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AHCA: WHAT EMPLOYERS NEED TO KNOW

May 25, 2017

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The U.S. House of Representatives passed the American Health Care Act of 2017 (AHCA, H.R. 1628, as amended) on May 4, 2017, by a vote of 217-213. Although that vote conjures up a sense of certainty, the path forward for repeal and replacement of the Affordable Care Act (ACA) remains extraordinarily uncertain. The enrolled version of the House AHCA Bill requires a vote by the U.S. Senate, which could decide to adopt the bill, amend the bill, or propose an entirely new bill. As of the publication date for this newsletter (May 25, 2017), sentiments are strong that the Senate will either significantly amend the bill or propose an entirely new bill.

On a recent trip to Washington D.C., I spent some time listening and learning from colleagues and commentators located in D.C. and across the nation about the AHCA. The demarcation line between Republican and Democrat views was clear. Democrats focused their comments on various procedural objections under the Byrd Rule. Republicans focused their comments on the substance of the AHCA changes. In an effort to make this newsletter as impartial as possible, we will first discuss the Byrd Rule and then discuss the substance of the AHCA changes in its current version.

I. THE BYRD BATH THAT COULD DO MORE THAN RUFFLE A FEW FEATHERS

As most of us know, a normal legislative bill in Congress can take months to pass because debate is unlimited, filibusters can happen, countless amendments can be added, and the bill must pass with a 2/3rds vote. The AHCA, however, was not drafted as a normal bill. It was drafted as a "reconciliation bill." A reconciliation bill enjoys an expedited legislative process wherein debate is

limited to 20 hours, it is not subject to filibuster, there are limitations on amendments, and it can pass with a simple majority vote. The reconciliation bill process spawns from the Congressional Budget Act of 1974 to assist Congress with enforcing budgetary laws.[1]

Now that the AHCA has moved over to the Senate, Section 313(b) of the Congressional Budget Act, also known colloquially as the Byrd Rule (after Senator Robert Byrd, D-WV), will prohibit the Senate from considering matters that are extraneous to budget reconciliation. Although the Senate parliamentarian has crafted the Byrd Rule over time, there are many questions about what constitutes "extraneous matters" in the context of the AHCA provisions, which will likely be tested in the weeks and months to come.[2] Any Senator can raise a point of order during consideration of the AHCA, including in committees and conference reports. If the point of order is accepted by the Senate parliamentarian then the provision or amendment is stricken[3] unless proponents offer a 3/5ths (60) Senate majority vote to keep the language inside the bill.[4]

The Byrd Rule consists of six tests and at least four exceptions. It is decided upon by the Parliamentarian of the U.S. Senate, who is currently Elizabeth MacDonough, through a team of advisors in the Office of the Parliamentarian. The six Byrd Rule tests under Section 313(b)(1) of the Congressional Budget Act are described in the following chart:

Common Understanding for Byrd Rule Test	**Byrd Rule Test - A provision is extraneous if such provision:**
Provision must change a budget item.	1. Does not produce a change in outlays or revenue, including changes in outlays and revenues brought about by changes in the terms and conditions under which outlays are made or revenues are required to be collected;
Provision must be in compliance with the Fiscal Year Budget.[5]	2. Produces an increase in outlays or decrease in revenues whereby the net effect of the provisions fail to achieve reconciliation instructions;

[1] Titles I-IX of P.L. 93-344, as amended.

[2] Byrd Rule implications are likely going to be similar regardless of whether the Senate uses the House AHCA version or crafts its own version of the AHCA because there is a clear preference to pass ACA repeal/replacement under the structure of a reconciliation bill. There is no timeline for considering Byrd Rule requirements, except that each objection can be given 2 hours of debate time.

[3] Section 313(d)(2), Congressional Budget Act of 1974, as amended.

[4] Section 904(c)(1), Congressional Budget Act of 1974, as amended.

[5] As some of you may recall, the Fiscal Year Budget includes a budget resolution from the Senate Budget Committee Chairman, Mike Enzi (R-WY), that was passed in January 2017 with reconciliation instructions to adjust ACA spending and revenues to achieve at least $1 billion in deficit reduction over ten years (by each chamber, Senate and House). The Senate voted January 12, 2017, with 51-48. The House voted January 13, 2017, with 227-198.

