

Republicans release much anticipated ACA “repeal and replace” bill, but will it fly under the Byrd rule?

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On 6 March 2017, House Republicans in the Committee on Ways and Means and the Committee on Energy and Commerce introduced the American Health Care Act (AHCA), a bill that would repeal and replace key portions of the Affordable Care Act (ACA). The committees will begin considering changes to the bill on Wednesday, 8 March, with the goal of passing it within a few weeks. If ultimately passed by Congress and signed into law, the AHCA bill would substantially change portions of the ACA, but it would not repeal the ACA in its entirety.

The bill was introduced under the expedited reconciliation process. Although it has not yet been scored by the Congressional Budget Office (CBO), the bill may face an uncertain future in light of the Byrd rule, which—among other things—allows Senators to block legislation if the legislation significantly increases the deficit after ten years. In addition, the provisions of the AHCA bill are currently still subject to change either through direct amendment before the bill is voted on, and potentially passed, or through subsequent amendatory bills. The House Republican leadership has said that additional reforms will be proposed in subsequent legislation that will be considered under the usual rules for debate and voting.

Even if the AHCA bill does not ultimately survive the reconciliation process in its current form, or is otherwise not signed into law, the introduction of the AHCA reflects the keen interest of the new Republican-led Congress in reshaping former President Obama’s signature health reform law.

A. The reconciliation process and its consequences for the likelihood of passage

The Republican-led Congress is seeking to pass the proposed AHCA bill through the reconciliation process, which allows Congress to enact legislation by a simple majority—i.e., without being subject to a potential filibuster in the Senate. Measures that proceed through reconciliation must go through two steps. First, reconciliation instructions are included in a budget resolution passed by Congress. This resolution directs one or more House committees to develop legislation to change spending or revenues by amounts specified in the budget resolution. Second, an omnibus reconciliation bill is introduced in the House and Senate under expedited procedures.

Previously, on 13 January 2017, the House and Senate passed a concurrent resolution containing reconciliation instructions to facilitate the repeal of the ACA by providing a non-binding spending

blueprint for Congress to follow in its repeal and replace efforts. The introduction of the AHCA bill marks the second step of the reconciliation process.

However, not all bills are eligible for passage through the reconciliation process; under the Byrd rule, the reconciliation process can be made effectively unavailable if a bill contains “extraneous” provisions. Upon a point of order being made by any Senator against any extraneous material in a reconciliation bill, the extraneous material may be stricken, if the point of order is sustained by the presiding officer, under the advice of the Parliamentarian.

A provision is deemed “extraneous” and subject to the Byrd rule if it falls into one of six categories:¹

1. It does not produce a change in outlays or revenues.
2. It increases outlays or decreases revenues, and the net effect is that the provision fails to achieve the reconciliation instructions.
3. It is outside of the jurisdiction of the committee that submitted the title.
4. It produces only incidental changes in outlays or revenues, relative to non-budgetary components of the provision.
5. It would increase the deficit for a fiscal year beyond those covered by the reconciliation measure.
6. It recommends changes in Social Security.

Two of the Byrd rule’s definitions of extraneous are of particular relevance. Any provision of the AHCA bill that does not directly affect spending or revenue might be subject to exclusion as extraneous, with certain narrow exceptions.² In addition, to be eligible for reconciliation, the bill as a whole cannot increase the deficit after ten years.

The CBO has not yet provided a cost estimate, but if the AHCA bill is ultimately deemed to increase the deficit after 10 years, it is unclear whether there will be a way forward for it to be passed through the reconciliation process. In addition, the AHCA bill faces criticism from Democrats on the grounds that the bill will increase the number of people who are uninsured.

There is also a risk that some Republicans will be critical of the bill. On the date of the AHCA’s introduction, four Republican senators released a criticism of an earlier draft of the bill, which they described as “not adequately protect[ing] individuals and families in Medicaid expansion programs or provid[ing] necessary flexibility for states.”³ The AHCA bill may also face criticism from other Republicans who believe the benefits offered under the bill are too generous or that the bill retains too much of the ACA. Shortly after the bill was published, Senator Rand Paul stated on Twitter: “Still have not seen an official version of the House Obamacare replacement bill, but from media reports this sure looks like Obamacare Lite!”⁴ More than two Republican defections in the Senate could potentially prevent the AHCA from winning the requisite majority vote.

