



BENEFIT NEWS BRIEFS

House Passes American Health Care Act

The House of Representatives recently passed the [American Health Care Act \(AHCA\)](#), as amended, by a vote of 217-213. The Bill will go to the Senate where it faces many challenges. The Bill is the same Bill introduced in March of this year with the addition of some crucial vote-getting amendments. See [Client Bulletin 2017-17](#) for analysis of the March Bill.

We will take a *brief* look at some of the things the Bill does and does NOT change, as well as the vote-getting amendments added to the prior version of the Bill. We say "brief" because as [several Senators](#) have already indicated, the Bill will undergo major changes in the Senate. Since the Bill will be voted on under budget reconciliation (only 51 votes are required to pass), it must also meet certain scoring criteria from the Congressional Budget Office. What the compromise legislation will eventually look like is anyone's guess.

The Bill still repeals over 15 taxes added by the ACA. The Bill also sets up Medicaid block grant funding, allows Medicaid work requirements, ends the ACA Medicaid expansion, and makes many more Medicaid related changes. For a detailed look at the Medicaid and other changes, see Congressional Research Service [Report](#) at page 8. FAQs on the Bill are also available at by "[clicking here](#)" and "[here](#)."

Some Changes of Interest to Employer and Group Health Plans

The Bill would:

- Reduce the [Employer Shared Responsibility](#) ("employer mandate") tax penalty for tax years beginning after December 31, 2015 to \$0.
- Reduce the [Individual Shared Responsibility](#) ("individual mandate") tax penalty for tax years beginning after December 31, 2015 to \$0.
- Delay the "Cadillac Tax" from 2020 until 2026.

Other changes affect contribution limits of FSAs, HSAs and HSA catch-up rules. The Bill also modifies the premium assistance tax credit to allow a refundable, advanceable tax credit beginning in 2020 for certain individuals who purchase health insurance and who are not eligible for other sources of coverage.

Some Things That Are NOT Changed

The changes in the Bill would not directly affect the plan design of employer-sponsored group health plans (GHPs), including multiemployer group health plans. The reforms under the ACA of no annual or lifetime limits, no rescissions, age 26 coverage, no waiting periods longer than 90 days, no pre-existing condition exclusions, SBCs and the grandfathered/non-grandfathered rules remain untouched.

Even though the employer and individual mandate penalties would be reduced to \$0, the Bill itself does not eliminate the ACA information reporting requirements for employers.

What about the Proposed Essential Health Benefit (EHB) Waivers and the Rules on "No Annual Limits on EHBs"?

Contrary to some published reports, the Bill does NOT change the way that "no annual/lifetime limits" rules apply. That is, the Bill does not change the way self-insured plans choose a benchmark state plan for determining compliance with the "no annual limits on essential health benefits" rules. More particularly, the state waivers for essential health benefits (EHBs) apply only to the individual and small group market and does not allow group health plans to use such state chosen EHBs as their benchmark, as discussed below.

The Bill, through the MacArthur Amendment, allows states to seek a limited waiver from the ACA definition of EHBs for the state's individual and small group insurance market.

Some commenters have noted that the ability of a state to obtain a waiver and modify that state's EHBs might impact GHPs if a state's new definition of EHB could serve as a "benchmark" for determining what benefits could be subject to annual or lifetime limits. If this were the case, what were once EHBs under the ACA and not subject to annual or lifetime limits could now be subject to those limits. However, a close examination of the language of the Bill leads one to conclude otherwise.

The AHCA only amends ACA Section 1302(a) and not Section 1302(b). Section 1302(b) is the section concerning EHBs referenced by the rule regarding "no annual/lifetime limits." Recent comments by Administration officials have indicated that GHPs would not be able to pick a state's waiver EHBs as a benchmark to skirt the no lifetime/no annual limits rules.