Provision must be under the Committee's jurisdiction.	3. Is not in the jurisdiction of the Committee with jurisdiction over said title;[6]
Non-budgetary items in the provision must be merely incidental.	4. Produces changes in outlays or revenues which are merely incidental to the non-budgetary components of the provision;
The next Fiscal Year must remain budget neutral.[7]	5. Increases (or would increase) net outlays, or decreases (or would decrease) revenues during a fiscal year after the fiscal year covered such bill and such increases or decreases are greater than outlay reductions or revenue increases resulting from other provisions in such title in such year; and,
Provision cannot change social security trust funds.	6. Contains recommendations with respect to the old-age, survivors, and disability insurance program (OASDI, or just the portion of federal payroll taxes to cover 6.2% for Social Security for each of the employer and employee; but not the 1.45% for Medicare).

The Byrd Rule has four statutory exceptions. Byrd Rule exceptions must be certified by the Senate Budget Committee Chairman (Mike Enzi, R-WY) and ranking minority member (Bernie Sanders, I-VT), as well as the Chairman and ranking minority member of the committee of jurisdiction.[8]

The so-called Byrd Bath cannot commence until after the Congressional Budget Office (CBO) releases its report on the final enrolled version of the House AHCA as passed, with amendments. As of yesterday afternoon the CBO issued its updated report. The first CBO report (with the Joint Committee on Taxation) on the AHCA concluded, on March 13, 2017 ("March CBO"), that AHCA would reduce federal deficits by a net of $150 billion in 2017-2016 due to new health coverage provisions. The March CBO report anticipated an increase of uninsured persons by 14 million in

[6] The jurisdictional rule is under Section 313(b)(1)(C) of the Congressional Budget Act of 1974, as amended. Section 313(b)(3) provides that a reconciliation bill will not be considered extraneous for jurisdictional purposes if the bill could be referred to such committee for special circumstances (e.g., for implementation or to create an exception).

[7] I heard at least one commentator describe this test as budget neutrality over the entire 10-year period that the Congressional Budget Office uses to review fiscal impacts for bills, which might be a reflection of the budget reconciliation instructions passed in January 2017.

[8] The US. House Committees with jurisdiction appear to be the (1) Energy and Commerce; and (2) Ways and Means. The U.S. Senate Committees with jurisdiction appear to be the (1) Health, Education, Labor and Pensions; and (2) Finance. The Chairman and ranking member of Senate Finance are Orrin Hatch (R-UT) and Ron Wyden (D-OR). The Chairman and ranking member of Senate Health and Eduction are Lamar Alexander (R-TN) and Patty Murray (D-WA).

2018, rising to 21 million in 2020, and 24 million by 2026. The March CBO report further found a 15-20 percent increase in average premiums in the individual policy market before 2020, with a subsequent decrease in average premiums to roughly 10 percent lower than under the current law by 2026. The new CBO report was issued on May 24, 2017 ("May CBO"). It anticipates a federal deficit reduction by a net of $119 billion in 2017-2016. The May CBO report anticipates an increase in uninsured persons by 14 million in 2018, rising to 19 million in 2020, and 23 million by 2026.

II. THE AMERICAN HEALTH CARE ACT OF 2017 – A SNAPSHOT AS OF MAY 25, 2017

As an employee benefits attorney with clients seeking clear guidance, I have been extremely reluctant to write about current trending issues for ACA repeal/replacement because speculation can be dangerous and efforts wasted on a bill that will ultimately change are counterproductive. However, it became apparent to me that some employee benefits attorneys are beginning to the sow the seeds of education about AHCA implications. I've decided those efforts are worthwhile because the activities of the coming months could transpire quickly and we need to be getting ready with our strategies. This next section will review some of the key implications of the AHCA.[9]

A. Essential Health Benefits

One goal of the ACA was to prevent insurance issuers and self-funded health plans from offering "skinny" plans that were less expensive but without meaningful health coverage. Essential Health Benefits were implemented to achieve that goal. Currently Essential Health Benefits (EHB) require that non-grandfathered plans cover: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care. Every state, including the District of Columbia, defines coverages for EHB based on a state benchmark plan. Self-funded plans nationwide have the ability to select any state EHB benchmark plan to use when defining coverage.[10]