¹ 2 U.S.C. § 604(a)(1)(A).

² See 2 U.S.C. § 604(b)(2)–(3).

³ [Letter from The Honorable Rob Portman, Shelley Moore Capito, Cory Gardner, & Lisa Murkowski, Senators, U.S. Senate, to The Honorable Mitch McConnell, Repub. Majority Leader, U.S. Senate \(Mar. 6, 2017\).](#)

⁴ [Senator Rand Paul \(@RandPaul\), Twitter \(Mar. 6, 2017, 2:02 PM\).](#)

The bill is also subject to amendment and certain provisions of the AHCA bill could potentially change significantly in the coming weeks or months. The reconciliation process does not typically prohibit all amendments from being offered; though amendments must be germane to the bill and the Byrd rule applies and may restrict certain amendments. In addition, bills could be subsequently introduced to alter or amend provisions of the AHCA.

B. Changes to Medicaid

If enacted, the AHCA bill would phase in fundamental changes to the Medicaid program and roll back the ACA's Medicaid expansion. Medicaid funding is shared between the federal government and states, with the federal government matching state Medicaid funding in accordance with a predetermined formula. Currently, Medicaid is an entitlement program; the federal government has an open-ended Medicaid funding commitment; meaning that the Medicaid program pays a percentage of each beneficiary's Medicaid costs, regardless of how many beneficiaries are enrolled in a given state.

Beginning in FY 2020, the AHCA bill proposes to fundamentally change the Medicaid program by converting the current federal Medicaid financing system from open-ended funding to per capita funding. Under the AHCA bill's per capita funding model, states would receive block payments from the federal government based on the number of Medicaid enrollees in the state. The federal government's payment to states would rise annually by a fixed percentage regardless of the actual rate of health care cost growth. Under the AHCA bill, states appear to be on the hook for any additional sums if health care costs grow at a rate in excess of the fixed annual federal percentage increase.

The ACA's Medicaid expansion would also see a phased roll back under the AHCA. Through 31 December 2019, individuals living in a state that has expanded Medicaid (an expansion state) who would qualify for Medicaid solely based on the ACA's expanded Medicaid eligibility criteria could continue to enroll in their state's Medicaid program. But beginning in 2020, states would no longer be eligible for federal matching funds for any new enrollees who would have qualified solely based on the ACA's expanded Medicaid eligibility criteria. With respect to such individuals who qualify for Medicaid on or before 31 December 2019 based solely on the ACA's expanded Medicaid eligibility criteria, expansion states no longer will receive federal matching funds unless the individuals maintain continuous Medicaid coverage.

States that have not expanded Medicaid under the ACA (non-expansion states) would also be incentivized to refrain from expanding Medicaid before the 2020 freeze takes effect. Under the AHCA bill, non-expansion states would receive a share of \$10 billion of additional safety net funding over five years. Beginning in calendar year (CY) 2018 and continuing until CY 2022, each state that has not implemented ACA Medicaid expansion as of July 1st of the preceding year would be eligible for the additional safety net funding to adjust payment amounts for Medicaid providers. Thus, in a given year from CY 2018 through CY 2022, each non-expansion state would receive a fraction of \$2 billion in safety net funds. A non-expansion state's proportion of the safety net funds would be determined based on the proportion of individuals in that state with income below 138% of the federal poverty line (FPL) in 2015, relative to the total number of individuals with income below 138% of FPL for all non-expansion states in 2015. If a non-expansion state implements ACA Medicaid expansion (as it is permitted to do until 2020), the formerly non-expansion state would then be disqualified from receiving the additional safety net funds for all future years.

Starting on 31 December 2019, the AHCA bill would also repeal the requirement that State Medicaid agencies must provide coverage for the ACA's pre-defined "essential health benefits." States would instead be allowed to define what mandatory health benefits are required for their Medicaid plans.

C. Changes to health insurance plans

If enacted, the AHCA bill would also dramatically revamp the ACA's rules on private health insurance plans.

1. Elimination of the individual and employer mandates

Retroactively, beginning for the 2016 plan year, the AHCA bill would repeal the ACA's individual mandate, which requires individuals to purchase insurance or face a tax penalty. The employer mandate, requiring larger employers to offer coverage for full-time employees, would also be eliminated under the bill.