The text of the Bill backs up that interpretation. ACA 1001 amended the Public Health Service Act by adding, among other things, a new Section 2711 (codified at [42 U.S.C. 300gg-11](#)) that contained the rules against lifetime or annual limits. The regulation implementing this section is found at [29 CFR 2590.715.2711](#) and says a GHP, may not establish any lifetime or annual limit on the dollar amount of EHBs for any individual, whether provided in-network or out-of-network. The regulation follows the statute and defines “EHBs” as “*essential health benefits under Section 1302(b) of the ACA and applicable regulations.*” The regulation goes on to state that health plans that are not required to cover EHBs must choose a benchmark plan from one of the EHB-benchmark plans applicable in a State under [45 CFR 156.110](#) or one of the three Federal Employees Health Benefits Program (FEHBP) plan options as defined by [45 CFR 156.100\(a\)\(3\)](#). Plans that are not required to cover EHBs include self-insured plans, including multiemployer self-insured plans.

Thus, even if a plan is not required to cover EHBs, such plans must nevertheless choose a state benchmark plan to determine what plan benefits are not EHBs and could be subject to annual limits. Since the Bill would not affect ACA Section 1302(b), it would not change the rules for choosing a benchmark plan. Let’s take a closer look.

ACA Section 1302 is codified at [42 U.S.C. 18022](#). Section 1302(a) [*not (b)*] would be amended by the Bill to read as follows (redline text in the parenthetical under item (1) would be added by *AHCA*):

(a) Essential health benefits package

In this title, the term “essential health benefits package” means, with respect to any health plan, coverage that —

- (1) provides for the essential health benefits defined by the Secretary under subsection (b) *(or, in the case of health insurance coverage offered in the individual or small group market in a State for which there is an applicable waiver in effect under Section 2701(b) of the Public Health Service Act for a plan year, the essential health benefits applicable under such waiver)*;
- (2) limits cost-sharing for such coverage in accordance with subsection (c); and
- (3) subject to subsection (e), provides either the bronze, silver, gold, or platinum level of coverage described in subsection (d).

Since for the purposes of the no annual limits rules EHBs are defined by reference to ACA Section 1302(b), the Bill’s amendment of Section 1302(a) does not impact the rules for choosing a benchmark plan or what constitutes EHBs under Section 1302(b).

The Three Amendments to The Bill

As noted in the introduction, the original Bill was modified by the following three amendments (added to the Bill via [House Report 115-09](#)) which are summarized below:

- (1) the [Palmer-Schweikert Amendment](#) which creates a \$15 billion risk sharing program to help states lower premiums for health coverage offered in the individual market.
- (2) the [MacArthur Amendment \(summary\)](#) which allows states to waive essential health benefits, age rating, and community rating. Health insurers would not be allowed to deny coverage, discriminate based on gender or limit access based on preexisting conditions. States must explain how the waiver will reduce average premiums for patients, increase enrollment for residents, stabilize the state's health insurance market, stabilize premiums for individuals living with preexisting conditions, or increase patients' health care plan options.
- (3) the [Upton-Long Amendment \(summary\)](#) which increases the Patient and State Stability Fund by \$8 billion from 2018 to 2023 to States with an approved community rating waiver, as established by the MacArthur Amendment, for providing assistance to reduce premiums or other out-of-pocket costs to individuals who may be subject to an increase in their monthly premium rates as a result of the States waiver.

On To The Senate

Given that the Bill still must go through the Senate and then a Conference Committee to iron out differences between the House and Senate Bills and then be passed by both chambers again, we will not undertake a detailed analysis of the Bill's proposed changes. Various senators of both parties have expressed doubts about the present form of the Bill and substantial changes to the Bill by the Senate are predicted.

Conclusion

We will track progress on this legislation. Readers can track the Bill at: <https://www.congress.gov/bill/115th-congress/house-bill/1628>, which also has a Bill summary.

More information is also available at <https://housegop.leadpages.co/healthcare/>.

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