The MacArthur Amendment to the current draft AHCA includes the ability of states to request a waiver of any of the 10 EHBs, after 2020. If a state requests a waiver, such waiver can be in place for a period of up to 10 years. The state waivers of EHB requirements are still being debated heavily. However, self-funded plans are paying close attention and

[9] Any terms that are capitalized in this Section have a very specific definition under either the ACA or the draft AHCA. The definitions can be found in the law and are beyond the scope of this newsletter.

[10] Self-funded plans are not required to offer coverage consistent with the EHB standards. However, if the self-funded health plan does offer coverage for an EHB item, then it is not allowed to place a dollar limit on the EHB covered and must offer the coverage consistent with a state EHB benchmark plan.

wondering if plan designs could include dollar limits, including lifetime limits, on EHB coverage items if the plan chooses a state EHB benchmark plan with EHB waivers.[11]

B. <u>Temporary 30% Surcharge</u>

The current draft AHCA allows insurance issuers[12] to impose a temporary 12-month surcharge in an amount that is equal to 30% of the monthly premium rate otherwise applicable if an individual has 63 continuous days without health coverage. An individual is required to demonstrate that s/he had creditable coverage without a continuous gap of coverage for 63-days. Although the gap (63 days) is similar to the HIPAA pre-existing condition exclusion framework, including creditable coverage certification rules that existed pre-ACA, the draft AHCA is focused more on the amount of premium that can be charged (rather than rendering the individual totally uninsured).

Employers are watching the surcharge debate to determine how much more reporting and disclosure obligations might be imposed if the AHCA passes, including how frequently creditable coverage assertions might be required.

C. <u>Large Employer Mandate and Penalties</u>

There are two different employer penalties that can apply to Applicable Large Employers (with 50 or more full-time employees or full-time equivalent employees, generally known as "large employers") under the ACA. First, a large employer must (1) sponsor an Eligible Plan; and (2) offer the plan to full-time employees and their dependents or else pay a penalty of roughly $2,000 per year per full-time employee.[13] Second, a large employer that offers an Eligible Plan to full-time employees and their dependents must also certify that the plan coverage (1) provides Minimum Value; and (2) is Affordable, or else pay a penalty of roughly $3,000 per year per full-time employee who seeks a an individual tax credit.[14]

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[11] The ability for self-funded plans to select any state EHB benchmark is written directly inside the ACA law, but more importantly, the concept is also described in the Preamble.

[12] The current draft AHCA has specific language for "insurance issuers" and the premium rates allowable. As of today, it appears that self-funded group health plans might not be able to use a temporary 30% surcharge. The MacArthur Amendment to the AHCA provides that states can apply for a waiver, beginning in 2019 (and 2018 special enrollment), and apply the 30% surcharge for individuals with a break in coverage of at least 63 days as well.

[13] IRC 4980H(a), indexed for inflation with $2,260 applicable for 2017, except that the penalty is calculated on a monthly basis rather than an annual basis and certain exceptions can apply regarding the percentage of people who receive an offer of coverage and for employees in a limited non-assessment period. Further, IRC 4980H penalties (both subpart (a) and (b)) only apply to the extent that an individual employee secures individual exchange insurance coverage and applies for an individual tax credit.

[14] IRC 4980H(b), indexed for inflation with $3,390 applicable for 2017, except that the penalty is calculated on a monthly basis rather than an annual basis, certain exceptions can apply for employees in a limited non-assessment period, and this penalty is limited to equal the IRC 4980H(a) if the 4980H(a) penalty is less.