The individual mandate was likely the least popular ACA provision, but was also argued by some to be necessary to maintain insurance market stability. The ACA prohibits insurers from charging enrollees more or denying coverage on the basis of a preexisting health condition. Insurers and advocates of the ACA's individual mandate have argued that this so-called guaranteed issue provision provides a disincentive to healthy individuals to buy insurance. That is because they are guaranteed coverage if they become sick and later need to purchase insurance. Thus, the argument goes, a guaranteed issue requirement will result in a pool of insureds that is disproportionately composed of sick individuals and will not contain a sufficient number of healthy individuals to spread the costs of insuring the sick. The ACA therefore created a mandate on individuals to be insured, in order to counterbalance the risk that guaranteed issue would "drive th[e] market into extinction."⁵

The AHCA bill leaves the ACA's guaranteed issue provision intact but repeals the ACA's individual mandate. Critics have argued that this could result in an insurance market "death spiral," if healthy individuals increasingly opt out of purchasing insurance until they become sick—leaving an insurance pool that is too sick and too small to effectively spread costs.⁶

The AHCA bill attempts to address this potential problem by encouraging continuous coverage. The bill would allow insurers offering plans in the individual and small group markets to increase premiums by a 30 percent penalty for one year for individuals who had a gap in coverage of at least 63 continuous days in the previous year. However, it is unclear whether such a penalty would prove sufficient to encourage low risk individuals to maintain continuous coverage or prevent any danger of disruption to the insurance markets.

⁵NFIB v. Sebelius, 132 S.Ct. 2566, 2613–14 (Ginsburg, J., concurring in part and dissenting in part) (quoting Hearings before the House Ways and Means Committee, 111th Cong., 1st Sess., 10, 13 (2009) (statement of Uwe Reinhardt)).

⁶[See Larry Levitt & Gary Claxton, Henry J. Kaiser Foundation, Is a death spiral inevitable if there is no mandate? \(June 19, 2012\).](#)

2. Elimination of metal tiers

On 31 December 2019, the AHCA bill would eliminate the ACA's "metal coverage tiers," which designate a plan at a particular metal tier (bronze, silver, gold, or platinum) based on the percentage of the full actuarial value of the benefits provided under the plan. The actuarial value standards for determining metal tiers also would be repealed on that date. Elimination of metal tiers would give issuers more flexibility in designing health care plans; however, because plans would no longer be standardized, it would be more difficult for individuals to compare the benefits offered and the relative quality or value of coverage among different plans.

3. Changes to subsidies and age rating ratio

The AHCA bill would also restructure the subsidies offered to individuals under the ACA. The bill would repeal the ACA's income-based tax credits for out-of-pocket costs and subsidies for premiums, which were intended to assist low-income populations to pay the costs of insurance. The AHCA bill would replace the ACA's income-based subsidies with tax credits based upon an individual's age. The tax credits would apply to exchange plans, including catastrophic coverage plans, and range annually from \$2,000 for individuals under 30 to \$4,000 for individuals over 60. Individuals who are offered coverage through their employer would not be eligible for the tax credits, and the tax credits would be gradually phased out for high-income earners. The phase out begins for individuals who make \$75,000 per year (\$150,000 for households) and the tax credits are fully phased out for individuals who make over \$215,000 per year (\$290,000 for households).

Overall, the new tax credits would be less generous than the ACA's credits. In addition, because the AHCA bill's tax credits are no longer tied to lower income level, critics have charged that those populations with incomes only marginally above the line for Medicaid eligibility would see the biggest increase in uninsured individuals.

The AHCA bill would also allow insurers to charge older individuals up to five times more than younger individuals, which is more than the currently-allowed three-to-one ratio. The bill's assistance for the elderly is only twice what younger individuals would receive; if plans become up to five times as expensive for older populations, insurance could become particularly costly for older individuals.

D. Other key changes

1. Taxes

The AHCA bill would repeal most of the taxes created by the ACA, with one significant exception. Instead of repealing the so-called Cadillac tax, a 40 percent excise tax on high-cost employer health benefit plans, the AHCA would extend the current moratorium on the tax from its current implementation date in 2020 until 2025. Under the AHCA bill, beginning in 2025, such high-cost employer health benefits plans would be subject to the Cadillac tax.

