies were required, however, to transfer 90 percent of premiums collected for each MGARA-placed enrollee into the program, which helped finance some claims reimbursements.

Under the amendment, the CMS Administrator has broad responsibility to consult with stakeholders and determine parameters for FIRSP operation, including parameters regarding the eligibility of individuals, the development and use of health status statements, identifying health conditions that automatically qualify individuals for the FIRSP and defining a process through which insurance companies may voluntarily qualify additional individuals, the percentage of insurance premiums insurance companies are required to transfer into the program, and the thresholds at which the program will make payments to insurance companies.

Some conservatives may be concerned that this amendment gives exceptionally broad power to the secretary to define the parameters of the program, and states may be better equipped than the federal government to determine how best to stabilize their individual markets. Moreover, future secretaries may exercise this power in unpredictable ways. Some conservatives may also have concerns that this provision furthers the ACA's policy of bailing out insurance companies for losses incurred as a result of ill-priced policies, and may be concerned that there will be pressure to appropriate additional federal funds to meet the programs obligations. A Milliman study indicates that anywhere from $3.3 to $17 billion per year could be needed to run the program, and the amendment provides only $15 billion available over nine years.

MacArthur Amendment – This amendment would strike a provision in H.R. 1628 added by a managers' amendment that would allow states, beginning in 2018, to define essential health benefits for the purposes of determining premium tax credits. Thus, the HHS Secretary would maintain responsibility for defining essential health benefits beyond the ten broad categories outlined in the ACA. This amendment would instead increase state flexibility by providing States the option to waive the essential health benefits and/or

certain other federal requirements imposed by the ACA in order to achieve state goals of lowering average premiums, stabilizing premiums for individuals with pre-existing conditions, stabilizing insurance markets, increasing enrollment, or increasing consumer choice.

The secretary would be required to automatically approve all waiver applications within 60 days or notify the state of reasons for denial within that timeframe. Waivers would be in effect for up to 10 years, but would become void if a state ended its risk-sharing program. Some conservatives may be concerned that the amendment gives broad power to the secretary to approve waiver applications, which might not be judiciously exercised.

Specifically, the amendment would allow states to:

- Increase the age rating ratio beyond the 5:1 ratio established in H.R. 1628, beginning in 2018
- Allow insurers to vary premiums for individuals based on their health status (medical underwriting) for individuals who fail to maintain continuous coverage, beginning in 2019. States that wanted to allow medical underwriting would be required to operate a risk mitigation program or participate in the Federal Invisible Risk Sharing Program.
- Define essential health benefits in the individual and small group markets, beginning in 2020.

The amendment also includes several rules of construction stating that nothing in the bill shall be construed as permitting health insurance companies to discriminate in rates for health insurance by gender or limit access to health coverage for individuals with preexisting conditions.

The amendment does not apply to certain ACA provisions that could run afoul of the Senate rules governing reconciliation and thus jeopardize privilege of the bill in the Senate, which is required to ensure a 51-vote threshold for approval. These provisions include the ACA requirement that Members of Congress and their staff obtain health insurance on the ACA Exchange, which may violate the rules because it is in the jurisdiction of a committee that did not receive reconciliation instructions as part of the FY2017 budget. A bill introduced by Rep. McSally (R-AZ) is expected to be considered on May 4 and would ensure that if H.R. 1628 is enacted, this non-application provision would not apply.

Reconciliation measures are intended to implement budget resolutions, and the Byrd rule allows Senators to raise a point of order against any provision that is "extraneous" to reconciliation legislation. Among other things, this includes measures that do not have a budgetary effect, measures where the budgetary effects are "merely incidental" to the policy objective, or measures that involve the jurisdictions of committees without reconciliation instructions. Points of order against non-budgetary provisions make those provisions severable from the bill and may be adjudicated on a case-by-case basis without jeopardizing privilege. However, involving the jurisdiction of a non-reconciled committee is automatically fatal to the privilege of full bill, regardless of the size or scope of the provision.

The Senate requires 60 votes to waive a point of order, as compared to the 51-vote threshold for a reconciliation bill. Moreover, the Senate Parliamentarian may determine that a base bill that contains a substantial number of Byrd violations is not privileged and thus must be considered under a 60-vote threshold. The Senate Parliamentarian does not rule on the parliamentary inquiries of Members of the House, but the House has attempted to comply with the Byrd rule based on guidance from the Senate Budget Committee, among others.

Upton Amendment – This amendment would provide an additional $8 billion to the Patient State Stability Fund between 2018 and 2023 and require that states granted a waiver from community rating requirements under the MacArthur amendment use these funds to provide assistance to "reduce premiums or other out-of-pocket costs" for individuals who may experience increased monthly premium rates related to the waiver. Some conservatives may be concerned that the amendment gives broad discretion to the secretary to determine how to allocate the subsidies, including the size and scope of assistance.

COMMITTEE ACTION:

S. Con. Res. 3 directed the House Energy and Commerce and House Ways and Means committees to produce reconciliation recommendations to achieve at least $1 billion in deficit reduction each. The Ways and Means and Energy and Commerce committees both convened in markup on March 8 and completed markup on March 9. The House Budget Committee met to report the combined recommendations on March 16, and the reported combined recommendations were introduced on March 20 as H.R. 1628.

Read the report from the Budget Committee here.

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