The current draft of the AHCA reduces both of the large employer penalties described above down to zero, retroactively to all months beginning after December 31, 2015.[15]

As an advisor to many of the large employers in our region, we found that large employer penalties were usually avoided, resulting in zero or low costs for large employers' penalties. There were, however, very significant costs associated with reporting obligations for large employers, on IRS Forms 1094-C and 1095-C, the associated system upgrades for tracking employees and coverages offered, and any new contracts by large employers to outsource the reporting and tracking obligations. The current version AHCA does not eliminate any of the large employer tracking and reporting obligations.[16] We anticipate that large employers will be anxiously watching AHCA developments to understand whether reporting obligations and tracking obligations will be alleviated.[17]

We further anticipate that removal of future large employe penalties could motivate some employers to reassess how they define benefit-eligible individuals (e.g., whether to define full-time employees as those working 30 hours per week). However, certain eligibility standards will continue to apply (e.g., all employers, regardless of size, are subject to the strict limit for 90-day waiting periods).

D. Overall ACA Penalties for All Employers

All employers[18], regardless of size, are subject to an overall ACA penalty that can be assessed at a rate of $100 per day of non-compliance "with respect to each individual to whom such failure relates."[19] Non-compliance means any failure to comply with the laws governing group health plan requirements. The current draft of the AHCA does not address overall ACA penalties. We anticipate that employers will become more cognizant of the overall ACA penalties and we remind employers to continue to maintain compliance with group health plan laws.

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[15] We anticipate that some large employers that paid these penalties for 2016 offers of coverage will be quickly filing requests for refunds if the AHCA passes. See AHCA Section 206.

[16] IRC 6056. Since the reconciliation rules associated with Byrd Rule requirements might limit Congress' ability to change IRC 6056, there has been speculation about whether the reporting obligations could be addressed directly by the Secretary of Treasury.

[17] During informal comments by the IRS at the mid-year American Bar Association Tax Section meeting in Washington D.C., May 12, 2017, we were repeatedly told by the IRS to not read too much into the Presidential Executive Order from January 20, 2017, and that taxpayers should continue to file tax returns as they normally would. See also, IRS comments at https://www.irs.gov/tax-professionals/aca-information-center-for-tax-professionals, visited May 17, 2017.

[18] The overall ACA penalty applies to all employers except those offering "governmental plans." The overall ACA penalty applies to employers offering "church plans."

[19] IRC 4980D, subject to certain minimum and maximum excise tax thresholds.

E. Small Employer Tax Credits

Currently a small employer can receive a tax credit if it has (1) 25 or fewer full-time equivalent employees[20]; (2) average annual wages that do not exceed approximately $51,000, indexed; (3) payments by the employer at a uniform premium payment of not less than 50%; and (4) purchased a qualified health plan through the Small Business Health Options Program (SHOP) marketplace for small employers.

The current draft AHCA makes two changes for small employer tax credits. First, the tax credit will no longer be available for SHOP coverage that includes coverage for abortions.[21] Second, the tax credit will not apply after December 31, 2019.

The SHOP marketplace had one of the rockiest starts of all ACA-implemented items, at first crashing on the HealthCare.gov website and then only being available for the first 12 months if a small employer filed a paper copy application by mail. The topic of smooth SHOP enrollment procedures continues to garner attention. The U.S. Department of Health and Human Services, through its Centers for Medicare and Medicaid Services (CMS), recently issued a letter that proposes less use of the HealthCare.gov website and greater use of private brokers and insurance companies, targeting January 1, 2018 effective plans.[22]

F. Individual Mandate and Penalties

One of the hotly litigated issues surrounding the ACA was the individual mandate.[23] The individual mandate requires individuals to maintain Minimum Essential Coverage, for each month, for the individual and the individual's dependents. The penalty for noncompliance is either a percentage of the person's household income in excess of the return filing threshold [for 2017, 2.5% of income above the threshold[24]] or a flat dollar

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[20] Note that "full-time equivalent" employees for purposes of the small employer tax credit is defined very differently than full time equivalent employees for purposes of determining Applicable Large Employer status.

[21] See a later footnote regarding abortion coverage in the context of individual tax credits. The definition of abortion coverage is nuanced and continues to be the subject of debates. The apparent legislative intent is to follow the so-called Hyde Amendment, which bars use of federal funds to pay for certain types of abortions.