The AHCA bill would repeal the annual excise taxes imposed on branded prescription drugs and on medical devices. Specifically, the bill provides that no drug fee shall be imposed "with respect to any calendar year beginning after 31 December 2017," and that the device tax "shall not apply to

sales after 31 December 2017.” The AHCA bill would also repeal the annual fees imposed on certain health insurers.

2. State innovation grants

The AHCA bill would also grant \$100 billion to the states over a period of nine years for “state innovation grants” to help fund coverage for high-risk individuals, help stabilize premiums in the health insurance market, and reduce costs for health insurance coverage. This appears to be at least partially intended to be used by states to fund high risk pool insurance plans that were commonly used prior to the ACA.

3. Funding cuts

The AHCA bill would cut off funding for Planned Parenthood for one year, beginning on the date the bill is enacted. Likely as an attempt to compensate for the cut to Planned Parenthood, for 2017 only, the bill increases the amount of funds distributed to the Community Health Center Program by \$422 million dollars. The AHCA bill would also end the Prevention and Public Health Fund, which accounts for almost 12 percent of the U.S. Centers for Disease Control and Prevention’s funding and supports programming on immunization, lead poisoning prevention, and state public health initiatives, at the end of 2018.⁷

4. Health and Flexible Savings Accounts

The AHCA bill would allow individuals to protect more of their income from taxes by placing more pre-tax income into health savings accounts (HSAs) and flexible savings accounts (FSAs). Beginning in 2018, the bill would increase the basic limit on annual HSA contributions to equal the maximum of the sum of the annual deductible and out-of-pocket expenses permitted under a high deductible health plan—\$6,550 for individuals and \$13,100 for households. Also beginning in 2018, the AHCA would lift the current cap of \$2,500 on FSAs. As no replacement cap for FSAs is included, it appears FSA contributions would be limitless.

E. Changes not included in the bill

It is also important to note what is not currently included in the AHCA bill. The bill retains several of the ACA’s most popular provisions and does not adopt any express new revenue streams.

The AHCA bill would not affect any of the changes to Medicare made under the ACA and does not change the requirement that insurers cover essential health benefits as defined by the ACA for private plans (as opposed to Medicaid). An early draft of the bill leaked on 10 February 2017, included a provision to give states control over essential health benefit requirements for private plans. That provision appears to have been removed from the official version of the bill introduced on 6 March 2017.

The AHCA bill also does not change many of the ACA’s other more popular provisions. As previously noted, the bill does not allow insurers to deny coverage or charge higher rates for

⁷[See Centers for Disease Control and Prevention, Accomplishing CDC’s Mission with Investments from the Prevention & Public Health Fund, FY2010-FY 2016.](#)

individuals with pre-existing conditions. Insurers would also continue to be prohibited from imposing annual or lifetime caps on benefits. Individuals under the age of 26 would also still be eligible for coverage under their parents' plans. The bill likewise would not affect the Centers for Medicare & Medicaid Services' ability to test innovation models for Medicare and Medicaid. The bill does not affect the Sunshine (Open Payments) payment disclosure requirements enacted as part of the ACA.

Also notably, the AHCA bill does not include any revenue sources. A previous version of the bill that was leaked to the media included a tax on generous employer health plans; however, that proposal was not included in the official version of the bill introduced on 6 March 2017. Without an express new revenue stream it is uncertain whether potential savings from changes to Medicaid will be sufficient to pay for the bill's costs and tax cuts over the next ten years. As a result, as described earlier, it is uncertain whether the bill can survive challenges in the Senate under the Byrd rule. It will be critical to see how the CBO ultimately scores the bill.

The drafters of the AHCA may have declined to incorporate certain changes to the ACA in an effort to comply with the Byrd rule; for example, state control over essential health benefits for private plans. The AHCA may also leave certain aspects of the ACA—such as the ACA's Medicare provisions—unchanged for political reasons. These changes could be proposed in future legislation.

We at Hogan Lovells will continue to closely monitor the progress of the AHCA bill, along with any other health care legislation and changes to the health insurance regulatory landscape.

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