[22] CMS Letter, dated May 15, 2017, at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/The-Future-of-the-SHOP-CMS-Intends-to-Allow-Small-Businesses-in-SHOPs-Using-HealthCaregov-More-Flexibility-when-Enrolling-in-Healthcare-Coverage.pdf, visited May 18, 2017. Some news sources inaccurately reported the CMS Letter as though SHOPs were going to disappear altogether. CMS issued two additional letters during the week of May 15, 2017, which indicate an intent to structurally change HealthCare.gov for individual coverage as well.

[23] IRC 5000A.

[24] The applicable income filing threshold is based on filing status and age, ranging from gross income excesses of $10,350 up to $23,200.

amount [for 2017, $695 per adult or $347.50 per child, and $2,085 family maximum], whichever is greater.[25]

The current draft of the AHCA reduces the individual mandate penalty described above down to zero, retroactively to all months beginning after December 31, 2015.[26]

G. <u>Individual Tax Credits</u>

The ACA provides individuals with a refundable tax credit, also called a subsidy, in certain circumstances.[27] An individual is not eligible for the tax credit if he or she is eligible for Affordable, Minimum Value, employer sponsored health coverage. There are several tax credit requirements[28], but it generally applies on a sliding scale based on a household income range from 100% of the federal poverty line (full credit) to up to 400% of the federal poverty line (credit fully phased out). For one person in 2016, 400% of the federal poverty line was approximately $47,000 per year ($63,720 for a family of two). The credit itself is calculated based on the difference between the individual contribution and the premium.

The current draft of the AHCA makes several changes to the individual refundable tax credit. First, an individual is not eligible for the tax credit if he or she is eligible for any employer sponsored health coverage (eliminates Affordability and Minimum Value factors). Second, the sliding scale calculation for federal poverty line requirements will not apply for taxable years beginning after December 31, 2017 and before January 1, 2020. Instead, the tax credit will use a sliding scale based on modified adjusted gross income, phased out for income starting at over $75,000 for a person filing single.[29] Third, the credit will not be available if the individual exchange insurance policy includes coverage for abortions, for taxable years beginning after December 31, 2017.[30] Fourth, the credit is not determined based on actual premiums paid, it is a straight age-banded sliding scale.[31]

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[25] IRC 5000A(c). Total penalty is capped at the national average premium for a bronze level health plan available through the exchange.

[26] See AHCA Section 205. We anticipate that CPAs may experience an increase in filing amended Form 1040s for the 2016 taxable year for individuals who will be seeking a refund for penalties paid.

[27] IRC 36B.

[28] The tax credit is available for individuals that: (1) have a certain household income range; (2) do not file as Married Filing Separately; (3) cannot be claimed as a dependent by another person; (4) have health insurance from the individual exchange marketplace; (5) are not eligible for Medicaid, Medicare, CHIP, or TRICARE; and (6) pay a share of premiums not covered by an advance credit.

[29] See AHCA Section 215(c).

[30] The definition of abortion coverage has a nuanced background. Policies may cover abortions necessary to save the life of the mother or any abortion with respect to a pregnancy that is the result of an act of rape or incest. Further debates include concepts about "medically necessary" abortions versus "elective abortions" and the general notion that federal tax credits are not available for policies that cover elective abortion. Nothing prohibits an individual from securing separate abortion coverage, provided that no tax credit is offered for such separate coverage.

[31] See AHCA Section 215(c).

Fifth, the tax credit is available regardless of whether an individual purchases the insurance on the exchange.[32]

Here is a chart of the allowable credits, age-banded (age measured as of the beginning of the taxable year):

Age Band	**Credit (stated Annually; calculated Monthly)[33]**
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

Here are two example charts (one for single filing status and one for married filing status) of the modified adjusted gross income thresholds, phased out using different scenarios to illustrate age-banding and filing status:

MAGI	**Single, Age 29**	**Single, Age 61**	**Single, Age 35 with 2 Dependents**
$75,000	$2,000	$4,000	$6,500
$85,000	$1,000	$3,000	$5,500
$95,000	$0	$2,000	$4,500
$105,000	$0	$1,000	$3,500
$115,000	$0	$0	$2,500
$125,000	$0	$0	$1,500
$135,000	$0	$0	$500
$145,000	$0	$0	$0
$155,000	$0	$0	$0

[32] See AHCA Section 202(a)(1)(A). If there is no enticement (individual subsidy) to offer insurance policies on the individual exchange, many are wondering whether fewer insurance companies will offer exchange policies.

[33] The tax credit is further capped at a maximum annual amount of $14,000 and the maximum number of individuals to take into consideration are the five oldest individuals.

MAGI	Married, Both age 29	Married, Both age 61	Married, Both age 35, 2 Dependents
$150,000	$4,000	$8,000	$9,000
$160,000	$3,000	$7,000	$8,000
$170,000	$2,000	$6,000	$7,000
$180,000	$1,000	$5,000	$6,000
$190,000	$0	$4,000	$5,000
$200,000	$0	$3,000	$4,000
$210,000	$0	$2,000	$3,000
$220,000	$0	$1,000	$2,000
$230,000	$0	$0	$1,000
$240,000	$0	$0	$0

We anticipate that employers and employees alike will be watching AHCA carefully with respect to the reporting and certification obligations. The AHCA would require an employee to obtain a statement from his or her employer to determine whether the employee has been offered employer sponsored health coverage in connection with their employment.[34] Some professionals are wondering how often an employer might be required to make such statements and whether the obligation will be ongoing throughout the entire taxable year. In addition, there is a new proposed reporting obligation under the AHCA that would require employers to report on Form W-2 "each month with respect to which the employee is eligible" for employer sponsored health coverage.[35]

H. <u>Account-Based Health Benefits: HSAs, FSAs, HRAs</u>

Health Savings Accounts (HSAs) have several component features that could change under the current draft AHCA. Notably, the annual contribution limits are almost doubling and have been set to mimic the total annual out-of-pocket maximums that can apply to high deductible health plans. The AHCA further contemplates an account set-up grace period that would permit reimbursements with HSA dollars for expenses incurred

[34] See AHCA Section 215(b).

[35] Discussions are starting to surface about the implications for using Form W-2 rather than modifying the existing health coverage reporting on Forms 1094 and 1095. If the reporting remains on Form W-2, the codes could be fairly complicated in order to capture several variations of month-to-month coverage offers. If the reporting shifts to Forms 1094 and 1095, the employers who already invested significantly in resources and tracking to complete the original forms should anticipate substantial form changes.

during the initial 60 days of high deductible health plan coverage provided that the HSA is established within the 60-day period.

HSAs	**Current Law**	**Draft AHCA**
Annual Contribution Limit, Self-Only Coverage	$3,400, indexed	$6,650, indexed
Annual Contribution Limit, Family Coverage	$6,750, indexed	$13,300, indexed
Catch-Up Contributions	Only allowed for the account-holder	Allowed for both the account-holder and his/her spouse
Over-the-Counter Drugs	Only allowable if under a prescription (except insulin)	Allowable expense
Distribution Tax for Non-Medical Expenses	20% tax rate	10% tax rate (effective 2017)

Health Flexible Spending Arrangements (Health FSAs) would have at least two features from pre-ACA that might come back again:

FSAs	**Pre-ACA**	**Current Law**	**Draft AHCA**
Annual Contribution Limits	No limit	$2,500, indexed	No limit (after 12/31/2017)
Over-the-Counter Drugs	Allowable expense	Only allowable if under a prescription (except insulin)	Allowable expense

The ACA made several changes for Health Reimbursement Arrangements (HRAs), such as formally defining an HRA as a group health plan and correspondingly requiring an HRA be "integrated" with an employer sponsored health plan that satisfies the coverage mandates (e.g., first dollar preventive care coverage). The AHCA is silent regarding general HRA structure, which means it leaves HRA group health plan restrictions intact. For reimbursements, the AHCA proposes to allow all over-the-counter drug expenses for HRAs. Further, the 21st Century Cures Act (passed in December 2016) created a Small Employer Qualified HRA, or QSEHRA, that entitled small employers to a new tax credit. The current draft AHCA disallows QSEHRA tax credits if the plan pays for abortions, effective December 31, 2017.

I. Other Taxes and Credits

There are a few other taxes and credits that have been getting attention with the AHCA. Most of these are loosely considered negotiating items or issues that can be added or dropped to achieve budget neutrality.

1. COBRA Subsidies

The AHCA was originally proposed to include tax credits to pay for COBRA coverage that is unsubsidized. The COBRA subsidy language was removed in a subsequent manager's amendment to the AHCA, but it remains a negotiating chip for future discussions.

2. Age-Banded Rating Ratio

The AHCA includes a change to the allowable difference in age-banded rating. The ACA only allows a 3-to-1 (3:1) ratio difference between the premiums for the youngest person and the oldest person on a particular policy. The AHCA increases the age-band ratio to 5:1 for those states that request the increased ratio, for plan years beginning on or after January 1, 2018.[36]

3. Cadillac Tax Delay

The largely unpopular ACA Cadillac Tax[37] is currently under a temporary delay. It is no surprise that the AHCA also delays the Cadillac Tax, to January 1, 2025.[38] There seems to be support on both sides of the aisle for some type of delay with the Cadillac Tax, but not complete repeal, because it continues to play a role in balancing out the 10-year budget neutrality goal.

4. Net Investment Income Tax

As of January 1, 2013, the ACA includes a 3.8% tax on net investment income items for individuals with modified adjusted gross income above $250,000 (married filing jointly). The taxed items include interest, dividends, capital gains, rental income, royalty income, and certain passive activities. The current proposed AHCA repeals net investment income tax, effective for taxable years beginning after December 31, 2016.[39]

[36] See AHCA Section 135.

[37] Cadillac Tax, as originally set forth under the ACA, would impose a 40% excise tax on the value of employer sponsored plans exceeding $10,200 for individuals and $27,500 for family coverage, indexed for inflation.

[38] See AHCA Section 207.

[39] See AHCA Section 251, see also manager's amendment for new effective date.

5. Health Insurance Tax

The ACA includes a health insurance tax (HIT), calculated based on a health plan's gross premiums over $25 million. The current proposed AHCA repeals HIT, effective for calendar years beginning on January 1, 2017.[40]

6. Medical Device Tax

The ACA includes a 2.3% tax on the sale of medical devices. The current proposed AHCA repeals the medical device tax, effective for sales after December 31, 2017.[41]

7. Medicare Additional Tax

As of December 31, 2012, the ACA includes an additional Medicare tax of 0.9%, assessed on taxable earned income in excess of $250,000 (married filing jointly). Technically, the medicare portion of payroll taxes has historically been established at a rate of 1.45%. The ACA change implemented a rate of 2.35% for high income earners. The draft proposed AHCA reverts medicare taxes back to pre-ACA status, at just 1.45% for all income earners, effective for taxable years beginning after December 31, 2017.[42]

8. Individual, Itemized Medical Expenses

Individuals who qualify for federal income tax itemized deductions have historically been required to satisfy a floor of 7.5% of a person's modified adjusted gross income before being entitled to itemized deductions for medical expenses paid out of pocket. Effective as of January 1, 2013, the ACA changed the itemized medical expense floor to 10% of a person's modified adjusted gross income. The current draft AHCA, through a manager's amendment, includes a change to the itemized medical expense floor to 5.8%, for taxable years beginning after December 31, 2016.[43]

III. Conclusions

A few disclaimers are in order. This newsletter is not meant to be all-inclusive of the AHCA provisions. Most of the analysis is focused on the employer's obligations as a plan sponsor. Further, I have purposefully left out the discussion about Medicare. No doubt, the AHCA makes significant changes to Medicare provisions, but it is also one of the most hotly debated topics under the AHCA that could see equally significant changes during the Senate process. The AHCA state stability fund grants are one other item missing from this newsletter. Those grants attempt to address potential state waivers of EHBs and risks associated with high health cost individuals. A better discussion of the state stability grants and high cost health care can be found in the May CBO report. Finally, this newsletter is merely a snapshot in time and many of the AHCA provisions are anticipated to change over the coming weeks and months.

[40] See AHCA Section 222, see also manager's amendment for new effective date.

[41] See AHCA Section 211.

[42] See AHCA Section 214.

[43] See AHCA manager's amendment #5.

For More Information

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If you require assistance with a particular employee benefit matter, or have questions or comments regarding this newsletter, please contact one of the attorneys listed below.

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